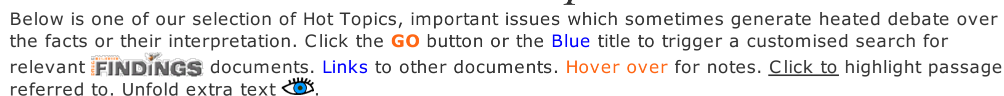

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GO What is addiction treatment for?

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What should drug addiction treatment try to achieve and for whom? The answers might seem obvious, but these are contested issues deeply entangled with today's recovery agenda. Inevitably that 'should' word plunges us into the worlds of values and politics not susceptible to resolution via randomised controlled trial, while overcoming addiction cannot properly be considered without also considering the nature of 'addiction' itself – a territory so wide and so diverse that we can only highlight a few landmarks. Apologies in advance if what you consider major landmarks are omitted – but do use the comment/query option above to tell us.

The core issue which determined our choice is the degree to which we can limit addiction, recovery and treatment to drug use, versus the degree to which all three are inextricably bound to the 'addict's' wider life context. The focus is on illegal 'drugs of dependence', of which the archetype is heroin – not because it is denied that alcohol is a powerful drug, but because the position of drugs like heroin in British society, and in the US society responsible for much of the research and ideas, is so different.

Our aim is not to reach a resolution of such questions, but to pose them with the aid of a few key studies and the thoughts of researchers and commentators.

We all want 'recovery' – but what is it?

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", an ambition which echoes those of the government in England dating back to the mid-2000s for more drug users to leave treatment, come off benefits, and get back to work – and become an economic asset rather than a drain.

Do experts and the people on the ground see it the same way? Not all, and the definition of recovery has been so contested and so crucial that special commissions have been set up to try to reach a consensus. In 2008 the non-governmental UK Drug Policy Commission brought 16 experts 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 expanded on each element of the definition, explaining that that by "control" they meant "comfortable and sustained freedom from compulsion to use" – the traditional treatment goal of sustainably ending addictive patterns of substance use. But that was, they said, not enough; recovery is not just about ending pathology, but about gaining "positive benefits ... a satisfying and meaningful life".

Note what was *not* in their definition. Abstinence was missing, and so too was 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.

Is treatment about creating ideal citizens?

The commission's 16 included a few 'experts by experience' in the form of past problem drug users or drinkers, but what of the wider views of those it is hoped will 'recover' from such problems? When in 2014 problem drug and alcohol users in and out of treatment in England were asked about their views on recovery, none of the drug-focused criteria identified by senior treatment staff gained widespread endorsement. Instead, participants "repeatedly argued that recovery meant 'being normal' and 'living life like everyone else'." The route to 'normality' entailed neither being like each other nor like other people, but was an individual itinerary, and would be diverted, limited and shaped by the usual human frailties and faults. Rejected were "superhuman" requirements which seemed to demand they become more worthy and better balanced than many people who have never had a substance use problem.

Though modestly expressed as a process of moving towards, the view that overcoming addiction entails developing lives more fulfilling than many was well represented by a definition from the US agency for substance abuse and mental health. It saw recovery from these problems as "A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential." In there were: "Making informed, healthy choices that support physical and emotional wellbeing"; "A stable and safe place to live"; "Meaningful daily activities ... and the independence, income and resources to participate in society"; and "Relationships and social networks that provide support, friendship, love, and hope". Explaining its vision, the agency said: "Recovery encompasses an individual's whole life, including mind, body, spirit, and community."

That view seems a far cry from the view of drug addiction evangelically promoted by another set of US officials – that addiction is a brain disease brought on by repeated use and that physical treatments based on the "influence of genetics and environment on gene function and expression" are a key way forward, one of the orthodoxies cogently challenged by psychologist Stanton Peele, co-author of the 1970s classic *Love and Addiction*.

In a blog he has listed "12 concepts of recovery that have stood the test of time." According to this vision, the key to

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recovery is not better medications, but having "larger purposes that rule out the allure of drugs, or alcohol, or smoking, or shopping, or random sex." Among these, the "number one reason" is love: "the desire to be loved and to do the best thing for the one you love is the most potent force on this list." Also there are: feeling empowered and in control of one's life; overriding values incompatible with a life dominated by substance use; discovery of the "real ... true ... free" self beneath disruptive and addictive behaviours; engagement with communities of interest and shared values incompatible with addiction – "The world is your oyster, a banquet of such options and opportunities"; "acceptance that this world – and your part in it – is valuable and not something to be escaped"; joy as the capacity to take pleasure in the people, things, and activities available to us; competence as the ability to master relevant parts of our environment and the confidence that our actions make a difference; the rewards of a non-addicted life such as being able "to awake with a clear head, to have the respect of others (as well as self-respect), to save money for something you want, to have satisfying, positive relationships, to care for yourself"; and self-tolerance or forgiveness.

What might that mean for treatment?

Having at least loosely defined the desired 'recovery' outcome, and looked at some of the mechanisms which might lead there, it should then be possible to work backwards to what that means for treatment. Logic dictates that if recovery is the aim, its characteristics should determine how to assess success in treatment, and the inputs needed to achieve it. Potentially that transforms addiction treatment into an endeavour of daunting proportions – achieving a kind of redemption in lives which among the caseloads of publicly funded addiction treatment services are often so divorced from the world's "banquet of ... opportunities", the love and respect of others, and the "income and resources to participate in society", that it is hard to see them getting there, even if drug use stops altogether.

Perhaps it is not the chronic state of addicts' brains which leads to the chronicity of addiction, but a chronically impoverished deal in life

Aware of this implication, some argue that inputs related to non-drug focused elements like wellbeing and social reintegration are not essential components of 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 advancement, family services, artistic and creative opportunities, and whatever else their patients need to move towards a meaningful and productive life. Pause and shift ground from illegal drugs to tobacco or alcohol: Would you 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? Imperfect they may be, but only in ways they share with many people who have never been addicted, and perhaps too in ways not entirely under their control, like employment, housing and family relationships.

But perhaps there are good reasons why these wider issues intrude for the more socially unacceptable addictions like those involving heroin and cocaine, in a way they don't so much for smoking and drinking. 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.

In contrast, 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 needing 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 war in Vietnam, where heroin was widely available to and widely used by the soldiers. 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 into addiction.

Rat Park; impoverished lives generate addiction

It might easily be assumed that combat stress and relieving it with the powerful narcosis of heroin explained why the US soldiers turned to the drug, but when asked, they gave more prosaic reasons. The most common were to combat boredom and depression, pass the time, and to better tolerate the rule-bound constraints of army life. Divorced from their normal productive and social lives and responsibilities, with little meaningful to do, and with nothing active they could do to change or get out of the situation, they chose to be numbed rather than frustrated.

In effect, they were penned in an inescapable cage where life was impoverished and devoid of its normal rewards and interests, and in which they had been deprived of their 'agency' to determine their own lives. They had been reduced from fully fledged actors in life to soldiers in a war which to them made little sense. And according to psychologist Bruce Alexander, for the same kind of reasons, caged experimental rats of the 1960s compulsively pressed levers to get heroin, morphine or other drugs in experiments thought to prove these substances were inherently addictive.

Not so, argued Dr Alexander, demonstrating in his iconic 'Rat Park' study that given a stimulating social and physical environment which allowed the rats to be what rats naturally are – productive, active and social creatures – they consumed far less of the same drug, in this case, morphine. Even physically dependent rats would avoid further morphine and suffer withdrawals in preference if housed in an enriched environment, while isolated caged rats continued to take the drug.

It was as if, Alexander thought, the rats wanted nothing to do with morphine because it interfered with the satisfying life in Rat Park. Deprived of those pursuits and satisfactions, the drug became addictively attractive. Similar findings

have (but not entirely consistently) emerged

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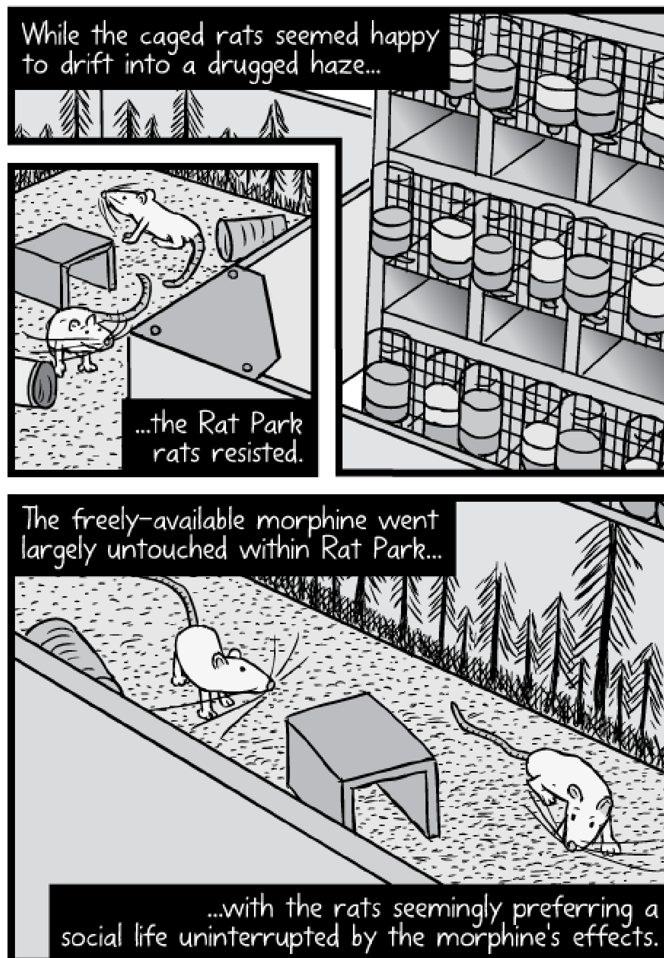
have (but not entirely consistently) emerged from other experiments, including one from China which confirmed that rats in a socially and physically rich environment do not find morphine rewarding, while those in more limited conditions show the expected preference for places where the drug has been available.

Stepping up the evolutionary scales, monkeys too seem to experience the protective nature of satisfying social relationships. Isolated in cages, researchers have found they self-administer cocaine sometimes to addictive levels, but when transferred to group cages holding four monkeys each, those who became socially dominant administered relatively little. Apparently their social status did a good enough job at raising their brain dopamine levels, and cocaine was not needed. The subordinate monkeys carried on fixing. There seems a clear parallel with the protective nature of social 'capital' (the key element of 'recovery capital') in human beings, and conversely the vulnerability of the socially stigmatised and excluded.



Frames from Stuart McMillen's entertaining and informative Rat Park comic book.

If addiction is socially generated, are treatment services part of the engine or the brake?

Far apart though the sites and the subjects were, the commonality in the findings from Rat Park and Vietnam raises fundamental questions about addiction and its treatment. Should we accept repeated and widespread post-treatment relapse as a sign of the intractability of addiction (or as US guidelines have it, the persistence of drug-induced brain dysfunction), or is it a sign of the inadequacy and mistargeting of treatment? Perhaps if we intensively, extensively and energetically addressed the multiple *non*-drug problems of patients seen in treatment services, addiction for them would not be chronic, and they would be more like the broader population who at times get in to an unhealthy tangle with drugs or drink, but have enough resources in their lives to sustainably pull themselves out? Perhaps it is not the chronically dysfunctional state of addicts' brains or their intractable weakness of will which leads to the chronicity of addiction, the but the chronicity and intractability of an impoverished deal in life dealt them by fate, and by societies predicated on having winners and therefore also losers?

From this perspective, treatment may be part of the solution, but conceivably too part of the problem, playing a dual role in an addiction-generating and addiction-sustaining society. Though those who later become addicts often start with few personal, social and economic resources, the little they do have will be eroded by criminalisation and social stigma, and by services which explicitly or inadvertently encourage the adoption of an addict identity. Retaining the non-drug related social ties (family, non-addicted friends, work) and associated identities which help prevent a descent into loss of control requires drug users to keep their use secret. When they have to come out into the open, these props are lost or taken away, and with them the resources needed to lever oneself out of the loss of control represented by the term 'addiction'. At this stage, descent into what is clinically recognised as dependence is rapid and turning back becomes extremely difficult. The ladders are hauled up (or, to switch analogies, the doors are closed behind them), blocking a return to normality, a chronicity laid at the door of the addict's supposedly chronic, relapsing condition.

Instead of being something they do among others (such as being parents and partners, students or workers), users of illegal drugs are led to see their drugtaking as central to their identity because this is how they are treated by other people and institutions (notably the criminal justice and health systems) who have power over their lives, among whom are treatment personnel. If they too come to see themselves as nothing but a 'junkie', the route to recovery is likely to be that much harder. Creating a new identity both in terms of one's self-conception and one's social network is an important task in avoiding a return to addiction (1 2).

But accepting the identity of addict and patient gains access to the micro-world of addiction treatment services, in which (at their best) the addict is accepted, made the focus of caring attention and an optimistic assessment of what they might become, moving them beyond an addict identity rather than reinforcing it. When such relations are lacking in (non-)working, family and social lives, the revelation of finding these qualities at a service and in a counsellor or doctor have been seen as the key therapeutic force. The problem, of course, is that it is a *micro* environment. Even when it is 24 hours a day for months as in residential services, the effects typically erode on leaving.

Yet the truth in the focus on treatment exit within recovery thinking is that this is a big step towards the goal of being reintegrated into society, and being seen as 'normal', escaping, in Stanton Peele's formulation, "perpetual identification and separation as being 'addicts', rather than human beings". There may be no justification for – and severe risks in – forcing or urging people out of treatment from which they might still benefit, but few people like or feel empowered by being in treatment, whatever the condition.

Recovery treatment for the few or amelioration for the many?

Such thoughts pose practical dilemmas for treatment. If treatment takes on the recovery challenge and widens its agenda, how many fewer patients will we be able to afford to treat, and will that be counterbalanced by greater

success in avoiding the revolving door of treatment re-entry due to relapse? Is it simply beyond the reach of any

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success in avoiding 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, keep patients alive and ameliorate the fallout from addiction, itself the fallout from an addiction-generating society, only modestly if at all accelerating the normal processes of remission (tracked in these studies: 1 2 3). Griffith Edwards, now deceased but arguably modern Britain's most prominent and respected addiction treatment expert, was modest in his claims for treatment: "The basic work of therapy is largely concerned with nudging and supporting movement along .. 'natural' pathways of recovery." Realistic views, or a self-fulfilling lack of ambition which fails to grasp the recovery challenge?

The dilemmas were sharply put by Professor Neil McKeganey, responsible for the Scottish national drug addiction treatment study of the early 2000s. In his book on controversies in the field, he asked whether a "revolution" in treatment was required which might see dual tracks of intensive help for the (perhaps relatively few) committed to recovery and abstinence, and a holding, harm-reduction track for the remainder. Another way to square the recovery ambition with the numbers addicted and diminishing resources would, he argued, be to refuse treatment or truncate it for those not committed to abstinence-based recovery. Without some such retrenchment, he foresaw the "very real possibility that current poor practices ... will continue ... and the vision of recovery ... will remain at the level of political rhetoric".

Though the solutions may be unpalatable, and the focus on abstinence an unnecessary hurdle, there seems no denying that getting to recovery as typically defined requires more of treatment services in the face of diminishing resources. Professor McKeganey reminds us that decisions have to be made – or perhaps more realistically, not made quite so explicitly as we muddle through and make those decisions by default, locality by locality. With the National Treatment Agency for Substance Misuse merged into Public Health England and its much wider and prevention-oriented remit, and with the demise of the English drugs field's representative body, DrugScope, the focus for a sense of the need to work out these issues on a national scale has been eroded. Instead of trying to determine how best to get value for money – entailing an appreciation of what 'value' consist of – we are descending towards a treatment system where money only counts – where the cheapest way to provide services wins out in the face of budget cuts. According to the former head of the National Treatment Agency for Substance Misuse, Public Health England 'has disinvested' from the local presence which characterised his agency, "limiting not only its ability to promote and share best practice, but also the local intelligence it previously provided which enabled Home Office and Department of Health to understand what was really happening on the ground." Lowest-common-denominator poor practice may be taking hold, but no one centrally will know until the consequences become apparent, perhaps as in the recent increase in drug-related deaths.

Run this search for everything we have indexed as about the intervention goal in drug addiction treatment, and this one for the natural recovery processes which set the context for treatment.

Thanks for their insights and information especially in relation to the Rat Park study to Shaun Shelly of the University of Cape Town in South Africa; see especially his lecture, Myths of Addiction. Thanks also for their comments on this entry to Shaun Shelly, Neil McKeganey formerly of the Centre for Drug Misuse Research in Scotland, and US-based psychologist Stanton Peele. Commentators bear no responsibility for the text including the interpretations and any remaining errors.

Last revised 10 May 2016. First uploaded 01 September 2014

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