Drug Matrix cell A2: Interventions; Generic and cross-cutting issues

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S Everything you believed about heroin addiction is wrong (1977). Or biased to an extreme degree by a vision usually restricted to the atypical users who enter treatment in societies where the drug is illegal, hard to obtain and demonised. In the 1970s a high proportion of US soldiers became addicted in Vietnam but (even if they still dabbled) 'recovered' without treatment on return to the USA, highlighting the importance of environment and the rewards of a 'normal' life; those for whom this is not enough or who cannot access these rewards face problems other than their substance use.

S 'Pre-recovery' foundations of recovery orientation (2000). Though relatively recent, justification for the 'seminal' tag is that this study predated by many years the recovery era in British policy, but laid some of the foundations for its shift in emphasis from the psychological or biochemical grip of addiction to lifestyle change which breaks with the past satisfyingly enough to forge a positive, non-addict identity and prevent relapse.

K Remission is the norm but some take much longer than others (2011). US national population survey found that ten years after meeting criteria for dependence, in respect of cannabis two thirds were no longer dependent and three quarters for cocaine. Reanalysis (2013) of data from the same series of surveys points out most remit without treatment and that since onset is typically around age 20, by age 30 most people formerly dependent on cannabis or cocaine are no longer dependent.

K English treatment services vindicated (1999). NTORS which recruited its sample in 1995 remains the most important treatment study in Britain. Conducted when all the treatment modalities it studied (inpatient, residential and methadone) were under political and/or financial threat, it seemed to show they reaped benefits which greatly outweighed their costs. Recruiting its sample about eleven years later, DTORS (2009) reached similar conclusions, but nearly three quarters of the sample could not be followed up.

K Abstinence rare outcome in Scotland (2006). Recruiting its sample in 2001, DORIS was the Scottish equivalent to the English NTORS and DTORS. The apparent mismatch between the abstinence ambitions of the patients and the lack of abstinence outcomes was the main theme, but the findings were not so clear cut. See also these reports from DORIS on employment (2008) and crime (2007) outcomes, and an omnibus report (2008) on the project's findings.

K Influential treatment process model emerges from US studies (2002). DATOS was one of the US equivalents to the Scottish DORIS and the English NTORS and DTORS studies. Instead of heroin, cocaine was the main drug. For the UK the study's significance lay less in its outcomes, than in the highly influential model of how treatment works and therefore how it can be improved which emerged from this and other studies by the same US research institute.

K Motivating aftercare (2007). US inpatient treatment centre systematically applied simple prompts and motivators to substantially improve aftercare attendance and sustain recovery. See also later report from same study.

R Substantial annual rate of remission from dependence on illegal drugs (2010). Synthesis of treatment and general population studies helps fill the gap in the key study above relating to dependence on opiate-type drugs; each year one or two patients out of every ten overcome their dependence. For amphetamines corresponding figure was from one in two to one in six, and for cocaine from one in eight to one in twenty.

R Remission is the norm (2010). In the general population and in treatment samples, on average studies have found half (or more in recent studies) of all problem substance users were later in remission. After treatment, six out ten remitted by becoming abstinent, but among general population samples, six out of ten continued to use.

R Engaging the treatment-resistant (2010). Confrontation and tough love are not the best ways for families to persuade their problem drug users to get help.

R Tailor induction (2005). Some patients need motivation bolstered and options explored, for others this is not just unnecessary but counterproductive.

R Chronic care for chronic conditions (2009). Generally the offer of long-term continuing care or 'aftercare' leads to better outcomes; the implication for this US expert reviewer is that dependence is best treated as a chronic condition. A later review (2014) built on his work, adding 13 studies to the 20 previously identified and aggregating all substance use outcomes reported in the trials. The result was a less positive picture than the previous review's count of studies which found at least one measure enhanced by continuing care.

G Recovery defined (2008). In 2008 a national UK charity aiming to foster evidence-based debate about drug policy brought together 16 experts to (if they could) agree an understanding of 'recovery' from problem substance use. Remarkably, they did agree, characterising it as "voluntarily-sustained control over substance use which maximises health and wellbeing and participation in the rights, roles and responsibilities of society".

G Treatment principles ([US] National Institute on Drug Abuse, 2012). Presents 13 research-based principles of addiction treatment, seven of which have been tested against the North American evidence. Principles relating to individualising treatment were consistently supported.

G Strategies to promote continuing care (2009). Expert US consensus on practical strategies to promote continuing care based on review above.

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For subtopics go to the subject search page or hot topics on promoting recovery through employment, on mutual aid and user-involvement, the need for residential care, on individualising treatment, and on recovery as a treatment objective.

Matrix Bite a commentary on this cell from the cell-by-cell Matrix Bites course funded by the Society for the Study of Addiction

Click underlined text to highlight text/link in cell

What is this cell about? Whether medical or psychosocial, chosen positively or under pressure, patients have to decide to get help, find their way to treatment or get sent there. Decisions must be made about treatment objectives and the form, intensity and duration of care, relationships forged, and attention paid to psychological problems and social circumstances which affect the chances of a sustained end to dependent substance use. Seen as important is the very fact that someone or some institution sanctioned by society has identified the patient/client as in need and deserving of help, believes they will benefit, and has the status of an expert in the problem and its solutions. This cell is about these generic functions and 'common factors', now widely recognised as at least as important as the particular therapy. Also here we touch on the nature of addiction and the nature of the caseload seen in treatment services, helping place those services in the context of the spectrum of dependent drug use in society and the 'natural' processes of recovery which treatment seeks to harness and accelerate.

Where should I start? Perhaps at the end, with what treatment should be trying to achieve. Inevitably that 'should' word plunges us in to the worlds of value and politics not susceptible to resolution via randomised controlled trial. Our interest in this course is not to even try for a resolution, but to learn at least two lessons: how those worlds sometimes very directly generate research in the expectation that the results will help further those agendas; and how those worlds influence the research itself, which like every other intentional human action, is a *motivated* endeavour; science is never *just* about science.

The governments of the UK agree that above all what they want out of treatment is 'recovery'. What they mean by that is not spelt out, but the broad themes are clear: some of the most marginal, damaged and unconventional of people are to become variously abstinent from illegal drugs and/or free of dependence and (as Scotland's strategy put it) "active and contributing member[s] of society", echoing governmental ambitions in England dating back to the mid-2000s for more drug users to leave treatment, come off benefits, and get back to work, becoming an economic asset rather than a drain.

Do experts and the people on the ground see it the same way? In 2008 the non-governmental UK Drug Policy Commission brought 16

together to thrash it out. They couldn't agree what *being* recovered was, but did agree that *getting* recovered is "characterised by voluntarily-sustained control over substance use which maximises health and wellbeing and participation in the rights, roles and responsibilities of society." Their brief report expands on each element of the definition. Note that by 'control' they meant "comfortable and sustained freedom from compulsion to use" – the traditional treatment goal of ending addiction. But that was, they said, not enough. Recovery is not just about ending pathology, but "accrual of positive benefits ... a satisfying and meaningful life".

Note what is *not* in their definition. Abstinence is missing. So too is leaving treatment, a rejection of what for government dating back to 2005 was the starting point of their emphasis on social reintegration which morphed in to recovery – the need to move patients through and out of the treatment system to free up slots in what was clearly going to be a less resource-rich era. Another government ambition was to get ex-patients back to work, and that the commission's 16 accepted, but in a softer formulation which allowed for other routes to a meaningful and productive life. This then is the agenda for the UK's recovery era – or at least, the most worked out version we have.

Highlighted study Burned in to the memory of participants in the UK drugs field in the mid-90s is the National Treatment Outcome Research Study, better known by its acronym NTORS (pronounced 'entors'). It was succeeded but not superseded by DTORS and in Scotland, DORIS, and remains the most important treatment study ever conducted in the UK. It also exemplifies two lessons for this 'bite': that research is generated in order to support or challenge politics and values; and how that research is conducted and presented is affected by (perhaps a different set of) politics and values.

The study was spawned by a task force set up in 1994 by Dr Brian Mawhinney, a UK health minister who saw his mission as infusing biblical values in public life. It was his challenge the task force's chair Reverend John Polkinghorne was alluding to when he said the impetus for his review included concern that "treatment might often be insufficiently oriented towards the attainment of abstinence. More specifically ... there were those who questioned the acceptability and legitimacy of methadone maintenance programmes, which seemed to some simply to replace an illegal drug with a similar drug legally prescribed" – sentiments strikingly similar to those expressed by the current UK government.

Suspicious of 'expert' opinion, Mawhinney had condemned the "'drug industry' who resist any threat to their present autonomy." Ironically, his review commissioned its key research project from the heart of that industry, the National Addiction Centre, whose allied health services provided the treatments he questioned. The questionable, headline-grabbing '£3 in social benefits for £1 spent in treatment' extrapolation from that study will be dealt with in cell E2. For the moment we record that while acknowledging room for improvement, it vindicated all the treatment modalities it studied (inpatient, residential and methadone), described by the researchers as a "powerful national asset". Yet with no control group of non-treated problem drug users, the improvements it documented could not be (but effectively were) wholly attributed to the treatment episodes on which the study focused. That was the major if perhaps unavoidable weakness in the study, but there were others (see the linked report), including some which make sense as a protective tactic. Highly political, the genesis of the study was an attack on the drug treatment sector, and the study itself can be seen as that sector fighting back. But like many essentially well designed studies, almost despite the agendas involved, lessons emerged which none of the parties to the endeavour would have wanted or predicted.

Issues to think about

▸ *A new life – or just the ending of addiction?* With the desired 'recovery' outcome defined, let's work backwards to what that means for treatment. Logic dictates it should determine how to assess success and the inputs needed to achieve it. Some argue that inputs related to non-addiction elements like wellbeing and reintegration are not essential to the treatment of *addiction*, but the business of other welfare, employment and health services. The UK group which defined recovery did not let treatment off so lightly. Their definition was, they said, about "the goals of treatment and rehabilitation ... that could be applied to all individuals tackling problems with substance misuse, and all services helping them."

Take that seriously, and surely it means treatment services will need to gear up with integrated access to vocational experts, family re-unification inputs, artistic and creative opportunities, and whatever else for their patients is needed to move towards a meaningful and productive life. Pause and shift ground from illegal drugs to tobacco or alcohol. Would we say someone who has sustainably stopped smoking or drinking, but hasn't found a job, is still on benefits, maybe even offending, and who remains at a loss for meaning in life, has failed to recover from their addiction?

But perhaps there are good reasons why these wider issues intrude for socially unacceptable addictions like heroin and cocaine, in a way they don't for drinking and smoking. By the time you have narrowed down to the minority who try these drugs, the very few who become regular users, those of the former who become clinically dependent, and then the subset of those who want to stop but can't without treatment, then you have selected a highly atypical and usually multiply and deeply troubled population – the caseload of addiction treatment services.

When a broader cross-section of young men is liberally sprinkled with heroin in an environment devoid of other interests and normal ties, the more deviant and drug-experienced among them may use regularly, but on return to their normal environments, all but a few will cease regular use and stay that way without ever having received any substantive treatment. These were the totally unexpected observations of Lee Robins and colleagues commissioned by the US government to investigate the looming avalanche of ex-military heroin addicts created by the Vietnam war. That avalanche never materialised, and the returnees barely troubled US treatment services. However, the few who did resort to treatment exhibited the classic pattern of multiple problems and post-treatment relapse.

Reflecting on the implications, Robins argued that "drug users who appear for treatment have special problems that will *not* be solved by just getting them off drugs." For her the reason why relapse is the norm after treatment seemed obvious: "It is small wonder that our treatment results have not been more impressive, when they have focused so narrowly on only one part of the problem." From the 1970s then comes this strong argument for what today we might call a recovery orientation in services treating addiction to drugs like (in terms of their social as well as pharmacological properties) heroin; that for these addicts, their drug use is entangled with social dislocation and multiple problems, which unless addressed will repeatedly precipitate them back in to addiction.

Now you may be in a better position to ask yourself: Should we accept repeated and widespread post-treatment relapse as a sign of the intractability (or as US guidelines have it, the persistence of drug-induced brain dysfunction) of addiction, or is it a sign of the inadequacy and mistargeting of treatment? If treatment takes on the recovery challenge, how many fewer patients will we be able to afford to treat, and will that be counterbalanced by greater success in closing the revolving door of treatment re-entry due to relapse? Is it simply beyond the reach of any feasible treatment service, even with partner services, to create environmental changes of the magnitude which led to rapid, widespread and lasting remission from dependence among Vietnam returnees? Must we set our sights lower, and ameliorate while

we seek usually only slightly to accelerate the normal processes of remission (tracked in these studies: 1 2 3) – or is that what could prove a self-fulfilling lack of ambition?

▸ *What do the patients want?* In the era of the consumer model of health service delivery, allusion to the primacy of the patient's wishes is required in any policy statement or guidelines. That makes those wishes contested territory; commentators committed to certain treatment goals will appeal for validation to what is seen as the ultimate authority – the patient. In turn that makes research on patient perspectives critical, and sometimes too contested.

The prime example comes from Scotland, where researchers from the DORIS national treatment evaluation study differed over the implications of their findings. It started with the "surprising" finding that 57% of Scottish drug treatment clients selected abstinence as their sole goal for changing their drug use, seemingly the first time any large-scale British research project had asked this fundamental question. For the lead author the answers were a sign that we have failed to match patients' ambitions and instead prioritised harm reduction. Rather than the reservations expressed in the scientific paper, he said "The drug users in the Scottish research have spoken with admirable clarity." But armed with further, more in-depth findings from England, later a former DORIS colleague disagreed. It was, she said, unclear what patients meant when they ticked "abstinence/drug free" in response to the question, "What changes in your drug use do you hope to achieve by coming to this agency?" Did they mean free from all drugs, or just the one(s) causing them problems? Free now or in the future? An aspiration rather than what even the patient would see as a realistic goal? It might also be asked whether the finding really was "surprising"; 44% were starting drug-free and/or explicitly abstinence-based treatments and the same proportion were in prison, where abstinence would normally have been the only sensible objective. Rather than a surprising mismatch, the paper can as easily be read as showing patients' objectives match those of the treatment they are entering and the constraints of the setting.

Still, the seeming contrast with the supposed finding that just 3% of Scottish methadone patients emerged from treatment drug-free was headlined as proving treatment fails patients, and used by politicians to justify what the media described as a "Cold turkey plan for Scots addicts." Their case was sharpened by the further contrast with what was portrayed as a corresponding figure of 25% in England.

All this was sloppy at best, deliberately misleading at worst. The iconic '3%' figure came from a DORIS report. Read our analysis, and you will see that it was based on patients who had entered methadone programmes only *after* leaving their first treatment during the study period. The corresponding figure for England instead (and more conventionally) related to the initial treatment. Also, the definition of abstinence in Scotland meant patients must not be using any illegal drug and not on methadone. In England, they could have been on methadone and using cannabis. Scottish apples were being compared with English pears, and then with the supposed ambitions of Scottish patients, which in reality were not at all clear.

Was this a case of science being bent to agendas? And even if it was, did it highlight a valid point about insufficient attention to patient wishes and whole-life recovery in Scottish services? As we point out in a hot topic entry, though important, misreading of the DORIS findings should not obscure the fact that, however the individual defines it, stopping use of some drugs (especially use so problematic that it has driven them to seek help) is a common long-term goal, and that for substitute prescribing patients, it often extends to eventually being free of legal substitutes too.

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