

GOVERNMENTS, POLICIES AND MANIFESTOS

“Government policies can improve drug problems – or worsen them,” White House drugs adviser Keith Humphreys succinctly noted. As Obama releases his first US drugs policy, and three contenders for the next UK government publish their manifestos, it is timely for Deirdre Boyd to identify key goals and outcomes with him and outgoing deputy drug czar Tom McLellan.

US DRUGS BUDGET 2011

The US *National Drug Control Budget* for 2011 requested \$15.5 billion to reduce drug use and its consequences, a rise of \$521.1 million on 2010. The resources are for five major functions:

- substance abuse prevention – \$1.7 billion supports education and outreach programmes aimed at preventing initiation of drug use
- substance abuse treatment – \$3.9 billion for early drugs intervention and treatment services
- domestic law enforcement – \$3.9 billion for the Departments of Justice, Homeland Security and Treasury, supported by the National Guard
- interdiction – \$3.7 billion to interrupt trafficking of illicit drugs into the US
- international support – \$2.3 billion mainly for Columbia, Africa and central Asia, to disrupt drug organisations and assist partner nations.

IRISH DRUG POLICY

For comparison, let's look at the UK's nearest neighbour. What is noticeable in the Republic of Ireland's drug policy 2009-2016 is the open differentiation between “treatment” and “rehabilitation”. It is based on five pillars:

- substance abuse prevention – key performance indicators include delaying the age of first use of alcohol and illegal drugs
- substance abuse treatment and...
- ...rehabilitation – key performance indicators of treatment and rehabilitation by 2012 include “100% of problem drugs users accessing treatment within one month of assessment” and “within one week” for those aged under 18 years, 25% increase in residential rehabilitation places based on 2008 figures; 25% increase in treating hepatitis C cases among drug users, and a treatment referral option for people who come to the attention of police and probation
- supply reduction
- research, mainly data collection.

US PRIORITIES 2010

The first drug policy from President Barack Obama's administration looks at five priorities:

- a national substance abuse prevention system – “the time is right,” explains McLellan, “as we now have a large evidence base to build on”
- engage primary care
- close the addiction-treatment gap
- special cases for offenders
- improve related data systems.

DEFINITION OF RECOVERY

“A voluntarily maintained lifestyle characterised by sobriety, personal health and citizenship...
...with or without medications”

As Addiction Today went to press in April, the US drug policy had not yet been released – but we give you a preview of its content. This is informed by insights from Tom McLellan and Keith Humphreys, who had a series of meetings with Addiction Recovery Foundation CEO Deirdre Boyd in London.

Keith Humphreys PhD joined the White House Office of National Drug Control Policy as the senior policy adviser to the deputy director, working to integrate scientific information into policy. He was professor (research) of psychiatry and behavioural sciences at Stanford School of Medicine.

A Thomas McLellan PhD stands down in June as deputy director of ONDCP, after assisting the formulation and implementation of the US *National Drug Control Strategy*. He has worked for over 35 years in addiction treatment research, most recently at the Treatment Research Institute, a non-profit organisation he cofounded in 1992. He has published over 400 articles on addiction research.

In May, the next UK government will start to draw up a national drug policy, drawing on proposals submitted to it by a range of think tanks and stakeholders. Across the Atlantic, the first US drug policy under president Barack Obama has been prepared – ready for publication, it was delayed by Obama's release of controversial healthcare reforms. So is there anything new? And are there ideas worth adopting here?

“There are at least two significant changes from the Bush administration,” McLellan and Humphreys revealed.

“For the first time, the White House has an office for recovery [from substance abuse/dependency]. And this year's drug policy will for the first time have a chapter on recovery.”

One indicator of changing priorities is that, when McLellan visited London this spring, he was on his way to Vienna to represent the US at the 53rd Commission on Narcotic Drugs – the first demand-reduction representative to do so. Usually, all the representatives are from law enforcement.

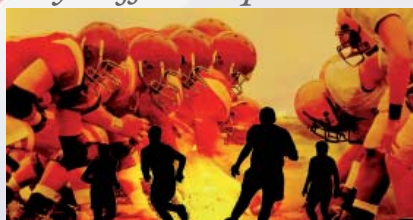
“Historically, 70% of funding has been for law enforcement and 30% for prevention and treatment. We hope to move demand-side budgets up to the level as supply-side,” he said.

“There is a pronounced change of policy,” Humphreys stressed. “The Bush administration policy was based solely on number of drug users – irrespective of severity of use or intensity of treatment. But chronic heavy users must have different treatment statistics.”

This is particularly relevant to the UK, where statistics do not differentiate between lighter users – who might need merely a brief intervention – and people who are chronically dependent. Rehabs and 12-step linked organisations have tended to treat the latter but this is not counted by government/NTA measurement tools.

“Aids was not included before,” Humphreys continued. “Drug driving and motor safety are also a new inclusion. And there is a chapter on data science.”

“Methadone in the US and in the UK is like football in the US and UK: very different practices.”



President Barack Obama had tasked the ONDCP to get out and meet agencies across the US before drawing up the drugs policy. Over 150 members of 34 federal departments and agencies participated in subcommittees to help formulate long-term policy goals for preventing and treating substance abuse, and input into budget guidance. They returned with the following priorities:

- create a national prevention system
- integrate prevention and care of substance use disorders into mainstream healthcare
- improve and expand evidence-based ‘specialty care’ for addiction
- create safe, coordinated managing/monitoring paradigms for drug-involved offenders, and
- a permanent performance monitoring system.

“There will be a focus on prevention, early interventions, treatment and crime,” Humphreys and McLellan confirmed. “And we will use law enforcement differently... The three things which science has shown to work are prevention, treatment and enforcement.”

“For instance, research now shows us that addiction has an ‘at risk’ period. Prevention should be done throughout that period, not merely once or twice.

“Also, risks have common antecedents so single interventions can have multiple effects. We, and patients, do not need 164 different interventions – which is why we do not need 164 types of grants. We must simplify that.

“We need a few, as we also know that combined interventions give enhanced impact.”

Early screening goes hand in hand with cultivating “prevention prepared” communities, with particular focus on adolescence. “If people do not develop a disorder by the age of 21, they have a low chance of developing one,” McLellan explained. “If this risk period was identified for diabetes, they would address it; we must change the way we deliver addiction prevention services. And if we cannot prevent or intervene, let’s treat.

“The relapse rates for diabetes, hypertension and asthma are almost identical to the relapse rates

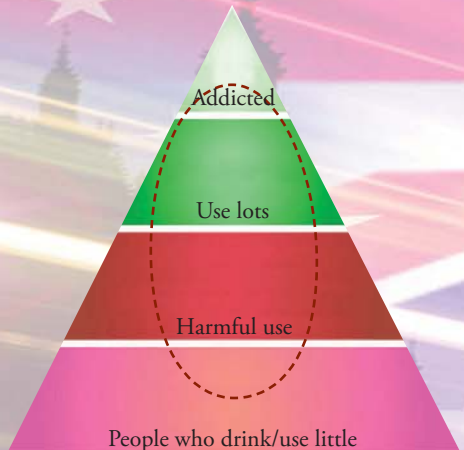
for any addictive disorder – 50% per year. But when diabetics relapse, they are treated. Now it is time to close the gap between those who qualify for treatment and those who are not getting it.”

Mainstream primary healthcare should be at the centre of this, requiring culture change. “Most doctors are not trained in how to treat substance misuse – they do not see it as a disease/disorder.” Integrating addiction services into mainstream healthcare stretches from early screening through to an active role in their patients’ recovery.

The need for different types of prevention and treatment priorities, and the numbers of people who can benefit from them – and thus the need for different performance measures – can be illustrated in the triangle below. At the bottom of the triangle are people who drink little; here the focus is on prevention.

Just above that is harmful use of substances, estimated to affect 68million people; here the focus is on early intervention.

Above that are an estimated 25million people who use a lot; the focus is on treatment. And at the top are people receiving treatment of some sort; this is estimated to be 2.3million people. The oval represents people presenting for help, who can be from across all levels.



“It is good business for addiction treatment programmes to cultivate medical referrals and work/support doctors as they begin a difficult job,” recommend McLellan and Humphreys.

Both see the addiction treatment field as a business – with customers. “The most important is the patient. But there are others such as referrers. They want satisfactory products: outcomes.”

What do they see as official outcomes: “Reduction of use, definitely. Abstinence, ideally. Integration is key. Employment is another goal for outcomes. We want to reduce crime; there are many referrals from courts and the criminal justice system. Families want an end to embarrassment and drunken violence.

“These are outcomes because, regardless of how they are attained, they are good things to achieve... During the course of treatment is a good time to mention outcomes. People can strive for them while in treatment. That is useful for patients, for therapists, coaches, AA sponsors.

“Not getting this right has resulted in the production and use of unnecessary resources as shown, for example, in getting referrals back from emergency room and trauma admissions.

To produce those outcomes, guidelines should be offered and applied from as soon as people are assisted. This could start with something as simple as early identification, screening before intervention. That will work for some people.

“For people with more severe problems, there are about 15 evidence-based therapies,” McLellan said. “Evidence-based means independent evidence in controlled trials. Some medications appear to help. It is not about one method over another, but good versus bad practice.

“It is good to measure patients and outcomes monthly; it also proves demand from the start.

“The worst thing is to automatically give someone methadone without going through the screening, identification and brief interventions process. If people become stable, create healthy relationships, find employment, that would be fine – but that rarely happens. So we must review

patients regularly – for example, a month later.

“Urine samples should be taken to confirm self reports. If they are positive, the professionals can follow through by saying something on the lines of: “You are drinking/using, your family is not happy, etc. So take counselling. Perhaps you need to be re-evaluated for other problems”.

The therapeutic goal is to move people towards those outcomes. Should we have different lists of outcomes for different people? “That is a conversation,” responded Humphreys and McLellan. “But certainly we should go for reduction with a goal of complete abstinence.

“Residential care is important and necessary, but follow-up and an aftercare plan are equally as necessary to sustain the work started in rehab. There is a long way to go to re-educate commissioners in this way of thinking.

“In the US, we were thinking about addiction as just a lot of drug use, so we have been purchasing stupidly. Commissioners claim to purchase a continuum of care: ‘we purchase detox from him, we purchase residential care from him, and we get outpatient care from him’. The problem is that there are no clear relationships here. I want to say ‘I won’t buy from anybody until you show me a package that’s going to meet their needs’.

“People receiving care in the public sector do not have much choice; it is the opposite to business. One way to give them choice is through vouchers for recovery which must be spent in the treatment centre or a support service. Clients become the purchasers. Trials show that those given vouchers are more likely to be clean and sober. They give patients more control, giving better outcomes. They vote with their feet.”

MEET THE POLICY SHAPERS!

Professor Keith Humphreys will speak at UKESAD. David Burrowes and James Brokenshire will also be offering insights into future policy affecting readers. More details in programme at www.ukesad.org.

Images: Devation-nl, Oscity, KisDesign, Laurin Rinder, Kheng Guan Toh

MANIFESTOS FOR THE FUTURE?

Below is everything we could find – unedited by *Addiction Today* – in the manifestos of the three main political parties about prevention & treatment of substance abuse and addiction*.

LABOUR PARTY MANIFESTO

“Alcohol treatment places will be trebled to cover all persistent criminals where alcohol is identified as a cause of their crimes...

On drugs, our message is clear: we will not tolerate illegal drug use. We have reclassified cannabis to Class B and banned ‘legal highs’. More addicts are being treated, with a higher proportion going on to drug-free lives.

We will switch investment towards those programmes that are shown to sustain drug-free lives and reduce crime.”

LIBERAL DEMOCRAT MANIFESTO

“Ensure that financial resources, and police and court time, are not wasted on the unnecessary prosecution and imprisonment of drug users and addicts; the focus instead should be on getting addicts the treatment they need. Police should concentrate their efforts on organised drug pushers and gangs.

Always base drugs policy on independent scientific advice, including making the Advisory Council on the Misuse of Drugs completely independent of government...

Move offenders who are drug addicts or mentally ill into more appropriate secure accommodation...

Clamp down on anyone who is aggressive or abusive to staff in accident and emergency departments. We would encourage better working relationships between hospitals and the local police to provide an increased police presence at times of high risk, and increase prosecutions. At the same time, we will ensure that problem drinkers or substance abusers are referred for appropriate treatment.”

CONSERVATIVE PARTY MANIFESTO

“At the moment, many prisoners leave jail and lapse back into a life of drink, drugs and re-offending. We will never bring our crime rate down or start to reduce the costs of crime until we properly rehabilitate ex-prisoners. So, with a Conservative government, when offenders leave prison, they will be trained and rehabilitated by private and voluntary sector providers, under supervision.

We will use the same approach that lies behind our welfare reform plans – payment by results – to cut re-offending, with organisations paid using savings made in the criminal justice system from the resulting lower levels of crime...

Drug and alcohol addiction are behind many of the crimes committed on our streets, but the treatment that too many addicts receive just maintains their habits.

We will give courts the power to use abstinence-based Drug Rehabilitation Orders to help offenders kick drugs once and for all. We will introduce a system of temporary bans on new ‘legal highs’ while health issues are considered by independent experts.

To reform our system of rehabilitation further, we will:

- apply our payment by results reforms to the youth justice system;
- engage with specialist organisations to provide education, mentoring and drug rehabilitation programmes to help young offenders go straight
- pilot a scheme to create Prison and Rehabilitation Trusts so that just one organisation is responsible for helping to stop a criminal re-offending.”

* We omitted general remarks re alcohol pricing. Also, there were general commitments to NHS patients being diagnosed and treated on time; perhaps this could be applied to drugs/alcohol.