

Leap

into recovery

Addiction treatment is turning into a form of learned hopelessness, argues Dr David McCartney. Galvanised by the need to do something positive, he explains how he formed the LEAP team with colleagues in Edinburgh to give clients a springboard to recovery.

If you're going to keep your sanity here, you have to get one thing straight from the very start. Get it firmly into your head that none of these people are ever going to get better.'

This was the advice of a medical colleague to me as I visited the service she worked in. She was talking about the clients in her care, mostly opiate addicts, in a large UK city. The service manager sat beside us nodding his head in agreement. He'd been showing me round some of the drug teams in the city as I contemplated applying for a job there.

At that moment and with utter conviction, I made two decisions almost instantaneously. The first was obvious: I could not work in a service where attitudes like that were embedded and accepted, albeit as a rationalisation for self-protection and preservation; it is after all, a challenging field. The second was 'I need to do something about this'.

I knew from my own practice in addictions that clients too often had the belief that nothing would ever change. It is a form of learned hopelessness. When professionals share the belief, inertia is inevitable. It was around this time that the concept for the Lothians & Edinburgh Abstinence Programme was born.

Methadone, often our first choice for opiate addicts, makes a significant impact – more so for some than others. But it doesn't seem to help people achieve their goal of becoming drug free.

Part of my addictions training was a spell of working in an abstinence-oriented residential treatment centre. In this setting, there is plenty of corroboration that recovery is an attainable goal for many. There is evidence too from British studies that a drug-free state can be reached. NTORS (National Treatment Outcome Research Study) in England and DORIS (Drug Outcome Research in Scotland) found that residential treatment was the intervention most strongly associated with abstinence.

As Professor David Clark has pointed out in *DDN*, in his excellent series on Recovery and Communities of Recovery, treatment is a tool to help people resolve their substance abuse problems. The key is helping the individual gain self-efficacy

and behaviours which will maintain recovery in the longer term. Hooking people into recovery communities is an essential part of sustaining recovery. Promoting a recovery culture will help clients in our services achieve it.

Cost can be one limiting factor for accessing residential treatment with only a minority of those seeking treatment getting to residential centres. We know from surveys conducted by the NTA and from DORIS that between 56 and 80 per cent of those coming to treatment services want to become drug free. We also know that most don't achieve this and I wonder if one of the reasons for this is that we as treatment professionals set our sights far too low for our clients. If we believe that recovery is impossible and carry on doing what we have always done, then the chances of it happening are slim.

Helping people to abstinence is not about hosting a debate on whether harm reduction or abstinence is better. It is about accepting the part methadone can play on the recovery journey, but not losing the momentum of travel. When working in maintenance clinics, I was always asking clients, 'What next? Where are you going next?' The harder question is: 'How are you going to get there?'

If many clients want a drug free recovery and it looks like residential treatment is too expensive for most, then the question arose in my mind: could we offer the quality of residential treatment services but do it in the community at a fraction of the cost? That's the question LEAP is hoping to answer.

Rather than reinvent the wheel, we looked to the evidence base of what seemed to work, drew on the latest brain science to inform practice and visited Providence Projects in Bournemouth, the forerunner of quasi-residential treatment in the UK. Their CEO, Steve Spiegel freely shared their data, which I'd originally heard presented at a European conference, but also shared valuable experience and essential elements of their programme with us, which was hugely helpful.

What is LEAP?

LEAP is an intensive detoxification and rehabilitation treatment programme based in the heart of Edinburgh. It is funded by the Scottish Government through the DAAT to NHS Lothian. Further specialist funding comes from the Robertson Trust. The core programme lasts three months and is delivered from a day centre. The majority of clients in the project are housed in supported accommodation provided by the City of Edinburgh Council. We have a core team of ten, including myself as clinical lead; Eddy Conroy, head therapist; Gillian Fulton, admin manager and three further therapists (Robert, Tracey and Richard), two nurses (Jim and Helen), a pharmacist (Mandy) and administrative support (Jan). We're delighted to have recently appointed seven volunteers to the team. We started treating clients in September 2007.

There are four evidence-based pillars to the LEAP model. These are: medical and therapeutic; housing; vocational training; and self-help.

Medical and therapeutic

After a three-stage assessment process which looks, among other things, at motivation and readiness for change, but is just as much about developing a therapeutic relationship, suitable clients are admitted to the programme. They are given a physical examination, a mental state assessment and offered screening for blood borne viruses and immunisation against hepatitis B and A. If detoxification is required, the client is involved in planning this and is offered choice. We use opiate, alcohol and benzodiazepine withdrawal rating scales during the detoxification period. The therapeutic programme is structured and pretty full. From the outset, the emphasis is on personal responsibility, adopting self-caring behaviours and taking action on one's recovery. Group sessions, one to one working, presentations, workshops, alternative therapies and recreation are components. A rolling programme ensures no two weeks are the same.

Housing

We are working with partners, the City of Edinburgh Council, to provide supported accommodation to the majority of clients coming to the programme. Clients live together a short distance from Malta House, where the day programme is delivered. They share shopping, cleaning and cooking duties on a rota system they manage

themselves. Housing staff do their own assessment and help clients meet their social needs. They support clients, particularly in the evenings and at the weekends when the day programme is not running. Planning for next stage housing starts from the outset and our goal is that nobody will complete the programme without satisfactory accommodation to move on to.

Vocational training

Sian Fiddimore manages 'Transition', a local agency geared up to help clients get back into training, education and the workplace. In association with Sian and her team, we have developed a working partnership, which has resulted in a two-hour session on 'personal effectiveness' delivered during our weekly programme, leading to a certified qualification if clients complete the rolling programme. There is published evidence that if services address vocational training needs outcomes are better for clients. The plan is that most clients will progress to complete the transition programme on leaving LEAP.

Self help

The new Orange Book National Guidelines, the NICE Guidelines on Psychosocial Interventions and on Detoxification all recommend referral to self-help groups as standard for those clients wanting to stop using. With the accumulation of evidence on the efficacy of such groups it is no longer justifiable to simply dismiss them. We know from British research that professionals are much less likely to have positive attitudes to 12-step groups than clients are, and this really needs to change. The psychosocial guidelines say; 'Staff should routinely provide people who misuse drugs with information about self-help groups. These groups should normally be based on 12-step principles; for example, Narcotics Anonymous and Cocaine Anonymous'. That's what we do at LEAP.

Helping clients find recovery communities where they have clean friends, new social networks and support systems, structure for the evenings and an ongoing recovery programme are fundamental tools in the recovery toolbox. This will complement our own aftercare programme. For some LEAP clients, their first experience of a group of clean addicts in the community is at a 12-step meeting. Role modelling is part of the recovery process. There are 1,000 self-help meetings weekly in Scotland; this resource is too good to miss.

At LEAP we offer family and couples therapy where appropriate. Families are suffering too and family members may be entrenched in negative or unhelpful beliefs and attitudes. We encourage family members to attend the graduation ceremony held at the end of the 12 weeks, to celebrate success in completing what is a rigorous and demanding programme. We had our first graduations in November at a ceremony which turned out to be emotional and joyful. The community room was packed with significant others, support workers, peers and children of clients. The graduates spoke movingly of their recovery journeys and their peers in treatment affirmed the achievements they'd made. Seeing clients recover from addiction is a wonderful thing. Evaluation is hugely important to us. We have appointed external evaluators to robustly monitor our processes and outcomes and we plan to publish the results. When I was researching what works in recovery focussed interventions, I discovered that few of us are looking at outcomes. We will at LEAP.

We had a visit recently by a senior official from one of our funding agencies. He spent some time with the clients and felt moved by listening to their experiences. He took away two key messages from his morning at LEAP. The first was that these addicts had lost hope that they would ever recover until they came into treatment and dared to believe that it might just happen for them. The second was that until they came to LEAP they had the belief that they weren't worth very much.

This rebirth of hope and belief in one's own ability to recover is the first stage in recovery. It needs to happen not just in our clients, but in some of our colleagues as well. We're seeing it happen at LEAP.

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