Pathways to Recovery

A Manifesto for Drug and Alcohol Treatment

EATA

November 2009

EATA is the membership organisation representing the majority of drugs and alcohol treatment providers in the UK who work with many of the 200,000 drug users engaged in treatment. This manifesto has therefore been produced with a view to publication prior to a General Election in 2010.

EATA European Association for the Treatment of Addiction (UK)

the independent voice of the sector

PATHWAYS TO RECOVERY

A MANIFESTO FOR DRUG AND ALCOHOL TREATMENT

Executive Summary

1. EATA is the membership organisation representing the majority of drugs and alcohol treatment providers in the UK who work with many of the 200,000 drug users engaged in treatment. As the sole acknowledged independent voice of the sector, EATA wants to contribute to the greater success of treatment outcomes, not only for the benefit of users, but for their families and the wider society. This manifesto has therefore been produced with a view to publication prior to a General Election in 2010. Consultation on the document was undertaken with the membership through a series of events. The resulting document has gained depth and weight from the considerable experience of participants.

2. Seven principles underpin the manifesto and include: fostering independence and developing courageous leadership to change systems and objectives at all levels in current treatment approaches.

3. The manifesto includes alcohol as an equal partner with drugs at the treatment table.

4. The manifesto recognises that polydrug use and alcohol problems compromise treatment outcomes. This is in line with the EMCDDA report on polydrug use 2009[1] which states: " polydrug use and concomitant alcohol problems are now the defining elements of the European Drug Problem.". A recovery approach at the outset of treatment would move current treatment modalities away from substance specific treatment to holistic treatment.

5. An outcome-focused approach will benefit individuals by basing outcome funding on factors that include: health improvement, social well-being, abstinence, training for work, being in work for six months and coming off benefits.

6. The manifesto promotes recovery-oriented treatment as the starting point for the treatment journey from initial assessment onward.

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[1] From EATA's inception it has recognized the need for a European dimension in drug treatment strategy and that countries in Europe should learn from each other. The recent report on Polydrug use by the EMCDDA (Nov 2009) can be found at http://emcdda.europeeu/publications/selected-issues/polydrug-use

7. The manifesto proposes the engagement of 'recovery mentors', to be identified in communities. The experience and empathy of mentors are key to carrying an effective message of hope to those in treatment or who are about to embark on treatment.

8. Self-help groups such as Alcoholics Anonymous (AA), Narcotics Anonymous (NA) and Cocaine Anonymous (CA) are already well embedded in communities across the UK, at no cost to the State.
   They encourage lifestyle change and offer support during the day, evening and at weekends. Users can become part of a support network with people who have made a commitment to leading lives free of drugs or alcohol. Formalising a pathway for users to investigate these groups among all professional drug workers can help improve outcomes for the user. Professionals themselves need to better understand what these and other self-help groups have to offer.

9. A personalisation agenda' as part of the recovery approach gives power and resources to the individual service user to use for their needs. Well-managed flexible services should be able to respond better to client needs.

10. EATA has designed an outline of an evidence-based local treatment model (Point 5). Recovery plans will be inputted as data.

11. Within public expenditure constraints, EATA believes that rationalisation of complex bureaucracy will provide savings. Streamlining costly acute medical services will also yield savings. Third sector organisations will be able to provide professional services working with GPs to reduce numbers of those in long term methadone treatment by helping them to abstain and move into recovery and independence.

12. Competitive community care funding for substance misuse treatment (drugs & alcohol) will need review if the tier 4 rehabilitation is to be sustained.

13. Current commissioning needs reform – with the PCTs joining with Local Authorities to plan and prioritise within a framework of a recovery approach.

14. Drug and alcohol misusers need choice and motivation to become drug and alcohol free. Harm reduction has a role as does prescribed substitutes such as methadone. It is EATA's contention that this is the beginning of the treatment journey and recovery should be a constant theme from the outset.

15. Drug treatment can no longer stand in isolation apart from other relevant Government policies and needs to be mainstreamed. A policy implementing a recovery approach needs to become part of strategy and policy planning across social care, including policies for children and families and public health care in order for it to be fully effective. .

1 BACKGROUND AND CONTEXT

What do we want from drug and alcohol policy in the UK? This is the question we need to ask in advance of a General Election in 2010.

EATA members comprise over 100 UK drug and alcohol treatment organisations and - hundreds of projects or services. Almost all members operate in the not-for-profit 'third sector'. They largely depend on Government funding and contracts that are designed to meet Government's strategic objectives to reduce the harm that drugs cause to individuals and communities.

Over the past two decades, Governments have responded to rising illicit drug use with unprecedented investment and policy built on the three pillars of prevention, enforcement and treatment. The National Drugs Strategy for England and Wales 2008-2018 is driven by a determination to reduce crime. Over time, treatment has gradually become more of an equal partner with the other pillars of strategy in comparison to its marginalised position at the outset of strategy. Much of the treatment delivered by the not-for-profit agencies has been and continues to be either based within the criminal justice system or closely linked to it.

The cost of drug and alcohol misuse is enormous. It affects the criminal justice budgets with approximately 70% of prisoners having drug and alcohol problems and related offending. Health resources are affected detrimentally especially in A&E, Acute medical, mental health and primary care. Substance misuse affects thousand of children and social care budgets bear the cost of interventions. Drug and alcohol treatment must now be placed in the mainstream, offer recovery in all polices aimed at reducing offending as well as being introduced into social welfare such as benefit allocation.

1.1 The Role of EATA

EATA as a representative body of treatment agencies has a natural remit to help develop a manifesto for drugs and alcohol treatment and ensure Government hears the voice of the sector. Consultation took place among members through a series of events. The resulting document has gained depth and weight from the considerable experience of participants.

The manifesto intends to inspire and make a truly constructive contribution to treatment policy. While it believes savings can be made in costs, it avoids being simply a platform that calls for immunity from public sector cuts. There are other forums in which that case must be made more fully. The manifesto outlines seven unifying principles upon which a redirection of policy could be based.

The seven principles attempt to define the values needed for a policy based on recovery. They frame a renewed vision for treatment, one in which the path individuals take towards leading drug-free lives is measured and where outcomes are evaluated.

1.2 A focus on recovery

For many years, treatment has seen an imbalance of investment in favour of acute medical services. At a rough approximation, upwards of fifty eight per cent of the drug

treatment budget within the NHS is spent on acute medical treatment and delivery of methadone based programmes.[2] Methadone is highly addictive but has benefits for some who need stabilisation and/or detoxification, yet, there is good evidence that over half of all users want to stop using drugs altogether[3]. Worryingly, many drug users who are assessed as needing abstinence treatment placements can not secure funding. Currently, detoxification and rehabilitation centres are struggling with funding and many are closing. Abandoning this sector to market forces and a failure to address the causes and consequences could lead to problems in the delivery of effective treatment responses in the future, and ultimately in increased costs.

1.3 Alcohol - the 'elephant' in the treatment room

Alcohol misuse affects many more individuals and communities than drugs in the UK, yet there is no comparable treatment policy response to dealing with it. There are various economic, cultural and historic reasons for this outlined in consultation responses to the Government's Alcohol Harm Reduction strategy[4]. Additionally, alcohol plays a part in undermining the effectiveness of drugs treatment among individuals. We will suggest where savings can be made in bureaucracy and non-essential areas of drug policy to arrive at a joined up substance misuse policy. We want to make the case for including alcohol misuse as an equal partner to drugs misuse in policy. This is not only a necessary development for effective substance misuse treatment as a whole but it would also bring real benefits to the wider UK society.

1.4 Failed expectations

It is axiomatic to say that how we measure 'What Works' in drugs treatment depends entirely on the objectives. If the major objective as stated in policy is to reduce social harms and harm to individuals, policy has had some beneficial effect, particularly as far as the spread of HIV is concerned. However, outcomes have disappointed and failed to meet the expectations of the public and the politicians. Despite numerous interventions to improve pathways out of the criminal justice system into treatment, the circular path back into custody is still a crowded one.

1.5 Environment

Rehabilitation centres are closing at a worrying rate. In response to the public debt, a programme of public sector cuts will be shared by major government departments including the Department of Health, and will adversely affect delivery of drug and alcohol treatment in community settings. PCT budgets are likely to become a soft target. A squeeze on local government is likely to see Community Care budgets reduced. The

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[2] In 2001, the methadone prescribing budget alone cost £67 per person per week or £3,484 per annum for 100 mls daily for stabilising chaotic users and for maintenance. (Variability in dosage is accepted). But this amounts to an approximate £156million per annum for the 45,000 methadone dependent users then known. The figure has increased since that time. This figure does not include the resource infrastructure for delivering methadone. Quoted in Phase I Birt Report to Government's Strategy Unit, 2003 based on NHS and NCIS data. In 2002, mainstream health spending on treatment was £180m and the pooled budget for treatment was £190m.

[3] Addaction, collecting the evidence, Jones et al, 2004 and R Yates University of Stirling, Interim Evaluation , & Project Match

[4] i.e. Addaction response to Government's alcohol consultation and the subsequent Alcohol Strategy, 2004

drugs strategy to date has relied on a commitment backed by funding from central government and driven by the Home Office. In the future we could see an undermining of services in what has been dubbed ‘localisation’ as people in communities are forced to make hard choices.

A large proportion, perhaps up to a third of current drugs spend, is absorbed in bureaucratic administration and process, or is spent on projects that have nothing to do with drugs. In this environment it becomes even more imperative to seek accountability and transparency on real costs, and to promote savings in non-essential processes by streamlining burgeoning administration.

2 THE CONSULTATION DOCUMENT

2.1 A consultation document was produced, aimed at the EATA membership and was circulated to chief executives of member organisations prior to discussion events held in Autumn 2009 and subsequently at two regional events. It is proposed to publish and publicise the document in 2010. It will be used to try to influence decision makers and to argue for secure funding tied to improved outcomes for sustained recovery. It will call for an immediate examination of bureaucratic processes and the way funding is administered in order to produce efficiencies. The manifesto will be underpinned by our own analysis and projections of costs and savings to be made by a change of direction towards a policy based on recovery to enable those in recovery to become a positive force in their communities. **(see Point 10, Next Stage).**

To summarise the context, EATA believes that individual drug and alcohol users seeking help must be placed at the centre of treatment, rehabilitation and recovery. The gains to be had from such a policy are potentially enormous, not only in crime reduction but in health improvement. The goal is nothing less than to transform dependent individuals who possess minimal expectations, to become healthy, working, taxpaying contributors to society.

3 SEVEN PRINCIPLES

i. **foster independence*** in the individual from the outset of treatment towards social well-being and away from social management. (*independence from drugs, alcohol, state benefits).Our aim is to integrate treatment for the individual as part of community reintegration and family life.

ii **instil absolute integrity & accountability** in researching and disseminating the evidence base for programmes, methods and models.

iii **have courage** – we accept that courage is needed to promote a policy of recovery in a climate that can be hostile to drug users, and is often polarised and protectionist. Applauding courage in leadership among the recovery champions who include supportive politicians and professionals, as well as recognising the courage required by those individuals who choose recovery goals, has to become part of our ethos.

iv **value people**. We will recognise the value of people who are abstinent

or in recovery and engage them to help others through mentoring support programmes, testimonials and appropriate publicity. The role of the family will be understood and nurtured and those in recovery will be enabled to support themselves and their families in a sustained way. Professionals should challenge stigma and ignorance whilst recognising those in recovery and service users can fill a valuable role in society.

v **be open to transformational change**. The culture of substance misuse treatment requires a quantum shift in the understanding of what is possible for the user, away from historic dependency on pharmacological-based treatment towards one of belief in the potential of transformational change for all people. This change will mark a new epoch in the annals of commissioning and the development of commissioners. We must also make the most of best practice by encouraging care management teams to spend time in rehabilitation centres that have good outcomes for abstinence.

vi **place success for people above successful process**. Funding must be linked to outcomes not processes (such as the completion of assessment reports).

vii **inspire and motivate the workforce**. Encouraging the development of professional workers, many of whom have never met a drug free client, is essential. People who work in the field are our strongest asset.

Across the UK courageous leadership could harness those in recovery to help build communities of recovery and to challenge stigma that exists in the workplace and in communities.

4 DRUG AND ALCOHOL TREATMENT, REHABILITATION AND RECOVERY

Key Messages

4.1 **Alcohol** is one of the most serious health hazards we face in the UK. Since the 1990s we have witnessed unprecedented levels of early-onset liver disease and other alcohol-related illness. The Government's Alcohol Harm Reduction strategy[5] offers little investment in treatment intervention and at best produces health education campaigns which have had a marginal impact on behaviours and harms. Alcohol is a factor in the drug treatment outcomes as it is a major secondary drug of choice. Alcohol and drugs need to be addressed together and not separated by diverse strategies and different funding streams. Mutual aid groups should not be seen or used as an optional extra but placed at the very heart of the treatment system.

10. **4.2** **Separate the drug from the person**. Too much attention is spent on what drug the individual takes and too little on what underlies the drug use. It is much more helpful in planning effective treatment responses to have knowledge

[5] SU 2004

of an individual's background, the culture and the triggers that lead to first use and subsequent patterns of use. But because of the focus on the type of drug and the methadone alternative, there is an abundance of opiate replacement services. We offer little for the stimulant or cocaine user, the alcohol dependent person, or, indeed, the cannabis user, so they do no get offered the chance for recovery. The manifesto recognises that polydrug use and alcohol problems compromise.treatment outcomes. This is in line with the EMCDDA report on polydrug use 2009[6] which states: "polydrug use and concomitant alcohol problems are now the defining elements of the European Drug Problem." A recovery approach at the outset of treatment would move current treatment modalities away from substance specific treatment to universal holistic treatment. Proposals in our manifesto promote treatment that focuses on the user not the drug. There should be a single point of access for treatment whatever the drug used.

4.3 **Addiction Fingerprint.** Users will often display common characteristics such as low self-worth, a lack of direction and anxiety. But the manifesting symptoms of addiction will be different with each individual. Each will have a unique profile based on family history, physical make up and length and depth of drug and alcohol misuse. The true rehabilitation of an individual is only possible once the drug is removed. Only then can potential and individuality emerge. We must also recognise that today's investment in recovery can interrupt and stop the generational cycle of substance misuse. There is much to learn from the recovery movement in the mental health field.

4.4 **Keeping your recovery by giving away your experience.** Mentors who have successfully sustained abstinence or are recovering find that sharing their experiences and helping others, keeps them firmly on the path to recovery. The 'new' recovering client respects the experience of a mentor, is inspired by a mentor's successes and feels understood. (One suggestion that could offer an inspirational example is to organise a "Recovery Roadshow" where a team of 15-20 users in recovery from all tiers could visit acute medical settings or other treatment settings).

4.5 **Self-help Groups**. Professional drug and alcohol workers rarely refer clients to self-help groups. Work and education is needed to address the lack of understanding by professionals of how the self-help programmes work. The most well known are Alcoholics Anonymous (AA) Narcotics Anonymous (NA) and Cocaine Anonymous (CA), but there are many different groups, including Adfam, and a range of family and parent support groups, as well as Al-anon for partners and children of users. Utilisation of self help groups will benefit those new to treatment at the triage stage of assessment in the very heart of treatment engagement especially within the NHS. Providers should support these

[6] From EATA's inception it has recognized the need for a European dimension in drug treatment strategy and that countries in Europe should learn from each other. The recent report on Polydrug use by the EMCDDA (Nov 2009) can be found at http://emcdda.europeeu/publications/selected-issues/polydrug-use

fellowships by making premises available for meetings in their treatment settings and by encouraging their clients to participate.

4.6 Individualism and Personalisation

Client choice can be helped by a planned personalisation agenda where clients will be given access and choice to buy treatment and care to best suit their needs. Models are being developed to help service users make the best decisions for themselves through informed choice.

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5 ELEMENTS IN AN OUTLINE RECOVERY MODEL FOR TREATMENT

To present just one model as an example:

5.1 Each locality will have access to three treatment and recovery elements. Each of these programmes will operate to a high standard and be accredited to an evidence base. Models of Care - Tiers should be a series of doorways with users able to access the system at any point.

5.2 First Point of Contact (Element 1)

- A well-publicised point of entry from the outset encompassing rapid response assessment and harm reduction within the ethos of recovery.
- Street agencies or community drug and alcohol teams assess, inspire, motivate and help the client through the early planning stages.
- ‘Engagement’ in this context, translates as a personal relationship-building exercise and not mere form-filling.
- ‘Recovery Plans’ will be inputted as data.
- ‘Peer Mentors’ will be available to inspire the individual and reduce anxiety.
- Detoxification or short term-prescribing may be required.
- Providing an integrated care and recovery plan for users once they enter the system

5.3 Detoxification and recovery oriented residential treatment (Element 2)

EATA has seen some extremely encouraging models of best practice – which can be integrated into the community and supported with funding locally. (Examples upon request)

5.4 Community recovery-oriented day programmes (Element 3)

Day programmes can be used as an alternative to residential services for those who already have a supportive living environment, including children. They can also be used as stepping stones when people leave residential programmes. Relapse prevention would be delivered along with employment training and job seeking support.
The benefit of aftercare will yield much reward.
Recovery is long term and sustainable. Commitment from those many people who have found recovery will support the changes required for diminishing crime, reducing criminal justice costs, rebuilding families and communities, and increasing independence and productive use of precious resources. The next stage of this strategy will be to model and cost programmes and to support current programmes with the changes required.

6 Funding and bureaucracy

6.1 The Government has developed a central infrastructure in its attempts to reduce crime.

6.2 The National Treatment Agency now has a turnover of £20million. This has more than doubled in five years from £9 million at its inception in 2004.

6.3 The numerous PCTs across the UK have a joint commissioning role for drugs and alcohol with local authorities. Additionally, there are DIP managers who are responsible for the delivery, monitoring and funding of the Drugs Intervention Programme. Around 149 DATs, DAATs and Drug Partnerships are responsible for commissioning community treatment programmes and overseeing treatment agencies at the local level. Another layer sees CDRPs (Crime and Disorder Reduction Partnerships) within local Boroughs. They join up disparate agencies to develop publicity programmes and other community initiatives but recovery rarely features within policy.

6.4 Local authorities fund residential treatment under Community Care where substance misuse clients are often competing for limited resource with the elderly and disabled. This is quite apart from the systems that pertain within prisons. These multiple layers are confusing. The administrative and care management resource required to manage them is often viewed suspiciously by some as soaking up too much precious money which could be better used on the front line.

EATA advocates a total but rapid root and branch review of bureaucracy to make funding simpler and less costly. Savings could be made there instead of on the front line.

6.5 Far more emphasis must now be placed on "outcome focused" funding where payment is made on the basis of results (PBR). (We know outcomes data exists that is heavily aligned in favour of medical treatments and is not recovery orientated)

We must address positive recovery outcomes for the benefit of individuals, families and communities. In line with PBR, EATA is examining the

potential for tariffs for specific outcome-based activities.

6.6 Commissioning needs a major reform to improve client outcomes. Re-tendering procurement is now often used as a tool to manage underperforming contracts but should not be used to manage current providers who are performing well.

Such changes are controversial and would inevitably cause anxiety at first and that would need to be managed through excellent and courageous leadership.

7 Workforce development.

7.1 The workforce should be adequately trained in recovery orientation to the highest standards. Individual workers should be accredited with, for instance an agency such as FDAP (Federation of Drug and Alcohol Professionals) on an annual basis with the minimum entry requirement being at NVQ levels 3 .Recovery champions (those in recovery) will be ideally placed to work in the field with an equal status.

7.2 Management development in clinical disciplines and business skills are required for those managing people and services.

7.3 The workforce should be competent to deliver recovery- orientated care to the highest standards. Qualifications and awards will need to be reviewed to reflect this. There may be a requirement to review or develop new national occupational standards to fully define the competencies required. All qualifications should be based on the National Qualification framework to ensure parity with the wider health, social care and criminal justice sector.

7.4 Practitioners will need to demonstrate appropriate continued professional development to continue to be accredited; this will improve quality and continue to advance practice.

Practitioners will need to develop skills for working in the community and with new partners in the community-based recovery communities.

To support these changes managers will need to improve their skills particularly in relation to staff development and Human Resources Management.

7.5 To support the culture change required to move individuals into recovery, EATA proposes to support the delivery of recovery-oriented motivation training sessions for those who work with users, in the near future. Development and training will be required for commissioners. Those already in recovery can play a vital role. A key stakeholder's recovery network would support local initiatives.

8 Tier 3

8.1 Enormous blockages exist in Tier 3 methadone programmes which are mainly run by NHS Mental Health trusts. George de Leon's Passages Programme[7] describes 1100 long term methadone maintained patients who were offered a recovery orientation – the outcomes showed that a third of the cohort stayed the same, a third dramatically reduced their prescriptions, and a third became abstinent and recovered.

8.2 Recovery partners should be contracted to work in these programmes to motivate change where the NHS staff offering acute medical services are not encouraging recovery or don't understand the process.

8.3 Prescribing methadone should be used as a tool for stabilisation and harm reduction but providers should prioritise work on an individual's recovery. All providers should either provide this or be partnered with a recovery agency especially within the NHS. Needle exchanges provide a good opportunity to access users who haven't accessed treatment in the past and helps to prevent the spread of blood borne viruses (bbv) such as Hepatitis C.

9 Recovery Mentors

9.1 Recovery mentors who have experienced both addictions and moved on to recovery are the greatest advocates for those who are still addicted. Good policy and practice will be augmented by their experience which carries substantial credibility underpinned by an esoteric empathy, hope and a solution not often available in current treatment settings.

9.2 Users' views are important but an imbalance needs to be addressed between the views of clients who are using or on methadone, and those who have abstained from use and are in recovery.

10 Criminal Justice

Intensive recovery oriented treatment programmes, which are backed by evidence and underpinned by the use of self help groups, provide a genuine opportunity to build on the effectiveness of coercive rehabilitation and treatment, which we accept can be a useful tool in reducing crime.

11 The Next Stages

11.1 In two stages, the manifesto will be subject to cost benefit analysis, factoring in social returns on investment, and suggesting projected savings to be made in implementing a new vision towards recovery-based treatment.

Secondly, we will be presenting the case to individuals and organisations who may be persuaded to support and help implement this new approach.

Ends

[7] Passages: a Modified Therapeutic Community Model for Methadone-Maintained Clients. George De Leon 'Community as Method' 1997, pp225-239

Final 4.3

GLOSSARY

Recovery

Recovery is "a process through which an individual is enabled to move from their problem drug use, towards a drug-free lifestyle as an active and contributing member of society."

"Recovery is most effective when service users' needs and aspirations are placed at the centre of their care and treatment... an aspirational and person-centred process"
(*The Road to Recovery, Scottish Government 2008 P.23)*

Abstinence

To refrain from the usage of chemicals or substances to which a person may have become addicted.
(*Treatment Solutions Network, Dictionary)*

Harm Reduction

Harm reduction is a term that defines policies, programmes, services and actions that work to reduce the: health; social; and economic harms to: individuals; communities; and society that are associated with the use of drugs.
(Newcombe,1992)