# Treatment of drug use disorders

*Do definitions of recovery, abstinence, harm reduction, reintegration need to change? Annette Dale-Perera looks to a more unified holistic approach.*

***Meet the author***
at the next Recovery Plus conference on World Drug Day where she will be expanding on this topic.

Europe faces increasingly diverse and complex drug problems – as does the US and elsewhere. Heroin and synthetic opioids remain a central issue but stimulants, 'misused medicines', new psychoactive substances and problematic cannabis are all important. About 2/5ths of people entering specialised treatment for drug use disorders (DUDs) in Europe are opioid users, almost a third are cannabis users, about a fifth are stimulant users (cocaine or amphetamines) and about a 10th use 'other' drugs. We must respond to a wider range of drug problems and related issues, including more patients with acute health issues presenting to emergency services due to new psychoactive substances and increased morbidity and mortality in prematurely ageing opioid users.

Europe also has a broad and diverse range of services to treat DUDs, with large variation between countries in drug trends and treatment services. According to the European Drug Report 2017, most treatment for DUDs is provided by specialist outpatient treatment centres: 974,000 people were treated in this setting in 2015. Other healthcare services provide outpatient treatment for people with DUDs, mainly in the form of opioid substitution treatment. 'Low-threshold' services also provide treatment. And in 2014, residential and inpatient treatment services treated about 116,800 people with DUDs. Prison-based treatment totalled 82,100 people.

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## Definitions of 'drug treatment'.

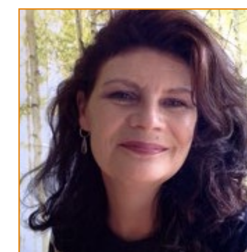
Many EMCDDA publications use the terms 'drug treatment' and/or 'harm reduction' interventions, but this article uses the term 'treatment of drug use disorders' in line with international standards (UNODC and WHO, 2016). This is to recognise from the outset that, in line with international evidence, an effective response to DUDs requires a coordinated and integrated system of treatment modalities and interventions provided by specialist and generic services in multiple settings to meet the diverse needs of different population groups affected by DUDs.

## Are treatment goals important?

Evidence indicates that services that are goal oriented and ensure that service users have individualised treatment plans are associated with better outcomes. Supportive, goal-directed treatment for DUDs is related to greater service user participation and satisfaction with treatment, and better drug use outcomes at discharge (Moos and Moos, 1998).
An international meta-analysis reported that in-treatment performance monitoring of behaviour against goals had significant positive effects on treatment outcomes – in particular, better drug use outcomes (Goodman et al, 2013).
National and international clinical guidelines on the treatment of DUD usually stress the importance of developing service user involvement in setting goals in the context of treatment or care plans (UNODC, 2008).

## Terminology associated with treatment goals.

**Harm reduction**. The World Health Organisation (2017) defines harm reduction as: "policies or programmes that focus directly on reducing the harm resulting from the use of alcohol or drugs without necessarily affecting the underlying drug use". The European Monitoring Centre on Drugs & Drug Addiction (EMCDDA) stated in 2010 that: 'harm reduction gives clear primacy to a public health perspective in which the imperative is to reduce immediate harms, and the question of longterm abstinence from drug use is either unaddressed or left open'.
Harm reduction is now part of the mainstream policy response to drug use in Europe (EMCDDA, 2010), including needle exchanges to prevent the spread of bloodborne disease.



***About the author***

Annette Dale-Perera has worked in addiction for over 30 years. She has a management consultancy (adpconsultancyuk) and is a lead consultant on an international project on quality drug treatment standards for the United Nations Office of Drugs and Crime (UNODC) and on development for CGL. Annette is also a government adviser (ACMD) and a trustee of 3 charities. Previously, she was an NHS strategic director of addiction and offender health, executive director of quality at the National Treatment Agency for Substance Misuse, director of policy for Scoda/DrugScope, research fellow at the University of London and a practitioner in therapeutic communities and community drug services. .
Read more on this topic at: www.emcdda.europa.eu/system/files/attachments/6322/EuropeanResponsesGuide2017_BackgroundPaper-Recovery-Reintegration-Abstinence-Harm-reduction.pdf

**Abstinence.** The term 'abstinence' means different things to different stakeholders.
More recently, abstinence can mean not using a problem or index substance, while the longer-held meaning was not using any drugs or alcohol. 12-step 'mutual aid' bodies equate 'abstinence' with not using the 'problem substance' or 'being clean' (Narcotics Anonymous, 2017). There is intense debate about whether patients in OST should be viewed as 'abstinent', with several authors and policy bodies recommending that those in OST are recognised as being abstinent from heroin (Betty Ford Institute Consensus Panel, 2007) or in medically maintained or assisted abstinence: 'formerly opioid-dependent individuals who take naltrexone, buprenorphine, or methadone as prescribed and are abstinent from alcohol and all other non-prescribed drugs would meet this definition of sobriety' (White and Mojer-Torres, 2010).

**Reintegration**. The EMCDDA sees reintegration as depending on three social pillars: housing, education and training, and employment (EMCDDA, 2012). Many EU countries report a gap in addressing the psychological and other needs

of people with DUDs, but drug policies have begun to focus attention on reintegration and recovery. EMCDDA also acknowledges that other areas of life are equally important, including supportive social networks and an ability to live free from stigma and discrimination. EMCDDA recommends that 'social re-integration includes all those activities that aim to develop human, social, economic and institutional capital and activities that promote social integration should be integral to treatment'.

**Recovery**. According to the United Nations Office on Drugs & Crime (2014), the term 'recovery' has many meanings, but all involve improvements in quality of life. Internationally, 'recovery' or recovery management as a core component of the treatment of DUD is now widely advocated (Betty Ford Institute Consensus Panel, 2007; Humphries and Lembke, 2013; UK Home Office, 2010; UNODC, 2014; CCSA, 2015). In the context of mental health, recovery is often described as a personal journey or process with three core principles: agency – a sense of control over one's life, opportunity – having a life beyond illness, including being part of society, and hope – belief that one can have a fulfilled life and should not settle for less (SLAM/SWLSTG, 2010). But the term 'recovery' in the field of addiction is still surrounded by

*"A more concerted focus on goals... could also help 'futureproof' services against new opioid epidemics such as that caused by fentanyl and the synthetic opioids crisis"*

controversy. It was associated historically with the '12-step' Alcoholics Anonymous mutual aid programme and with abstinence. The World Health Organisation still defines recovery as 'maintenance of abstinence from alcohol and/or other drug use by any means' (WHO, 2017). Others advocate that abstinence alone is not recovery, and that recovery is a wider concept involving a process of both 'voluntary control' of substance use plus working towards positive outcomes in a range of other recovery capital domains. This is similar to the 12-steps which mention abstinence only in step 1 with the other 11 steps about lifestyle changes to sustain this, but can differ in that relapse is seen as a risk of losing positive outcomes – jobs, relationships, health, housing – gained in recovery.

### Are treatment goals mutually exclusive or interrelated, or different hats on the same thing?

A 'hierarchy of goals' is recognised as important in the treatment of DUDs (ACMD, 1988), from reducing immediate harms caused by active drug use to the goal of abstinence. Some argue that abstinence-oriented interventions fall within harm reduction (EMCDDA, 2010). Others who are recovery oriented describe the need for initial interventions in a recovery journey to focus on preventing immediate harm (NTA, 2012). So harm reduction goals can be seen as intermediate steps on 'a road to recovery'. And interventions that could be called 'reintegration' (eg, facilitated access to education or training) could be called 'recovery' interventions. These concepts are clearly related and overlapping – so if a system dominates on 'harm reduction' or 'recovery', can this create negative unintended consequences?

### Treatment goals: a matter for debate?

Perhaps the service user group for which the question of goals is the subject of most current debate is that of opioid users, particularly those with long drug-using careers, high morbidity and poor reintegration, especially those in OST. Significant evidence shows that the treatment service itself, as well as its management, organisation, staffing and culture, has a significant impact on service user outcomes, even when services provide the same evidence-based interventions such as OST (Bell et al, 1995; Moos and Moos, 1998). A harm reduction orientation in OST can be appropriate to reduce risk from continued drug use and promote engagement and retention. But lack of focus on longer-term drug use goals or wider goals can create 'destination-free' OST and prevent service users from overcoming dependence and/or achieving goals in other domains.

Put differently, a short-term focus on meeting acute needs (through substitute medication) might not provide a longer-term or extensive model of care that supports lifestyle change to ameliorate the longterm health condition of opioid dependence. The welcome addition of a focus on reintegration and wider recovery goals, particularly after the initial stages of OST, might help service users achieve a better quality of life and a wider range of outcome goals.

### Challenges of incorporating harm reduction plus reintegration and recovery goals.

Drug policy is rarely evidence based and is often politicised. Many service users entering OST express aspirations to be drug free 'one day', but

how, when and if they achieve this are moot points. The absence of long-term goals can leave people in OST without ambition or hope – although this may enable service users, staff and services to avoid 'failure'. Conversely, having expectations of goal achievement can result in service users, staff and policymakers having unrealistic expectations of the pace and likelihood of achievement and the level and extensiveness of support needed.

### Opportunities.

Opportunities could be created by re-examining OST goals and paradigms. Studies indicate that the pattern of OST use is often episodic with periods of OST interspersed with periods of abstinence or drop-out, followed by relapse and return to OST (ACMD, 2014). This pattern of treatment utilisation militates against achieving outcomes in all domains. Implementing local systems for the treatment of opioid use disorders (including OST) with an initial focus on reducing harm and preventing opioid overdose deaths, but with a focus in OST on recovery and re-integration, could provide multiple benefits. It would help to keep people who use opioids alive. This could provide opportunities for service redesign, in partnership with service users, to ensure that new models are aspirational, with a focus on improving quality of life and meeting wider goals such as health, social networks, meaningful activity. Developing a new system of treatment for DUDs that can harness other local services and community assets to help people who use opioids achieve a range of recovery outcomes is also of particular importance in times of economic stress.

The potential role of mutual aid and 'experts by experience' is underutilised in some countries. Involvement with mutual aid increases service users' chances of achieving outcomes that include social connectedness and wellbeing. 'Experts by experience' working in services that treat DUDs can inspire hope, and 'co-production' can both enable volunteering and work placements in non-clinical posts and enhance service cost-effectiveness.

Re-examining our OST paradigm can provide opportunities to learn from other types of healthcare – such as mental healthcare, managing long-term conditions, other 'lifestyle change' areas – and can update definitions and models with new thinking and evidence. Implementing a recovery and re-integration approach could also provide opportunities for planners and providers to tackle local stigma and promote communities in helping those with drug dependence problems to re-integrate through promoting visible recovery and positive impacts.

The paradigms of abstinence, harm reduction and recovery alone are inadequate frameworks for goals and each brings its own bias and unintended negative consequences. A more nuanced approach is required. This should consider the systems of services required to meet the diverse needs of those with drug use disorders, provide a critical focus on services with goals to reduce the harm related to drug taking and (for those with long-term chronic relapsing conditions) should be an extensive, holistic approach more akin to long-term health condition management.

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