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### **Abstract**

There has been much talk in recent months as to developing a clearer more focus drug strategy. A drug strategy, that has a more clearly defined intention for both service users and those commissioning and providing the service. In Scotland this has produced a strategy that has placed the recovery process at its heart. In the rest of the U.K. the focus has been less explicitly stated. However, it is evident for recent conferences and debates in the media and within services that there is a momentum for change in how we deliver treatment and support services. Our challenge is to ensure that such a shift really benefits and is focused on those who are seeking to change behaviour, and is supported by an enthusiastic, competent workforce.

### **Key words**

Recovery, Abstinence, Treatment, Workforce, Drug Strategy

Why has it taken until now for policymakers to be openly talking about the need to promote recovery? More importantly, why is this supposed change in direction coming from policymakers as opposed to being led by those working in and managing services for those affected by drug and alcohol use. This article seeks to argue that too many people working with substance users (particularly for the purposes of this article – illicit drug users) have lost their sense of purpose, direction and appreciation of the nature of dependence. Not only has it been lost, but also, unfortunately for some service users, in too many cases commissioners, management and staff never had a shared sense of purpose, direction or understanding in the first place.

Some may argue that because the addiction field is now so large, so 'mainstream', and the problems of drug use so prevalent that it is inevitable that certain features may be lost along the way. However, if one was to compare the growth of the addiction field with other specialist areas of health and social care, there are a number of significant differences. It is these differences that appear to this writer, to help to explain why the promotion of recovery as a guiding philosophy is causing so much debate and confusion. Over the past three years, particularly in Scotland, those involved in the planning, developing and delivering of drug services have been actively seeking to understand not just the problems we face, but crucially why – despite significant investment in 2001 and again in 2005 – service provision seemed to be having minimal impact on the numbers of drug related deaths, waiting times or planned discharges.

Service providers talk of the length of time service users are engaged with their service in overwhelmingly positive ways. For, methadone maintenance, it is usually suggested that 12 months is the minimum optimal length of

treatment. However, there is little evidence to suggest that the benefits increase if people stay on methadone for years at a time. In fact, evidence from the DORIS research would suggest the opposite in view of that study's conclusion that the longer someone is in treatment, the more detrimental the effect on a number of social factors like employment, drug use, and relationships with family.

During my involvement in the development of the *National Quality Standards for Substance Misuse Services* (Scottish Government, 2006) and the *Essential Care Report* (Scottish Government, 2008) it was becoming increasingly apparent that there was a gulf between service users' expectations of drug treatment and support, what the public thought was available, what service providers were doing, and what senior managers (including central government policymakers) thought was available.

Many service providers would be hard pushed to state their philosophy of care, many staff working in the field would find it difficult to evidence what outcomes they help to achieve for their clients. It is not that managers and service staff are uncaring, lack knowledge or experience. However, it does point to a lack of clarity as to the intention of drug treatment and support. This lack of clarity, what is referred to above as philosophy of care, means that with an increasing emphasis on demonstrating outcomes and indeed on promoting recovery, a lot of people working in the field are confused as to what they are supposed to be doing.

In some cases, this confusion manifests itself by the demonstration of resistance to change, questioning of others' understanding and authority, or aggressive behaviour at public meetings/conferences. In fact, it is very similar to the behaviour of those who we are employed to support and help. Part of the problem is the lack of commitment to ongoing learning and development once working in the field. This is a situation shared with many other areas of work and cannot therefore be the total cause of the difficulties faced. The fact that people obtaining work in the addiction field can do so without having any formal, or indeed informal, qualifications or even direct experience is something we do need to make a serious commitment to rectify.

The stated purpose of state-funded drug treatment and support services is long overdue. Whether it should be 'recovery', and whether indeed those currently fuelling this debate first understand what they mean, and second, would also recognise it when it happens, is less obvious. The issue to be discussed and debated is not the definition of recovery but the purpose of drug treatment and support services *per se*. If promoting recovery is to mean anything it has to involve the person 'getting better', about 'moving on' and crucially about being in control of their own destiny. For this 'getting better' to be sustained and meaningful, others around the person need to be able to see that the person has 'got better', is 'getting better' and that they (the significant and not-so-significant others) benefit from this change.

This is the difference between talking about recovery and recovery being attained. What service providers should be working towards with service users is the promotion of recovery. Once an individual no longer has to actively use strategies to maintain the changes to behaviour they have chosen to make, they no longer need, nor should be encouraged to remain with a 'service'. This is not to say that they should not be actively encouraged to seek support for others in a similar position. DiClemente (2003) talks of '*termination from the*

*cycle of change*'. He explains that this termination '*allows addicted individuals to invest their entire energy and attention on creating the alternative lifestyle needed to become a successful ex-addict and ensure sustained recovery*' (p208). The point to be understood is that there is an end. In order to change behaviour, in this case problematic drug use, the individual has to actively decide to change, change, and move on.

The purpose of state-funded drug treatment and support services is that they should be focussing on helping the change. In some cases, for some individuals, service intervention can assist to identify the benefits of change and the costs of not changing, but ultimately a decision to change needs to be made. To remain a client of a state-funded service requires a commitment to change. If, for whatever reason the individual does not feel ready to make that commitment now, then alternative support should be offered. Here lies the crux of the problem. The vast majority of drug treatment and support services in this country do not differentiate between those who are ready and those who are not. In stages of change language we have services designed for those in the 'decision/action' phase, when in effect most people approach services in the 'contemplative' and even 'pre-contemplative'. Obviously, as we all know, this situation is far from static and changes constantly, yet having this knowledge does not seem to affect how we structure service access and delivery. Hence we have many services, employing numerous workers supporting thousands of service users with no clear idea of what they doing, where they are going, and what difference, if any, is being made.

Management and staff within all addiction services need to have a clear understanding of what the benefit is to the client in attending and be focused in assisting those service users ready to change and aspire to a better way of living.

This is not about a new assessment form, but it is about being very clear as to the purpose of assessment. It is the classic difference between assessing commitment to change by listening to the words spoken by the individual as opposed to the actions of the individual.

There is a view, prevalent among those working in the addiction services, that methadone maintenance is the only treatment option and that '*recovery does not begin until methadone detoxification is completed*' (White, 2008 p79). In Scotland, in many areas you would struggle to access a detoxification programme. Therefore, if the prevailing view is that all drug users are offered methadone maintenance, and recovery cannot happen unless they are detoxed from methadone, but they can't access a detoxification programme because it is seen as unnecessary, is it any wonder that those working in the addiction field are struggling to get their heads round what 'recovery' is.

The point has often been made about the gap between research and practice within areas of addictions. Unfortunately, this still shows little sign of closing. A recent publication (*More Than Methadone* (2008) provided evidence of the extent to which the treatment of drug dependency in Scotland is dominated by a focus on methadone as the treatment of choice. This is regardless of the fact that many drug users use more than one drug, and that methadone programmes are perceived in a negative light by service users and service providers alike. This report follows a number of other recently published reports, which all question the current range of treatment options available and indeed what we are trying to achieve by treatment *per se*. For example the Scottish Government's 2007 reviews, *Review of methadone in drug treatment*:

*prescribing information and practice and Reducing harm and promoting recovery: a report on methadone treatment for substance misuse in Scotland.*

Despite these reports and much discussion there has been minimal change. The fact remains that the majority of drug treatment programmes in the UK bear only passing resemblance to the evaluated programmes as described in clinical research. The differences are in terms of duration, dosage, additional support and competence of staff teams. This is not to say that it is delivered without compassion, though unfortunately that can no longer be as readily assumed, as was once the case.

My contention is that if drug treatment services are unclear as to their purpose, how can they ensure they employ the appropriate staff, support those staff with necessary ongoing training and supervision, set, measure and report on agreed outcomes and ultimately make any difference whatsoever to an individual's drug using behaviour.

If in addition to this lack of understanding of purpose we add resistance to establishing an agreed purpose, then we do have a serious credibility problem. It is apparent from recent pronouncements both online and at a conference that some individuals working in the field are resistant to the concept of recovery. They might explain their resistance on grounds of definition; this however, does not sustain scrutiny. The issue at hand is the purpose of intervention – in this case usually described as treatment and support. Why should the state fund drug treatment services if they cannot offer more than what is available either for free/minimal cost via peer support such as AA or indeed Smart Recovery?

One of the reasons why investment in the drug treatment field has levelled off is the minimal information available on what difference we are making. This is not just about abstinence versus harm reduction; it is far simpler than that false debate.

It is not unreasonable for the public to know, and more importantly for drug users to know that if they attend a drug service they will receive support for their drug problem, and that this will include support to become drug free if requested by the service user. As mentioned above, this is not necessarily the case. Hence, when we talk about recovery being a '*process through which an individual is enabled to move on from problem drug use, towards a drug-free life*' (Scottish Government, 2008) this is being interpreted by some as adding a couple of questions on to an assessment form. Or in other cases 'setting up a recovery group' to which people will be referred at the 'end of treatment'. An 'end' that very rarely happens. For those who insist that drug use is not problematic and that there should be no pressure to reduce or stop, I would agree that it has to be an individual choice. However, what is not necessary is for such a choice to be supported by a drug treatment service. Too many drug treatment and support services continue to provide support in the absence of even the most vague commitment from the service user to change. Why? This at best is a demoralising work practice and at worst, collusion.

*'One of the most important findings from several decades of research on substance use disorder treatment is that clinicians are a **key** factor influencing treatment outcome and retention.'* (Najavits et al, 2000)

In particular as cited in White (2008) '*what does seem to matter in terms of recovery outcomes are key counsellor traits: low level of hostility; hope;*

*optimism and confidence; a high degree of empathy; respect; genuineness; concreteness; minimal wish to control; and enjoyment in helping those with AOD problems'. (p84)*

Furthermore '*clinicians typically account for **more** variance in patient outcomes than do differences between active treatments or patients' baseline characteristics*'. (Najavits *et al*, 2000). This finding was one of the more conclusive findings from the Project Match work.

Thus we reach the crux of how we can better meet the demands of service users, the public and those deciding on the future funding of drug treatment services. If we, collectively decide to continue to invest public money in drug treatment then we have to focus more on what the clinicians, key workers and counsellors are actually doing. What would help is having the necessary structure in place to support this. A nationally agreed philosophy of care stating clearly the purpose of drug treatment and support would be a start. However, without this being reflected in the actual approach and interventions offered by services and in the training and ongoing support of staff it will have no effect whatsoever on the outcomes for those experiencing problems with their drug use.

Staff and managers working within this field need to focus on working with the person 'in the moment'. This is more than merely understanding what stage of change the person is in, but rather about properly listening and finding out what is happening in that individual's life, what helps and hinders their decision-making about behaviour change. There needs to be a greater understanding and appreciation that the role of the worker is as the facilitator of change. The worker is a source of knowledge of what will help and what will hinder that change, whether that knowledge is about local services and educational opportunities or about the bus service. However, it must also include talking about the actual substance use itself, not making assumptions and not acting on perceived information, supposition and prejudice as opposed to facts.

So in answer to the question at the beginning – no you can't recover what you never had. For some people this does not matter, for others it will make the process more painful. Not only to realise what was lost by drug taking but realising that, in some cases, you never had it too lose. But for those working to support them this has to be accepted as fact, and not avoided or ignored.

The concept of promoting recovery within the drug field needs to be seen for the opportunity it is. That is having a long overdue focus on supporting the individual with the drug problem in an appropriate way so that the drug use ceases to cause them the problems they are currently experiencing. We can do this by focusing and developing the core skills of the workers and ensuring that those managing said workers and those monitoring the service outcomes focus on meaningful information and not just that which can be measured.

If those currently working within the field are unwilling to work in this way and don't want to learn because of personal beliefs about the legal status of drugs or views on the value of detoxification and abstinence then perhaps they need to admit one thing and do another. Firstly, admit that it is not about them and secondly, look for another job.

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