

FROM HOPELESSNESS TO ACTION: MOVING ADDICTS INTO RECOVERY

We need 'saltation' – a successful leap to the major recovery league, a single mutation which dramatically alters the treatment phenotype, both a quantum jump and a series of rhythmical steps in time.

Deirdre Boyd lists system blocks to the country's recovery – and 'saltations'.



In June, prime minister David Cameron stated that “First, there is a problem in our national health service, in that we spend too much time treating the symptoms rather than necessarily dealing with the causes... Second, all addictions need proper attention, and proper treatment and therapy, to rid people of their addictions, whatever they happen to be.”

In July, he added that “We've got to get rid of the centralised bureaucracy that wastes money and undermines morale... If you've got an idea to make life better, don't just think about it – tell us what you want to do and we will try and give you the tools to make this happen”.

So let's outline some factors which stop people getting “proper attention and proper treatment and therapy” to rid them of their addictions. Then let's look at broad policy proposals down to a simple suggestion from *Addiction Today* to add to the jigsaw of recovery solutions.

BLOCKS IN THE CURRENT SYSTEM.

For 21 years, the Addiction Recovery Foundation charity – mainly via *Addiction Today* – has been identifying ways to recover from addiction/dependency and sharing best practice. In more recent years, we have questioned why ‘problematic drug users’ have not been given fair opportunities for recovery: less than 4% of people who turn to statutory services for help to quit drugs actually get a referral to ‘rehab’: rehab/quasi-residential/daycare programmes with a record of creating sustainable recovery (see glossary on page 17).

Hansard, which prints all MPs' speeches in the House of Commons, reported a comment in July by David Burrowes which encapsulates the chaos of the UK's addiction-treatment system. “The annual report of the National Treatment Agency for Substance Misuse, which was presented to the House... is in stark contrast with the 30th report of the Public Accounts Committee in March, which concluded that £1.2billion is spent on tackling drug misuse without the government knowing the overall effect of that approach.”

If we do get a new drugs policy aiming to get people off drugs and positively transforming their lives, how can it be implemented?

ABOLISH THE NTA.

The National Treatment Agency for Substance Misuse has been recognised as the biggest block to getting this country into recovery – *Addiction Today* was perhaps the first to publicly call for it to be abolished, after attempts to negotiate failed. In July came the first saltation: health secretary Andrew Lansley abolished the NTA.

PROTECTIONISM, OVERPRESCRIBING & LACK OF SOCIAL INPUT IN THE NHS.

The NHS has become more not less protectionist, keeping patients within its own control rather than referring them to more clinically-effective and cost-effective rehabilitation specialists. For example, although the NTA trumpets Liverpool as the “city of recovery”, Mersey Care NHS Trust has placed few patients with Sharp or Park View Project, local organisations which enable drug-free goals. Also, Nottinghamshire County Primary Care Trust decommissioned both day and residential services helping people to quit drugs – quoting as justification an out-of-context sentence from the NTA *Effectiveness Review*.

Add to this a NHS culture of overprescribing addictive legal drugs, and lack of integration with, for example, employment and crime, from funding to outcome measures. It all points to the necessity of sharing responsibility and power for addiction treatment between not merely the DoH via the NTA but also the Home Office, the Ministry of Justice and Department of Work and Pensions. This leads us to the next saltation...

ADDICTION RECOVERY BOARD.

At ARF's UK/European Symposium on Addictive Disorders in 2009, the idea of an Addiction Recovery Board to replace the NTA was floated to delegates in a policies workshop. It could create policy, manage finance: performance more simply

than the current system with less but more key outcome measures, and have a carrot-and-stick inspection system. Also, there is an acute need for more rehab places, which will require higher standards of training across the workforce, which could also come under the remit of an ARB.

The most popular recommendations for an ARB are that it must be less bureaucratic than the NTA, be more transparent and accountable, be able to influence budgets – and run alongside a ‘grievance system’ so that poor commissioning can be exposed and troubleshooting teams sent in to correct it without the current punitive backlashes on providers or patients who make legitimate complaints. Given the number of reports to *Addiction Today*, this will have to be clear, robust and staffed asap!

The ARB should be backed up by a cross-ministerial committee/council which can feed information to and from ministers in relevant departments such as Health, Home Office, Ministry of Justice, Work & Pensions – even Education, Family, Treasury and Cabinet.

TREAT ALCOHOL AND ALL DRUGS.

Combining policy and funding for both drugs and alcohol treatment should remove artificial barriers and duplicated bureaucracies. Treatment should be offered to people who have problems with any psychoactive addictive drug. Given the proliferation of polydrug use, this also opens the door to tackle cross-addiction, leading to long-term sustainable independence.

GREATER NUMBERS NEED HELP.

The NTA quotes 330,000 problematic drug users needing help – but its definition covers only heroin and crack cocaine. Add in powder cocaine, marijuana, ketamine, ecstasy, amphetamines and other mind-altering drugs, as well as methadone addiction, and the numbers needing help are recognised as much larger. They will be multiplied when/if people dependent on alcohol and legal drugs such as benzodiazepines are also helped.

THE 'SALTATION' WEEK

Sequence: Patient Placement Criteria*, followed by Saltation Week, then Patient Placement Criteria to select appropriate treatment
 New policy: system infrastructure must allow onward referral; commissioning divide between tiers 2/3/4 to be addressed.
 Followup reviews using Alcohol Concern's Star Outcomes developed for all substances.

Therapeutic sessions must be facilitated by a psychotherapist/counsellor familiar with and supportive of Prochaska & DiClemente's Stages of Change, Maslow's hierarchies of need, and 12-step programmes.

Motivational enhancement and cognitive behavioural techniques are useful

MONDAY

INTRODUCTIONS:

- why are we (clients in peer group) here?

CENAPS PRETREATMENT:

- What are current problems? Identify life dreams vs reality
- Given diaries. Assignment is to list barriers to dreams; diary actions/feelings until tomorrow.

UNDERSTANDING DRUGS/ALCOHOL & PHYSIOLOGY:

- the body group
- how substance use affects children/future children
- repairing the body in recovery: nutrition, neural pathways

TUESDAY

WELCOME/CHECK-IN:

- current feelings
- Diaries, linking to...

CENAPS PRETREATMENT:

- Identify causes of life problems already listed (realise it is drugs/alcohol?)
- Homework: how to solve

UNDERSTANDING DRUG/ALCOHOL DEPENDENCY:

- watch DVD on the neuroscience of addiction, *Pleasure Unwoven*, recommended by Bill White
- discussion of DVD
- identification with elements of the DVD – dependency vs misuse

WEDNESDAY

WELCOME/CHECK-IN:

- current feelings
- Diaries, linking to...

CENAPS PRETREATMENT:

- Link life problems to drugs/ alcohol, identify goals, wants
- Identify if willing to cut down or cut out substances

UNDERSTANDING THE NEED TO CHANGE:

- drink/drug balance sheet
- change plan sheets
- Stages of change
- Itep psychosocial manual can be used for exercises and assignments related to these and the next days' sessions

THURSDAY

WELCOME/CHECK-IN:

- current feelings
- Diaries, linking to...

CENAPS PRETREATMENT:

- Results of past 24 hours cutting down or cutting out substances
- Easy or difficult? Dependent or misuser?
- Identify if more help necessary

GOALS:

- goal sheet
- road blocks & detours
- high-risk situations
- realistic goals
- repairing the body (update)

FRIDAY

WELCOME/CHECK-IN:

- current feelings
- Diaries, linking to...

CENAPS PRETREATMENT:

- Identify necessary help

MASLOW, STAGES OF CHANGE:

- Do participants need/want:
- no further help
 - AA/NA alone...
 - ... or alongside therapeutic peer groups weekly/daily
 - maintain on a script
 - quasi/residential rehab
 - abstinence daycare
 - other (identify)

FEELINGS:

- Grief/goodbyes, hope

The Saltation Week to be held in a room easily visible to patients in detox or on maintenance drugs, so viewing role models/peers motivates them to enrol

The above sessions occupy only half a day, so providers can run one group in the morning and another in the afternoon.

If more structured time is required for participants, the day can be filled with activities ranging from meditation to literacy lessons, from individual or family therapy to financial/legal/resettlement advice identified from the above sessions as necessary to move forward.

ARE THERE ENOUGH REHAB PLACES?

If there are more patients to treat, alongside a move for more patients to be placed in rehabs – residential, quasi-residential or daycare – are there enough places? It is estimated that there might be only about 1,500 residential beds left – and that is available over the year as clients come and go, not at any one time (as a guide, count beds in the Directory at the back of *Addiction Today*).

DRUG/ALCOHOL ACTION TEAMS.

Most D/AAATS spend too much of the treatment resources on their own bureaucracy. And, as financial power sits with Primary Care Trusts, commissioning decisions are dominated by the NHS – a major factor in overprescribing.

Local commissioners must be free of central bureaucracy, but there must also be safeguards against creating local bureaucracy.

Perhaps responsibility for receiving funds and coordinating local partnerships should rest with local authorities? LAs are the only local public bodies with responsibility across the social policy agenda, and should not have an interest in directing resources into their own structures.

UNBALANCED CONTRACT BIDDING.

Harm reduction has a role alongside treatment, but not as a substitute for it. Tier 2/3 organisations offer lower-level services from advice to harm reduction, sometimes therapy – not rehabilitation. But 96-98% of those seeking help to quit drugs are referred to harm-reduction services. When treatment budgets are diverted here, that should be clearly stated: they have different outcomes.

Some tier 2/3 organisations get over 90% of their income from our taxes, via the statutory system. Indeed, just two of these organisations can

account for over £100million of our taxes a year. For this, up to 25,000 people could have been treated to rehab annually and be working towards lives independent of drugs and of the state and of our taxes. But the budget for the whole country refers only a third of that number to rehab.

This is a hugely imbalanced system. And those who received such largesse since the NTA was created in 2001 are determined to protect it.

PAYMENT BY RESULTS – IF YOU SURVIVE.

Payment by results, or PbR, sounds fair in theory – but risks becoming the most inequitable tool in the new drugs policy. Let's leave the measures of success – the choosing of which results matter – to one side, as these are being worked on by many groups. It has been suggested that PbR will mean no payment until after results are evidenced – perhaps up to a year later. The small quality rehabs



and their like survive on meagre budgets, powered by vocation more than profit. They could not survive six months, far less a year, paying without real-time reimbursement for patients to get well. Only the largest tier 2/3 players enriched in the past decade have the financial reserves.

“It is anxiety provoking to see the potential for vested interests to corner the pooled treatment budget into their own pockets and pretend that the drug problem will be solved by their organisations alone,” one commissioner explained.

“As placements are funded out of social care monies, it will let LAs off the hook and they will bail out of treatment as soon as possible. Payment by results will see off the small independents. Then prices will rise, competition reduce and some ‘one size fits all’ county providers will do for the rest. If the coalition rows back from an integrated locally determined approach, then we’ll be back right where we are, or worse.”

DEMORALISED STAFF

While rehab staff are under financial pressure due to lack of referrals from the unbalanced treatment system, NHS and other tier 2/3 providers are demoralised due to not seeing clients recover – too many drug workers say they have never seen addicts quit. This has an exponential effect in that, as Project Match proved, more people get better when their therapists believe they will.

A PIECE IN THE JIGSAW OF SOLUTIONS: THE ‘SALTATION’ WEEK.

So here’s another *Addiction Today* “idea to make life better”, as Cameron phrased it. It started when Dr Francis Keaney, vice chair of the Royal College of Psychiatrists and senior lecturer at King’s College London, and Dr Alison Battersby, research secretary and recovery lead of the RCPsych and consultant psychiatrist in Plymouth addiction services, asked how tier-2/3 services could move clients into recovery – and in the face of budget cuts. This was a time period that we had not previously looked at in depth to identify and

THERAPIES BEHIND THE SALTATION WEEK

- Patient Placement Criteria: overview, links www.addictiontoday.org/addictiontoday/2010/06/appropriate-treatment-patient-placement-criteria.html
- Stages of Change: overview, links www.addictiontoday.org/addictiontoday/2010/07/stages-of-change-carlo-diclemente.html
- Maslow’s hierarchies of need, recovery context+
- Tammy Bell pretreatment programme: www.amazon.com/dp/1450562736
- Itep psychosocial manual: www.nta.nhs.uk/uploads/itep_routes_to_recovery_part2_180209.pdf
- Nutrition, repairing the body in recovery: www.addictiontoday.org/addictiontoday/2010/07/nutrition-repair-your-body-in-recovery.html
- Neuroscience of addiction DVD: www.instituteforaddictionstudy.com/
- Star Outcomes: www.alcoholconcern.org.uk



share best practice: a period before people reach rehabilitation services, when many staff have given up on drug users’ ability to change.

It was a welcome challenge, showing a shift in thinking towards recovery and collaboration. The idea of a ‘saltation’ week developed from there.

Benefits of the saltation week are as follows.

- Participants get a thorough assessment – in what other health field are patients given a course of ‘treatment’ without a diagnosis?
- Assessment and consequent referrals are seen to be transparent, removing heated debates about whether tier 2/3/4/other are appropriate.
- Appropriate assessment, particularly with ASAM patient placement criteria at the end of the week, will identify who can get into recovery with less intensive, less expensive services – without clinical compromise; it is cost- and clinically-effective.
- The saltation week is a ‘brief’ intervention –

yet offers clients more therapy in a week than they currently get in a year on methadone maintenance (see research by David Best).

- It will propel clients through stages of change, from precontemplation to readiness for action, through Maslow’s hierarchies of need to safety and a sense of belonging; these not only motivate clients into recovery and related services but also reduce dropouts, so services give greater value.
- If there is a sudden demand for rehab, there might not be enough capacity – so the saltation week will act as a filter, a funnel.
- For some patients, this intervention might be enough in itself, with no need for more services.
- It will also act as a pretreatment week for patients on waiting lists due to lack of capacity, holding participants safely while they await treatment.
- Ideally, the saltation weeks should be run by people with no financial interest in organisations to which participants might be referred. This could be within the NHS – it might be easier to let go of protectionism if so – run by people such as Keaney and Battersby.

● On the other hand, if we are not to abolish tier 2/3 services, they could, with a few expert professionals, run such saltation weeks, adding capacity and enhancing services; referrals at the end of the week will need to be independent.

- If this week were incorporated in tier 2/3 services, it would increase throughput of patients at lower cost – and lead to recovery not same patients maintained on scripts the following year.
- Just as crucial is staff morale: witnessing positive results of their own work will boost motivation.
- Payment-by-results: results can be validated as soon as the saltation week is completed.

Turn the page for details of therapies behind the week, and results of a similar week trialled by Nottingham Community Alcohol Services.

MORE INFORMATION.

www.addictiontoday.org/addictiontoday/2010/08/hopelessness-to-saltation-move-addicts-into-recovery.html

Images: Scott Maxwell, Piccaya, JBS