Past, present and future in addiction treatment

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What were things like for the addiction treatment field 30 years ago?

The decade of the 1980s was really a heyday for short-term residential treatment centres both here and in the States.

Changes in U.S. Alcoholism Beds 1978 - 1984

	1978	1984
Government	10,240	10,458
Not for profit	4,952	11,520
For profit	813	4,003
Total	16,005	25,981

Source: USDHHS (1987), p. 121

In U.K. there was one free-standing (private, not-for-profit) alcohol and drug treatment centre in 1974.
By 1984 there were 25 private centres (for profit and charitable), and 400 private alcoholism/addiction beds in psychiatric hospitals “a number far exceeding NHS provision” (Curson 1991).

Political, economic and social reasons for this increase in both countries.

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What were things like for the addiction treatment field 30 years ago?

Clouds House in 1985

40+ patients in treatment most of the time (approx. 80% alcohol, 20% other drugs)

Treatment team:

11-13 counsellors in 2 or 3 unit teams. (Niebuhr, Akron, Mayflower):

Dermot Staveacre, Norman Taylor, Eric Hruska, Sally Gillingham, Joy Bannister, Tristan Millington-Drake, Steve Easton, Ben Vigrass, Helene Clerbois, Tim Leighton, Pippa Clarke, soon to be joined by Sim Proctor and Peter Pugh.

Full-time Medical Director (Margaret-Anne McCann) assisted by Dr Ken Prior.

Clinical Psychologist (Nick Barton).

Full-time spiritual counsellor (Fr Matty, Fr Con etc.).

Volunteer visiting spiritual assessors (Sr Louise, Helen).

A substantial team of nurses (full-time Nurse team leader (Collette Madden), full- and part-time staff nurses, nursing assistants).

Creative funding arrangements

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Principles of the Minnesota Model

- Treat people with alcoholism/addiction
- Treat them with dignity
- Treat them as whole persons – physical, mental, spiritual

- Multi-disciplinary approach
- Active linkage with community of recovery (AA members meeting patients, sending patients to meetings during treatment, in-house meetings, connecting them to home meetings/temporary sponsors)
- Routine active involvement of family, thinking systemically
- Work with employers

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Principles of the Minnesota Model

- Treatment environment was dignified but not luxurious or exclusive
- Responsible, communal, ordinary life

“I've been rakin' leaves with Liza, me and Liz clean up the yard -
Left my home in Music City, In the back of a limousine, now I'm doin' my own laundry and I'm gettin' those clothes clean.”
Detox Mansion, Warren Zevon, 1987

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Practices of the Minnesota Model

Genuinely multi-disciplinary assessment and treatment planning

Every patient at Clouds would be assessed face to face in a collaborative interview by:

- Medical staff – detoxification and medical stabilisation
- A counsellor – social history and current psycho-social issues
- Another counsellor – detailed addiction history
- Spiritual counsellor – beliefs and values assessment
- Psychologist – psychological assessment
- Family counsellor – family relationships and support assessment

At Hazelden (even better resourced!) they would also be assessed by

- An activities specialist – exercise and recreation
- An aftercare specialist – re-entry and aftercare planning

Each of these assessments would be discussed by the team to create an individual multi-dimensional treatment plan to be discussed and agreed with each patient

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Practices of the Minnesota Model

Great stress on team-working.

A sharing of the case-management of each client.

Each member of the team knows all the clients in their group.

Working directly and consistently with family members, offering help to them in their own right.

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Funding and regulatory compliance in the 1980s

Minimal regulatory compliance requirement, registration as nursing home required for programmes with medical component but not difficult to obtain.

No published standards

Funding – statutory: income support payments (£190 per week in a nursing home), probation service, occasional GP referral

Funding – private: private funds, health insurance, employers

What happened?

Early 1990s: the turning point

Community Care Act 1991

Insurers and employers take fright in late 1980s in the States

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Funding and regulatory compliance in the 1980s

Insurers and employers take fright in late 1980s in the States

General Motors' bill for employees' addiction treatment in 1987 was $78 million.

Introduction of aggressively managed behavioral health care leads to a 50% loss of residential treatment beds nationally in 1990s

U.K. Insurers also take steps to reduce spend on residential addiction treatment

After the Community Care Act kicked in, Clouds registration went down from 55 to around 35, and there were significant treatment team redundancies.

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What progress has been made since 1985?

We have made progress in our understanding of:

- Gender issues
- Sexual orientation
- Cultural needs

We have gained knowledge around:

- Evidence-based interventions.
- The vast and mainly positive evidence base of the role of mutual aid.
- Expanded recovery communities.
- The legacy of family addiction.
- The role of trauma in perpetuating addiction and complicating recovery.

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What does progress mean in practice?

With increased awareness of areas such as equality and diversity and health and safety comes increased quality assurance requirements and legislation.

Examples include:

- The Care Act (2014)
- The Mental Health Act (1983)
- Equality Act (2010)
- Health and Safety at Work Act (1974)
- Homeless Reduction Act (2017)
- Mental Capacity Act and Deprivation of Liberty Safeguards (2005)
- National Institute for Health and Care Excellence (NICE)
- UK Drug Strategy 2017
- Care Quality Commission (CQC)

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What does progress mean in practice?

In 2003, the creation of Supporting People teams in local authorities introduced a significant change to the way third sector services, including substance misuse services, were assessed.

The Quality Assessment Framework contained 5 objectives and 21 standards with each standard being graded at level A, B or C. The QAF asked for specific evidence to be provided at each level for each standard.

We only need to look at one of these to see high expectations had become.

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C1.1 Assessment and Support Planning

All clients receive an assessment of their support needs and any associated risks. All clients have an up-to-date support and risk management plan. Assessment and support planning procedures place clients' views at the centre, are managed by skilled staff and involve other professional and/or carers as appropriate.

Standard		Performance Level	Essential requirements (C) or Indicative evidence (A / B)	Evidence
This standard supports the service to meet outcomes in the following outcome domains: Achieve economic well-being, Enjoy & achieve, Be healthy, Stay safe and Make a positive contribution.				
		Basic minimum requirements for an adequate service (Performance Level C)		
C1.1.1	The needs of applicants / clients and any inherent risks are assessed on a consistent and comprehensive basis prior to a service being offered, or very shortly afterwards as appropriate to the needs of the client group.	Level C	The needs and risk assessment policy and procedure is written down and reviewed in response to changing legislative or contractual requirements and at least every three years.	
			The procedures state how clients will be involved.	
			Staff understand and follow the procedures.	
			There is a needs and risk assessment tool appropriate to the client group.	
			The needs and risk assessment procedures are covered in staff induction and training programmes.	
			Risk assessment procedures address: • Risk to self	
			• Risk to others (including staff and the wider community)	
			• Risks from others (including staff and the wider community).	
			Needs and risk assessments take into account the views of other services as appropriate.	
			Copies of all assessments are securely stored and accessible to relevant staff and clients.	

Care Quality Commission

Moving forward the introduction of the Care Quality Commission (CQC) in 2009 meant the regulation of substance misuse services started to come under their remit.

It was formed from three predecessor organisations:

- The Healthcare Commission
- The Commission for Social Care inspection
- The Mental Health Act Commission

In 2015 the CQC announced a revised approach to their regulation and inspection of substance misuse services. One major change being the reclassification of residential treatment (with in patient services such as detoxification) as hospitals.

This change affected many facilities, including Clouds House in Wiltshire, UK.

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Care Quality Commission – 5 standards

Is it **safe**?

➢ Has 6 key lines of enquiry (KLOEs) and 38 prompts.

Is it **effective**?

➢ Has 6 KLOEs and 34 prompts.

Is it **caring**?

➢ Has 3 KLOEs and 16 prompts.

Is it **responsive**?

➢ Has 4 KLOEs and 27 prompts

Is it **well-led**?

➢ Has 8 KLOEs and 47 prompts.

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Implications of progress

So it seems as though we have made progress since 1985.

- We have developed a greater understanding of individual difference and needs.
- We have legislation and practices in place to better protect people from abuse.
- Expectations are specified in the form of consistent quality assessment frameworks and regulatory standards.
- We have regulatory bodies who scrutinise what we do and ensure we are providing adequate treatment for people with addiction.

But, it also feels like we have lost something.

CQC criticisms of residential drug and alcohol services

Many of the clinics were **not**:

- Assessing the risks to the safety of people prior to their admission.
- Following recognised national clinical guidance on treating people who are withdrawing from alcohol or drugs.
- Storing, dispensing and handling medicines appropriately.
- Carrying out full employment checks or sufficiently training their staff.

Nearly three in four providers failed in at least one of the fundamental standards of care that everyone has the right to expect.

Almost two-thirds of providers were not meeting the requirement for providing safe care and treatment.

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Commissioning

The Advisory Council on the Misuse of Drugs (ACMD) wrote to Sarah Newton MP on the 6th September 2007 about their concerns that funding cuts and commissioning, were having a detrimental impact on drug and alcohol treatment services.

They presented **5** conclusions:

1. Reductions in local funding are the single biggest threat to drug misuse treatment outcomes.
2. The quality and effectiveness of drug misuse treatment is being compromised by under-resourcing.
3. There is an increasing disconnection between drug misuse treatment and other health structures.
4. Frequent procurement of drug misuse treatment is costly, disruptive and mitigates drug treatment recovery outcomes.
5. The current commissioning practice is having a negative impact on clinical research into drug misuse treatment across the NHS and third sector providers.

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So what might be the problem?

Some of the practices have slipped away, or they are done less consistently, or corners are seriously cut.

- Multi-disciplinary assessment and treatment planning
- Multi-disciplinary case management
- Supervision as a priority

Role-modelling by experienced clinicians; trainees learning by direct observation and being observed.

- Group facilitation
- Assessment and treatment planning
- Counselling techniques

So what might be the problem?

Assessment tending to be done by structured form-filling rather than collaborative interviewing.

- Becomes a tick box exercise
- The right information isn't gathered to produce a comprehensive treatment plan.
- Risk assessments are kept separate and not seen as an integral and helpful part of the process.

Less sharing of client work across the team.

- The multi disciplinary and multi-modal approach has suffered.
- Work is too clearly categorised per role.
- Whole team case management

So what might be the problem?

Less time to think and reflect.

- This includes regular supervision provided by a qualified supervisor.
- Reflecting on practice is essential to improve outcomes for clients and continuously improve.

Inconsistent roles

- A lack of regulation around the profession means roles are not clearly defined; addiction counsellors, counsellors, psychotherapists, recovery workers, substance misuse practitioners, drug and alcohol workers?
- CQC focus on medical and statutory roles e.g. GPs, psychiatrists, nurses, social workers.
- They make a brief reference to counsellors having the ‘right certification’ with a professional body (but don’t specify which body).
- CQC recommend staff new to this work look to level 2 or 3 diplomas in health and social care.

Discussion

How does or has this impact on your work/organisation?

What is needed moving forward to address:

- Increased quality assurance and regulation
- Decreased resources and inconsistent roles and responsibilities
- Improvement and maintenance of the quality of client outcomes?