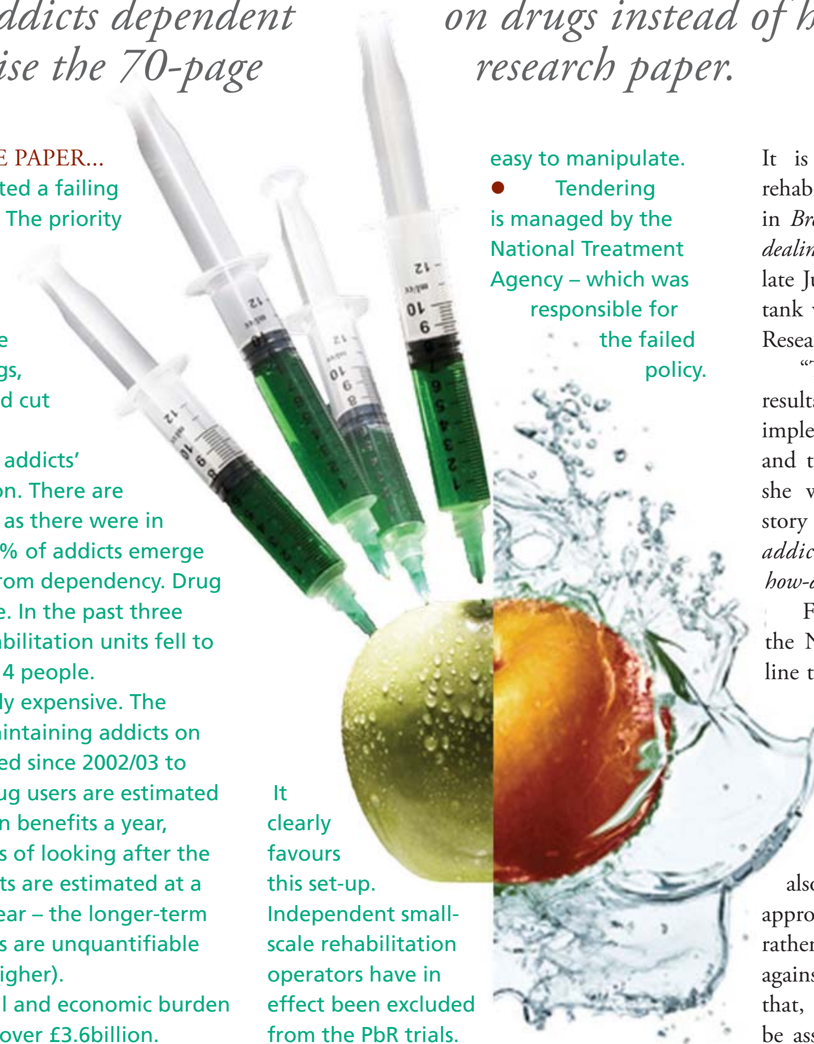
BREAKING THE HABIT: STOP PUSHING DRUGS AND START PUSHING REHABS

A paper by the Centre for Policy Studies grabbed headlines on BBC and Sky TV, radio and press at the end of June – revealing a £3.6billion cost to taxpayers of keeping addicts dependent on drugs instead of helping them to quit. We summarise the 70-page research paper.



KEY POINTS IN THE PAPER...

- The Coalition inherited a failing and costly drug policy. The priority was to prescribe methadone to drug addicts in the hope that this would replace their use of street drugs, reduce street crime and cut criminal justice costs.
- This policy impeded addicts' recovery from addiction. There are as many addicts today as there were in 2004/05. Fewer than 4% of addicts emerge from treatment free from dependency. Drug deaths continue to rise. In the past three years, referrals to rehabilitation units fell to an all-time low of 3,914 people.
- It has been extremely expensive. The cost to the state of maintaining addicts on methadone has doubled since 2002/03 to £730million a year. Drug users are estimated to receive £1.7billion in benefits a year, while the welfare costs of looking after the children of drug addicts are estimated at a further £1.2billion a year – the longer-term intergenerational costs are unquantifiable but are probably far higher).
- This brings the social and economic burden for this population to over £3.6billion.
- The Coalition wisely recognised the scale of the problem it inherited. However, its proposed solution is flawed.
- In particular, its 'Drugs Recovery Payment by Results (PbR)' approach will only reinforce the *status quo*.
- The PbR pilots will reward operators who show that addicts have improved health and employment, who have not offended recently and who are not in treatment. But solving the drug problem means recognising the problem for what it is: one of addiction. The solution lies in freeing people from it, not by measuring proxy outcomes which are easy to manipulate.
- Tendering is managed by the National Treatment Agency – which was responsible for the failed policy. It clearly favours this set-up. Independent small-scale rehabilitation operators have in effect been excluded from the PbR trials.
- PbR can work if:
  - the importance of abstinence-based rehabilitation is recognised and if bids from such operators are sought
  - there is one simple measure of success: that of six months abstinence from drugs
  - doctors, pharmacists and drug workers share in the rewards of getting addicts drugs-free (currently rewarded only for prescribing).
- This approach would also be consistent with the prime minister's vision for the Big Society. It would involve a real transfer of power from large distant organisations to small innovative providers.

It is time for the Coalition to give drug rehabilitation a chance, argues Kathy Gyngell in *Breaking the Habit: Why the state should stop dealing drugs and start doing rehab*, published in late June by the Centre for Policy Studies think tank with support from the Institute for Policy Research. It cites 126 research references.

"The Coalition plans for payment-by-results are well intentioned. But leaving its implementation to the Department of Health and the National Treatment Agency is wrong," she wrote – echoing *Addiction Today*'s cover story in March (*www.addictiontoday.org/addictiontoday/2011/03/real-rehab-revolution-how-drug-policy-will-fail.html*).

Following rationing-body Nice guidelines, the NTA made methadone its standard front-line treatment for opiate dependency – whether clients were injecting heroin drug users or not. It was expected to reduce HIV infection and overdoses as well as criminal activity by reducing addicts' street-drug dependency.

Nice's *Psycho Social Support Guidance* also recommended that psychological approaches to treatment should be supportive of, rather than alternative to, prescribing. It warned against "abstinence-based therapies" saying that, although "initially attractive (they) may be associated with subsequent increased risk of overdose death in the event of relapse after a period of abstinence during which drug tolerance is lost." On this basis, Nice recommends residential treatment only for those with comorbid mental health or housing problems or who have 'relapsed' into opioid use during treatment.

However, this was based on research showing death rates after detox at NHS hospitals such as the Maudsley not on rehabs and their successes – for example, Broadway Lodge rehab detoxed 7,500 addicts with no deaths. Just as with the Ntors study, NHS staff confused rehabs and detox and their very different outcomes.

Nice recently refused to review this guidance.

Where NICE led, the NTA has followed. This has ensured that pharmacology not psychology is the standard treatment for drug users. Formerly independent drug charities, who used to focus on abstinence-based rehabilitation, are now largely dependent on the state for generous £££multimillion methadone prescribing 'treatment' and needle exchange contracts. In contrast, most addicts want to be drug free.

MOST ADDICTS WANT TO BE DRUG FREE.

Of those coming into treatment, just 8% are referred from prison, with another 15% from arrest referral or through court-ordered Drug Rehabilitation Requirements. None are referred from the nationwide needle exchange services and a mere 1% from social services. The bulk, 40%, seek treatment of their own accord or are referred by their GP (7%).

When asked what they want, addicts overwhelmingly reply that they want help to overcome their drug addiction. Becoming drug free was also the single goal expressed by 76% of drug users recruited to the Drug Outcome Research in Scotland study. Heroin users were the most unhappy with their level of drug use: 81.2% wanted to stop using heroin completely. 76.6% of cocaine and crack users claimed they would like to stop using. But their wishes – and society's expectations – have not been respected.

BETRAYING THOSE WHO WANT TO QUIT.

Instead, the NTA manages 192,000 drug dependents and is 'in contact' with another 14,000. 150,000 of these are on regular doses of methadone or other opiate substitute. Far fewer are in treatment for cocaine (11,000), cannabis (14,000) and amphetamines (4,000). And only 3,914 of all of these contacting drug services in 2009 were referred to abstinence-based residential rehabilitation treatment.

Prescribing methadone is the default response of most drug services, even if the addict continues a cocaine or crack cocaine habit, for which methadone is inappropriate or if the heroin habit is secondary. There are at least 50,000 people on methadone whose heroin problem is not their primary or only drug problem.

AWARD-WINNING REHABS CLOSED.

In the two years before the general election, lack of referrals led to an average of one rehab closing every month, with loss of lives and loss of the highest-quality skills in the field. Closures have started again, with the Sanctuary in Weston-super-Mare and probably Sharp London daycare in July. The best estimate is that there are only 1,872 beds now available, equating to 4,000 places per year, at 'affordable' levels of about £500 or £600 per week run by not-for-profit projects or charities. There are no National Health Service rehabs. The sector is in near-terminal crisis.

It is this which has led to the formation of the Concordat (see pages 16-17 of this issue).

MONEY IS DRAINED AWAY.

The NTA's key defence is expense, that "rehab is about 13 times more expensive than methadone… So if we sent everybody to rehab, we could only serve one in 13 of the population that we've got". This greatly overstates the costs of effective rehab units and understates the costs of prescribing.

One typical urban Drug Action Team recently estimated how it spent the £10million allocated to it for drug treatment in 2010/11. Its spending priorities were roughly as follows:

- 30% on GP prescribing
- 22% on specialist prescribing
- 7% on Tier 2 harm reduction services such as needle exchanges
- 7% on day programmes – 60% harm reduction day care and 40% abstinence day care
- 6% on rehabilitation.

The balance of costs – 28% of the budget – was earmarked for DAAT administration and management. In comparison, a total of only 9% was planned for abstinence services.

Drug treatment funding in England has doubled since 2002/03 to £734million a year excluding prison treatment costs. It comprises:

- £380million NHS Pooled Treatment budget
- £205million local/community care funds
- £110million for Ministry of Justice Drugs Intervention Programmes
- £25million adolescent treatment funding (is putting children on methadone safe?)
- £19million+ for NTA running costs.

Last year this expenditure bought:

- 2.5million methadone prescriptions
- 3,914 residential rehabilitation interventions of varying lengths
- 9,392 inpatient detoxifications
- only 8,112 people (4%) discharged, claimed as free of drug dependency.

There is no abstinence requirement for "successful discharge". There are no follow-up checks. All the NTA analysis shows is that people are no longer on the treatment register and have not come back. They might have given up, be in prison, back on street drugs or have died.

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IS PbR THE ANSWER?

The Coalition knows that the treatment system it inherited is not working. Its stated goal is to help people recover from their addiction and to contribute to society instead of being a cost to society. This, it believes, can be achieved not by a change in treatment priorities but by a change of governance. Thus we have the ongoing Payment by Results, or PbR, trials.

The intention is to reward providers who meet nationally agreed outcomes for drug users. These outcomes are defined as improved health, crime reduction and employment as well as freedom from drug dependency. The idea is to incentivise treatment providers to find the best ways of getting addicts better. The government hopes this will allow 'what works' to emerge through 'market' factors and not by government diktat. It has also been decided that individual tariffs will be set for addicts; these will be weighted to reflect the severity of dependence and the complexity of social problems faced.

In theory, this makes sense.

PROBLEMS WITH PbR PILOTS.

Drugs Recovery PbR is to be tested out through eight pilot areas to run for one year from 11 October 2011. Problems are inherent from the start, in how they are being set up and in an absence of specific terms of engagement.

Those who led the failed methadone approach have now been given responsibility for implementing the new system. Those who provide drug services under the current failing system are the successful pilot bidders.

The denial of failure is endemic in the DoH and NTA, evidenced in the original invitation to tender and the pre-qualification process: "Existing drug funding, commissioning and delivery systems have helped to deliver an unprecedented increase in drug treatment, supporting individuals on their recovery journey". No change there, then.

Rehabs were ineligible from participation on the specious grounds of a potential conflict of interest over future contracts. Yet a greater conflict of interest was overlooked in the successful pilot bids, where commissioners employed by the NHS or PCT buy NHS services, or where mega-agency preferred suppliers drafted terms of reference before tenders went out. Some NHS drug services contractors are unashamedly named in pilots.

The tender documents thus show a lack of knowledge about the pros and cons of rehabilitation versus 'resettlement' programmes and approaches. They include the assumption that 'what works' is not known, a statement that all successful recovery providers would contest.

Few of the partnerships have expertise in addiction, personal experience of recovery, visited a rehab, or attended a mutual-aid meeting. By contrast, among the most successful of the rehabs, many are run by people themselves in recovery.

Also, many pilots have chosen to delimit the scope of treatment that PbR will be applied to, paying for prescribing by activity not result. This further retains the *status quo*.

Bracknell, for example, is not applying PbR to its primary care prescribing, needle exchange or "supervised consumption scheme". What budgets will be left for psychosocial or recovery interventions, which will be subjected to PbR?

Wigan proposes to restrict PbR 'eligibility' to clients in 'structured tier 3 drug treatment services only' plus dependent alcohol users. Its aim appears to relate more to resettlement services – housing, education etc – than providing treatment.

Resistance to innovation is also seen in Wakefield which plans merely to "quickly" adapt a two-year old system to its PbR model.

Oxford has decided that its current structured drug and alcohol interventions will simply be recommissioned under a "recovery framework". Its needle exchanges will be paid by activity.

None of the pilots involve any change of commissioning personnel, leaving the old guard in charge of reform.

Another main impediment to an 'abstinence recovery' provider bidding for contracts are punitive TUPE laws which mean taking on a NHS demotivated, poorly trained workforce unskilled in anything but harm reduction, plus NHS terms and conditions that a rehab cannot afford.

The proxy outcomes blend the worst of all worlds, being overly complex blunt instruments while being open to interpretation and abuse.

HOW TO MAKE PbR WORK.

REFORM 1: SIMPLIFY. Use a single payment criterion – freedom from all drugs including methadone and alcohol. A first payment could be triggered when the addict has achieved 90 days' abstinence and a final payment after six months' abstinence. Use a simple tariff scale; rehab recovery practitioners must be consulted on how tariffs are formulated

REFORM 2: ENGAGE DOCTORS. Give doctors a positive incentive to refer to rehab instead of paying only for prescribing, and set restrictions on methadone prescribing and dispensing.

REFORM 3: USE HARM REDUCTION SERVICES AS A GATEWAY INTO RECOVERY treatment and rehabilitation.

REFORM 4: INCLUDE GOOD MODERN REHAB EXPERTISE at all levels of the pilot developments.

MORE DETAILS: go to www.cps.org.uk.