

THE REAL REHAB REVOLUTION

“Drug free” is formally defined in government statistics as being on drugs, rehabs again face closure, redundancies are a reality, and the better NHS drug/alcohol services are being shut down. Patients, their families and society all lose. Rehabs have united in rebellion, to rescue the drug strategy – but will it be enough? Implementation remains with the previous regime’s architects and apparatchiks of failure who maintain symptoms. Deirdre Boyd reports

The real rehab revolution arose in January with a blog which became the subject of other blogs, followed by a declaration signed by an unprecedented union of half of England’s rehabs, organisations which have thousands of years’ experience between them in getting addicts drug free, as research demonstrates they want but have been denied with consequent loss of life.

The blog was the latest *Addiction Today* exposé of how, with the coalition government’s first drug strategy – *Reducing demand, restricting supply, building recovery: supporting people to live a drug-free life* – not even a month old, the Department of Health/National Treatment Agency for Substance Misuse rushed to incapacitate prime minister David Cameron’s vision of “supporting people to live a drug-free life”, indicated in the strategy’s title and which “is at the heart of our recovery ambition”. Every sentence in the blogs I research can be evidenced

with written proof, but might have appeared weaker because I had to anonymise sources of information due to the “punitive reprisals” they feared from the NTA by way of lost jobs, lost client referrals and revenue to their rehabs or lost grants which it was given power to influence.

This time, for the first time, CEOs of half the rehabs in the country publicly signed their names and added comments to the blog (read some of these on page 26 and at www.addictiontoday.org/addictiontoday/2011/01/camersons-drug-strategy-nobbled-at-starting-gate.html).

The rehabs then came together as one to work on applying to participate in the “payment by results pathfinders” which the strategy intended to be templates for the country’s recovery from drugs and all their attendant problems. With their long and successful track records of getting patients off drugs, it seemed logical that they would be consulted – or even just included – in the plans. Instead, the rehabs had individually found themselves excluded from the process, disqualified from participation despite public statements by those in charge to the contrary (see p26).

This bonding or concordat of half the country’s rehabs offered between them the seamless path of care desired in the drug strategy. With a unified core treatment ethos, the abstinence-based full-recovery treatment providers, delivering over 849 treatment beds at any moment in time nationwide, offered a solution focused on full abstinence recovery, using existing inpatient and outpatient detoxification, quasi-residential rehabilitation, residential rehab, daycare and genuine community rehabilitation programmes, offering first-, second- and third-stage care so that addicts can move from detox through a choice of proven treatments through to reintegrating drug free and with new life skills into the community. These programmes are already linked to some of the most effective recovery communities where people have been connected to housing, employment and wellbeing for decades.

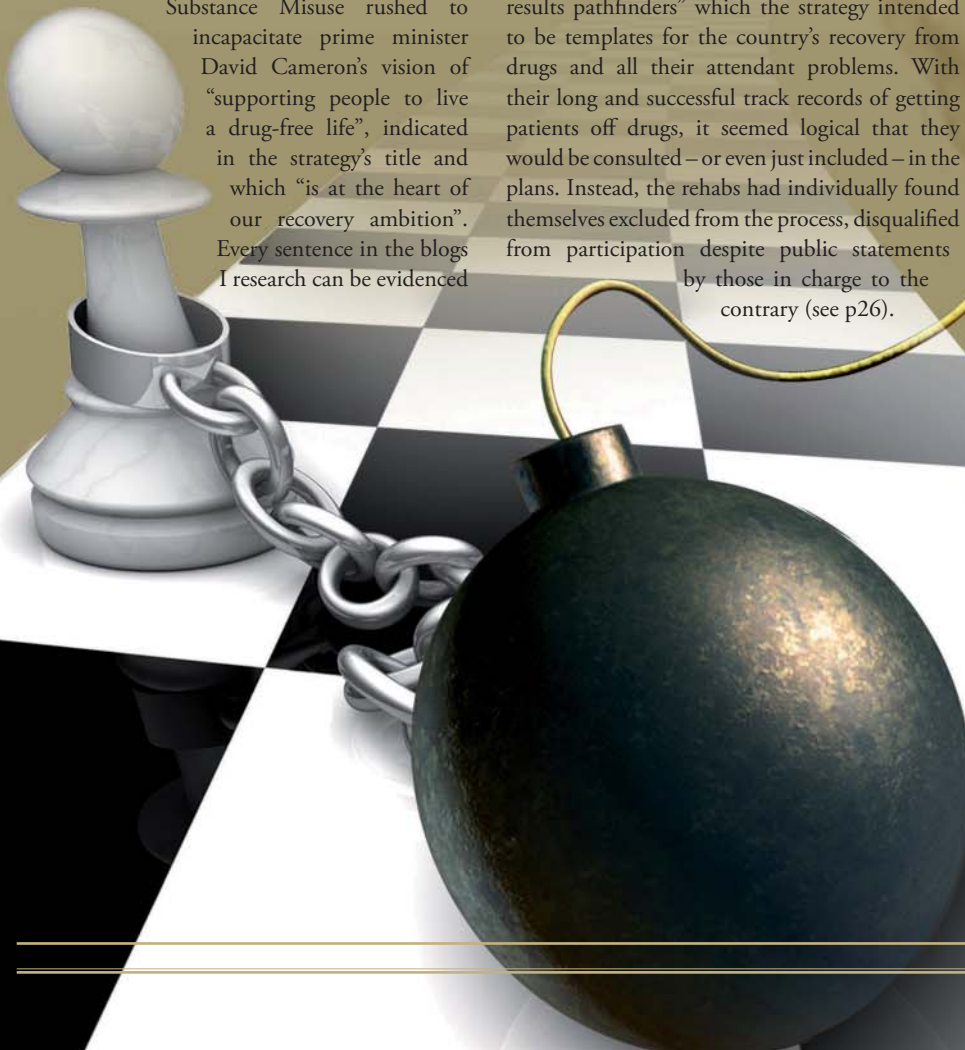
The Concordat bid was rejected in favour of “innovative” – ie, yet more unproven – pathways with no history of getting addicts drug free for the long term.

We need to be careful about the term “drug free”. *Addiction Today*, the general public, rehabs – and the prime minister and Cabinet – take this to mean free of all drugs, and having the help to change thinking/behaviour/lifestyles to stay free of drugs. But, while we know the NTA redefined the dictionary so that words no longer mean what we think, it was only recently I found that “drug free” is formally defined in the National Drug Treatment Monitoring System – which gathers the nation’s statistics – as being on drugs.

That one fact alone makes a mockery of the drug strategy’s welcome goal of helping addicts to become “drug free”.

This article endeavours to make the goal a reality, in the true classic sense of becoming drug free. The first step before action/implementation and the change the government wants is awareness. This article aims to raise that awareness.

While the enthusiastic formation of the concordat was an achievement in itself, some



HOW REHABS STARTED TO RESCUE THE DRUG STRATEGY

In January, with the Coalition's first Drug Strategy – *Reducing demand, restricting supply, building recovery: supporting people to live a drug-free life* – not even a month old, the Department of Health/National Treatment Agency for Substance Misuse rushed to incapacitate prime minister David Cameron's vision of "supporting people to live a drug-free life". Organisations with a track record of getting people truly drug free were excluded from recent treatment contracts, some quoting the NTA, and they were blocked from bidding for Payment-by-Results pilots, intended to be templates for the country's recovery from drugs and all their attendant problems. You can read details at www.addictiontoday.org/addictiontoday/2011/01/camersons-drug-strategy-nobbled-at-starting-gate.html. Forced to act to save lives and prevent closures and redundancies, 29 providers collaborated to offer a solution under the umbrella name of the Concordat; they were rejected. These experts-by-experience as well as by training, these champions of recovery, continue to have their services rejected.

COMMENTS FROM PROVIDERS WITH A TRACK RECORD OF FULL RECOVERY

"It is palpably absurd that all the richest reserves of knowledge re the delivery of recovery-oriented treatment are completely ignored." *Nick Barton, CEO of Action on Addiction*

"To not run PBR pilots with services which have been providing for a long time the kind of results which the government wishes to see more widespread, makes poor sense. It is a half measure and does not underpin the vision of the Drug Strategy 2010, inasmuch as we are haunted again by the same old failure." *Carl Edwards, director of ParkView Projects*

"We have spoken at length to the local DAT about their plans for a pilot project. We provided them with information that clearly demonstrated our ability to provide most of the services they say they would like to offer to clients. However, they have chosen not to include us in their plans." *Jan De Vera Davey, director of Open Minds*

"I find it very hard to understand that when the government wants to focus on recovery, the Department of Health / NTA bring out a pilot for payment-by-results that excludes nearly all the smaller organisations with the most experience and proven success of delivering recovery. This will lead to more people suffering." *Brian Dudley, CEO of Broadway Lodge & eATA board member*

"If I hadn't been informed by you, I wouldn't even know it was happening. I got in touch with DH who told me to contact NTA. I phoned NTA south west, they said talk to the DAT, then nothing." *Brendan Georgeson, treatment coordinator of Walsingham House*

"Didn't realise they were going for pilots until you contacted us. Typical really, we are never informed about anything by either our local CSDAT or the NTA. We are never informed about capital monies available or anything that may prove beneficial to our service." *Amanda Lea, director of Western Counselling*

"We do not get contacted by the NTA for anything! PBR will perpetuate the continued falsification of outcomes to demonstrate 'success' which has been happening for years. It thus opens the door further to fraud and corruption." *Paul Spanjar & Steve Spiegel, CEO of Providence Projects*

"We have not been approached. I am disturbed about PBR as they don't even seem to agree on what a result is yet. I have heard one government spokesperson describe a possible result as being full employment for a year. On that criterion, very few of us will get paid, whatever field we work in." *Chip Somers, CEO of Focus 12 and eATA board member*

"At a briefing event at the House of Commons, NTA CEO Paul Hayes talked about the pilot PBR schemes and made it clear this would be an opportunity for providers to apply. When I downloaded the invitation to participate, I was astonished to see this was not the case.

If the coalition government is committed to recovery then why is the DoH/NTA excluding small providers? The people who suffer are our beneficiaries, those most in need of recovery who will struggle with yet another complex navigation around a system."

Wendy Dawson, CEO of the Ley Community and eATA board member

providers felt squashed but, rather than being subdued as in the past, they are emboldened by the foreboding that there is nothing to lose and much to gain, most especially the lives of their patients. Redundancies have been made. Closures loom. They have lost contracts; in Nottingham, for example, contracts were stopped to abstinence-based treatment providers, with the NTA's flawed *Effectiveness Review* cited as justification. Liverpool, the NTA's "capital of recovery", has also been going down this route.

The rehabs also know that a decade of diplomacy and meeting ever-onerous bureaucratic demands has not worked. "Insanity," Albert Einstein said, "is doing the same thing over and over and again and expecting a different result." Different tactics must be used to save lives.

Incidentally, if the disclosure of "punitive reprisals" on page 25 sounds melodramatic, read Professor Neil McKeganey's experiences on pages 34-35 of this journal. He describes how officials pushed him out into the cold (*Addiction Today* was subjected to Damian McBride-style tactics until the general election) because his unbiased research found that most of the 1,000+ drug users his team interviewed said that they had only one goal, to become drug free (*McKeganey et al 2004*). Only a tiny proportion were looking for 'harm reduction', a policy of treating not causes but symptoms, which led to expensive dependency on state prescriptions, usually for methadone.

[*Addiction Today* believes in a role for harm reduction, but it is madness that only 2-4% of addicts in the treatment system get rehab or similar offering full, drug-free, classic recovery.]

McKeganey's followup analysis pushed him further 'outside the tent': it found that, three years after starting treatment, only 3% of people on methadone got drug free – but patients who went to rehab had over 10 times the success rate, free of drugs despite being shown in other research to have more complex, chronic problems.

To most of us, getting addicts off drugs is logical. The new government got off to a good

start last December with the wording of its first drug strategy. But it surrendered implementation to the old byzantine regime, via 'expert groups'.

OLD CULTURE, OLD WAYS.

"The longer he is in Downing Street, the more aware the prime minister is becoming of the forces that can thwart progress... every attempt at reform has to fight its way past vested interests and the forces of bureaucratic inertia," James Forsyth of *The Spectator* and *Daily Mail* recently noted. This government's humane goal of getting addicts off drugs is no exception.

The wrong people have been put in charge of implementing policy, repressing proven solutions and redefining language so it will camouflage failure to follow the spirit of the strategy. "The fact that the prime minister has to devote such attention to checking his instructions are followed across Whitehall suggests that parts of the Civil Service are forgetting that its role is to implement government policy," Forsyth observed.

"Successful reform isn't just about policy – it's also about the resistance and inertia in the face of vested interests," confirmed the Reform think-tank in its *2011 Scorecard*. It scored the DoH with a D for the NHS's lack of workforce flexibility or accountability to patients. It ranked the Cabinet as E for failing to make civil servants personally accountable for performance or value for money.

Before we look at provable examples, let's set a context for many readers new to *Addiction Today*, starting with an overview of the National Treatment Agency for Substance Misuse, the 'special health authority' tasked by government to implement its drug strategy, even though it abolished it.

Headed by Blair appointee and ex-probation officer Paul Hayes who is supported by heads of delivery Rosanna O'Connor and Colin Bradbury, the NTA was set up a decade ago to oversee Labour's drug strategy. It is, sadly, reasonable to say that it reigned over failure. Only 2-4% of problem drug users in contact with its system managed to get drug-free – an equivalent number to those

who managed to get into rehabs. Drug deaths are higher than when the NTA was established to reduce them. Methadone, a drug paid for by the state – taxpayers – to replace heroin but which is more addictive and harder to withdraw from than heroin and whose use soared with NTA advocacy, is now England's second-greatest drug killer. In a two-year period before the Conservatives were elected, rehabs facilitating drug-free lives closed at an average of one a month with permanent loss of beds and skilled staff. EU research showed the UK as having the worst drugs reputation in Europe.

Amid this, NTA staff numbers and salaries soared and its budget climbed to over £20million a year while it claimed to authorise the disposal of another £600million or so annually through local budget plans submitted to it.

Recognising this, health secretary Andrew Lansley announced the NTA would be abolished. But it was granted a two-year reprieve – thanks to the unions, it is said – during which it can embed its New Labour legacy of staff and practices across Whitehall and right down to local levels.

HOW THE DRUG STRATEGY WILL FAIL.

To give its drug strategy a chance of succeeding, government from the highest level must give an emphatic and unambiguous message to counteract the bulletpoint actions below as well as defining drug free as really being drug free. (The Centre for Policy Studies is due to publish a paper supporting the points below; we will alert readers to it.)

- In February, the NTA issued a press release saying how much treatment commissioners (local public-sector officials who allocate problem drug users to various forms of 'treatment') will get in 2011-12 from "a £570million budget for community and prison drug treatment services" – the promo with a three-page letter from Hayes made no recommendation that they use the funds to get addicts drug-free (www.addictiontoday.org/addictiontoday/2011/02/570million-but-not-for-drug-strategy-goal.html). Also, "community and prison" services implicitly excludes rehabs (www.addictiontoday.org/addictiontoday/2010/07/nta-evades-definitions.html).

In response to our blog, the NTA posted its first comment supporting a drug-free goal – but we since learned of the redefinition of "drug free".

- In charge of applications for payment-by-results pilots, the NTA instead of its usual expensive media hype quietly posted details on its website, not even flagged up on its homepage. It did so a few days before Christmas, with a deadline of 20 January when public-sector potential partners did not return to work before 4 January, so there was only about a fortnight to forge partners, less for those unaware of the web page. With the NTA's Bradbury as "chair of the cross-government selection panel", it did not contact providers with a history of getting people into full recovery.

- We have a statement from the NTA that rehabs are not to be consulted on the co-design due to start in April of the PbR pathfinders.

- The NTA is organising three events in March for rehabs to meet commissioners – the first such event after a decade overseeing drug policies. Some rehabs sent *Addiction Today* the invitation and we in turn sent it to rehabs in the Directory at the back of the journal – like us, they had not been informed, bar a handful. Moreover, prescribing organisations (whose annual revenues grew 15-25 times under the NTA) received invitations. NTA staff do not ease patients' access to rehabs!

- The 15 shortlisted partnerships in other PbR bids are also unhappy. "The Concordat was lucky to be rejected," said one fundholder. "We are expected to take all the financial risks – but are not free to make our own decisions. We must follow instructions from NTA expert groups."

- The NTA so-called expert groups guiding implementation of PbR and commissioning total about 50 people and are divided into six subgroups whose reports will control local assessments and referrals, patient placement criteria and more. By design or accident, by choice of experts or lack of motivation, participation by the 'experts' has become scant so that NTA payees present pre-



written reports to groups and it appears it will be left to them to write the final reports.

- ‘Expert’ groups on patient placement criteria – not to be confused with the ASAM use of this definition (www.addictiontoday.org/addictiontoday/2010/06/appropriate-treatment-patient-placement-criteria.html) – have been told not to mention abstinence. Increasingly uneasy members, including psychiatrists, complain that all discussion is about medication.

- One expert group is headed by John Strang, described by *Breakthrough Britain’s* addictions author Kathy Gyngell as the “psychiatrist most closely associated with the failed medico-clinical treatment approach of the past 20 years... key lobbyist for prescribing”. He is reported as urging the expert group that “abstinence is being on a script” (prescription), which links to the NDTMS definition of drug free as being on drugs.

- In another NTA expert group, Strang’s protegee John Marsden, who has been reimbursed by the NTA over the years, claims to support abstinence. Did he explain to members this could mean they authorised reports contrary to what they intend?

- One pre-written report on rehabs from the NTA stated that referrals should comply with rationing-body NICE’s guideline on *Psychosocial interventions in drug misuse*. NICE currently states rehab be considered for people who “have significant comorbid physical, mental health or social (for example, housing) problems... should

have completed detoxification... and have not benefited from previous community-based psychosocial treatment”. So patients cannot be admitted without a mental-health disorder – no mention of whether this is psychotic (inappropriate) or neurotic (appropriate), nor access for addicts without this diagnosis. It says detox is separate to rehab instead of within it, which would cut death rates. It denies rehab to patients who work to benefit enough from community treatment to move on to rehab. And it stops patients going direct to rehab, as they must drain community treatments first. “People sent to us even for detox are now literally at death’s door,” one eminent NHS psychiatrist said, reflecting similar scenarios in rehabs. NICE also inaccurately compares rehabs with community settings. The NICE panel was headed by Strang, supported by other prescribers.

- These NICE Psychosocial guidelines were due to be reviewed in February; its panel recommended this not be done. *Addiction Today* and members of the Concordat, including the Centre for Policy Studies’ addictions group, submitted stakeholder comments that the guidelines must be reviewed.

- On top of pre-written papers, the topic of rehabs has been moved until after the NTA leader and others left. So they could not record objections or consensus. Should we expect otherwise?

Bradbury and others in the NTA propagandise there is no evidence rehab works (www.addictiontoday.org/addictiontoday/2010/11/rehabilitation-evidence.html).

- Also overheard in the NTA expert groups: that talk is about “buying more of the same”, that non-rehab providers are classed as rehabs if they have housing and, ironically, an increase in process-driven systems to deliver the outcome-based systems.

CAMOUFLAGING OUTCOMES.

If abstinence means being on drugs as well as off drugs, if drug free also means being on drugs, and “free of drug of dependence” means still using drugs other than the main one so patients

become cross-addicted, how can we measure success or failure in PbR pathfinders or any other project?

If non-rehab beds are classed as rehabs but lead to very different outcomes, how will we measure which are the successes or failures?

If the NTA and its payees were ever to create an ideal payment-by-results template and ideal strategy implementation, we would never know. Similarly, we will not know when they fail, until we see the evidence in more addicts including alcoholics on our streets, in our homes, in the courts, in hospitals and in the morgue.

Addiction Today and independent researchers analysed failures in the NTA’s Top measurement form which feeds into NDTMS. Top does not count methadone or cannabis use, for example, nor mental-health issues, nor the greater severity of problems in patients entering rehab. Indeed, it does not even relay which methods or organisations yield the successful or failed results. And, being self-report instead of independently audited, it is open to manipulation by vested interests. It drains staff time filling it in, yet does not feedback to the organisations completing it to create improvement. It is not fit for purpose.

You can read details at www.addictiontoday.org/addictiontoday/2010/05/top-nta-response-versus-facts.html, as well as Bradbury’s defence of it and corrections of his inaccuracies.

At an All-Party Parliamentary Drugs Misuse Group in January, Home Office minister James Brokenshire reassured us that the PbR pilots would be evaluated independently rather than with Top. But rumours reach us that the contract is going to a company called Social Finance which has recruited Top author John Marsden. But perhaps the rumour is unfounded and there truly will be an independent audit of patient outcomes.

We recently highlighted the plight of patients on methadone for years then suddenly referred to rehab – with a broken clavicle and arm, a stroke, vomiting blood. They were probably marked on the NTA statistics as “successfully leaving tier 3”. We must stop this recurring. We must be clear about language – and so must be government.

Images: Benjamin Haas, Andrea Danti, Asrawolf