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Recovery, reintegration, abstinence, harm reduction: the role of different goals within drug treatment in the European context

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Introduction

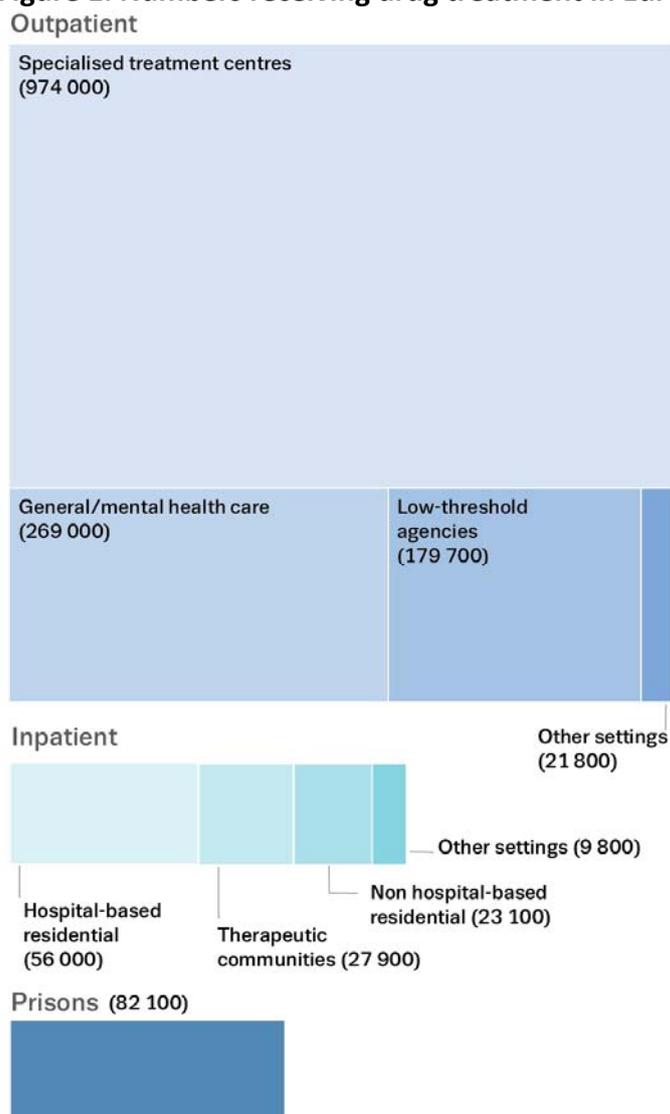
The purpose of this paper is to discuss the different goals of 'drug treatment' within a European context and the key implications for those planning or delivering health and social responses.

Europe faces increasingly more diverse and complex drug problems. Heroin and synthetic opioids remained 'a central issue' but stimulants, new psychoactive substances, 'misused medicines' and problematic cannabis are all important (EMCDDA, 2016a). About two fifths of those 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 around a tenth use 'other' drugs. Europe needs to respond to a wider range of drug problems and related issues, including increasing numbers of patients with acute health issues presenting to emergency services as a result of the use of new psychoactive substances (EMCDDA, 2016b) and increased morbidity and mortality among prematurely ageing opioid users.

Europe also has a broad and diverse range of services to treat DUDs (EMCDDA, 2016a), with large variation between countries in drug trends and the treatment services provided.

According to the *European Drug Report 2017*, the majority of treatment for DUDs in Europe is provided by specialist outpatient treatment centres (974 000 people were treated in this setting in 2015) (EMCDDA, 2017a). In addition, other healthcare services provide outpatient treatment for people with DUDs, mainly in the form of opioid substitution treatment (OST). This is provided by general practice surgeries in some countries, such as Germany and France, but in other countries, such as Slovenia and Finland, treatment for DUDs is provided by mental health services). 'Low-threshold' services also provide treatment. In 2014, residential and inpatient treatment services treated about 116 800 people with DUDs. Prison-based treatment for DUDs was reported for 82 100 people (Figure 1).

Figure 1: Numbers receiving drug treatment in Europe in 2015, by setting



Source: EMCDDA (2017a).

Definitions of 'drug treatment'

Although many EMCDDA publications use the terms 'drug treatment' and/or 'harm reduction' interventions, this report uses the term 'treatment of drug use disorders' in line with the *International standards for the treatment of drug use disorders* (UNODC and WHO, 2016). The rationale for this approach 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?

In short, evidence indicates that services that are goal oriented and those that 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). In relation to goals for people in

treatment for DUDs, an international meta-analysis reported that in-treatment performance monitoring of behaviour against goals was found to have 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 normally stress the importance of the development of service user involvement in setting goals in the context of treatment or care plans (UNODC, 2008).

Definitions of terminology associated with treatment goals

A number of key terms are associated with goals during treatment of DUD.

Harm reduction

The World Health Organization (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 EMCDDA (2010) states that: ‘harm reduction gives clear primacy to a public health perspective in which the imperative is to reduce immediate harms, and the question of long-term abstinence from drug use is either unaddressed or left open’. A core principle of harm reduction is often a hierarchy of intervention goals with primary emphasis on reducing the health-related harms of continued drug use. Harm reduction is now part of the mainstream policy response to drug use in Europe (EMCDDA, 2010). Arguably, the European Union (EU) and many European drug treatment services have ‘led the way’ globally in championing harm reduction goals and strategies, including the implementation of needle exchange to prevent the spread of blood-borne disease; indeed, ‘harm reduction’ has been called the ‘European way’ (IHRA, 2010).

Abstinence

The term ‘abstinence’ means different things to different stakeholders. Abstinence can mean not using a problem or index substance, but it can also mean not using *any* drugs or alcohol. Twelve-step ‘mutual aid’ bodies equate ‘abstinence’ with not using the ‘problem substance’ or ‘being clean’ (Narcotics Anonymous, 2017). There is intense debate about whether those in OST should be viewed as being ‘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’ (UKDPC, 2008; White and Mojer-Torres, 2010).

Reintegration

The EMCDDA considers reintegration to depend on three social pillars: housing; education and training; and employment (EMCDDA, 2012). Although many EU Member States report a gap in the support aimed at addressing the psychological and other needs of people with DUDs, drug policies have begun to focus attention on reintegration and recovery (EMCDDA, 2012). Although the term ‘reintegration’ is not used consistently in EU countries, the EMCDDA recognises that reintegration is a

key aspect of recovery from drug dependence but it also acknowledges that other areas of life are equally important, including supportive social networks and an ability to live free from stigma and discrimination. The 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' (EMCDDA, 2012).

Recovery

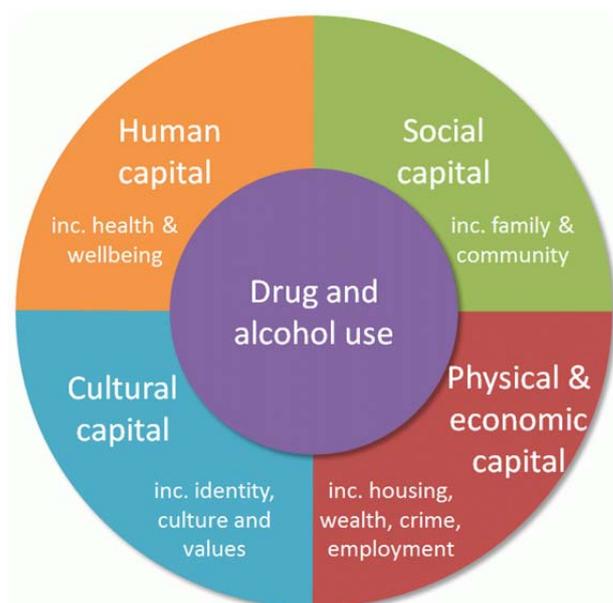
According to the UNODC (2014), the term 'recovery' has many and diverse meanings, but all involve improvements in quality of life. For example, the United Kingdom Drug Policy Commission defines recovery as: 'voluntarily sustained control over substance use which maximises health and well-being and participation in the rights, roles and responsibilities of society' (UKDPC, 2008).

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). The concept of recovery has its roots in both mental health and addiction. From the late 1980s to the 1990s the concept of recovery was incorporated into mental health policy in most western countries (Pilgrim and McCranie, 2013). In the context of mental health, recovery is often described as a personal journey or process that has 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).

However, the term 'recovery' in the field of addiction is still surrounded by controversy. It was associated historically with the '12-step' Alcoholics Anonymous mutual aid programme and with abstinence. The World Health Organization still defines recovery as '[maintenance of abstinence from alcohol and/or other drug use by any means](#)' (WHO, 2017).

Many authors 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. Granfield and Cloud (2001) consider these domains to be social capital (family and group relationships); human capital (health and well-being, aspirations, educational achievements, etc.); physical capital (housing and money); and cultural capital (values, beliefs and attitudes, and the ability to fit into dominant social behaviours) (Figure 2).

Figure 2: Domains of recovery capital



Source: ACMD (2013).

Services that treat DUDs consider hope and optimism to be important concepts contributing to recovery. For example, according to recent Scottish guidance ‘the service user should be seen as capable of changing and supported to do so’ (COSLA and the Scottish Government, 2014). In addition, the United Nations Resolution 57/4 stresses that countries should play a role in reducing the stigma, marginalisation and discrimination of drug users by promoting reintegration and recovery (UNODC, 2014).

A question of definition or paradigm?

Are the terms discussed in this paper just words related to goals in the treatment of DUDs, or do they represent more? Arguably, the terms ‘abstinence’, ‘harm reduction’, ‘reintegration’ and ‘recovery’ are focal points of intense cultural meaning. To some, the terms ‘harm reduction’ and ‘recovery’ in particular represent paradigms with fundamentally different models and aspirations of treatment and interventions for DUDs and have been the subject of debate and disagreement (White, 2007; EMCDDA, 2010; McKeganey, 2012).

What are the goals can of treatment for DUDs and how do they differ across Europe?

‘Top-line’ descriptions of each nation’s treatment provision for DUDs indicate that all EU countries provide ‘harm reduction and treatment interventions’; therefore, a range of treatment goals appear to be present to a greater or lesser extent in all EU countries (EMCDDA, 2017b). However, the balance of treatment modalities varies between countries, and these broad descriptions mask the complex development of national and local systems to treat DUDs and the resulting ‘dominant’ goals.

Factors influencing the goals of treatment of DUDs across Europe

Different types or modalities of DUD treatment have different goals. In-patient and residential services tend to be abstinence oriented. The latter also tend to have a focus on reintegration and recovery goals (for example, Belgium and Germany describe their residential rehabilitation services as having explicit goals around employment, housing and reintegration) (EMCDDA, 2014a). Interventions that are 'low threshold' and outreach services, such as needle exchange, extended brief interventions and drug consumption rooms in Germany, the Netherlands and Switzerland, have the stated goals of reducing acute harm and attracting people into treatment (EMCDDA, 2010).

The type, nature and severity of DUDs may have an influence on goals. At an individual level, goals may change over the course of a journey through a DUD. In some countries, goals may vary according to the nature of drug problems may influence goals; for example, in the Czech Republic, treatment for methamphetamine DUD features mental health and residential treatment focused on improving mental health, abstinence and reintegration, and community-based interventions to reduce acute harm are also available (EMCDDA, 2014b). Some new psychoactive substances are more likely to cause acute health episodes (EMCDDA, 2016b) than 'dependence', and treatment is therefore aimed at reducing acute health harm.

Treatment goals can also be influenced by trends in the problems associated with drug use. For example, human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) was identified among people who injected drugs from 1985, and this led to attention being focused on reducing the harm associated with injecting drug use (EMCDDA, 2010). Similarly, in the United Kingdom, the realisation in the 1990s of the high level of drug-driven acquisitive crime led, in 2001, to a significant expansion in OST with the goal of reducing crime, with an initial emphasis on retaining drug users in treatment (Audit Commission, 2004).

Goals also vary according to the target service user group; for example, for those in 'safety-critical' employment, such as doctors, train drivers and members of the armed forces, abstinence goals are often a condition of treatment and employment.

The 'favoured' approach in a locality or the historical dominance of a particular modality can influence the treatment options made available to different groups; for example, the type of cannabis treatment provided in different European countries is influenced by the dominant therapeutic approaches within countries (EMCDDA, 2015a).

The professional, cultural or religious background of those establishing and providing treatment for DUDs may also affect goals. For example, addiction psychiatrists tend to focus on the goals of overcoming dependence and improved mental and physical health outcomes, whereas a Christian rehabilitation unit is likely to take a more 'holistic' focus, including an emphasis abstinence and spirituality. The amount and source (public, private or health insurance) of funding for the treatment of DUDs, the

associated priority drivers and expectations of outcomes can all influence the dominant goals in a locality.

The perspective of different groups of 'experts by experience' or people who have used drugs have influenced goals. These perspectives are diverse and range from those involved in '12-step' abstinence-based residential rehabilitation and community 'mutual aid' to aid recovery (Narcotics Anonymous, 2017) to community harm reduction advocates (EMCDDA, 2010).

Political influences and changes in countries can result in changes in treatment goals. For example, countries that were previously part of the Soviet Union no longer insist on compulsory treatment for DUDs that is focused on abstinence (Latypov, 2011).

General trends in healthcare can impact on goals for the treatment DUD. The trend in mental healthcare in some European countries, from inpatient psychiatric care to outpatient models of care, with a focus on self-management and recovery, is an example.

It is worth noting that, although all countries now provide OST, the goals of OST are rarely recorded in national reports. However, some countries specifically state that OST programmes are designed to achieve 'wider goals'.

National reports (EMCDDA, 2015b) of systems of treatment for DUDs, including links with primary health services and mental health services, also describe goals to improve health (e.g. testing and treatment of blood-borne viruses in the United Kingdom). Similarly, countries that report integrated systems involving housing and employment have a focus on these outcome domains. For example, in Finland there are 'income-related activities, living and employment assistance to facilitate treatment and recovery' and Hungary reports 'specialist supported housing aimed at aiding reintegration'.

Are treatment goals mutually exclusive or interrelated, or are they the same man wearing a different hat?

A 'hierarchy of goals' has been recognised as important in the treatment of DUDs for many years (ACMD, 1988), from reducing immediate harms caused by active drug use to the goal of abstinence from the problem substance. Some authors have argued that abstinence-oriented interventions therefore fall within the hierarchy of harm reduction (EMCDDA, 2010). Similarly, authors who are recovery oriented describe the need for initial interventions in a recovery journey to focus on preventing immediate harm (NTA, 2012). Therefore, harm reduction goals can be seen as intermediate steps on 'a road to recovery'. Similarly, interventions that may be called 'reintegration' (e.g. facilitated access to education or training in some European countries) may be called 'recovery' interventions in others. These concepts are clearly related and overlapping, but if a system has a dominant focus on 'harm reduction' or 'recovery', can this create negative unintended consequences?

Treatment goals for opioid users and OST: a matter for debate?

It is possible that 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 levels of morbidity and poor reintegration, especially those in OST.

There is a significant body of evidence showing 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). However, are there real differences between how the 'recovery' and 'harm reduction' paradigms are operationalised in OST services, resulting in significant cultural differences and outcomes?

A harm reduction orientation in OST may be wholly appropriate to reduce risk from continued drug use and promote engagement and retention. However, a lack of focus on longer-term drug use goals or wider goals may, arguably, 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) may not provide a longer-term or extensive model of care that supports lifestyle change to ameliorate the long-term health condition of opioid dependence. The welcome addition of a focus on reintegration and wider recovery goals, particularly after the initial stages of OST, may help service users achieve a better quality of life and a wider range of outcome goals — irrespective of whether or not they remain in OST.

A case study

In 2012, in England, drug treatment services were asked to measure their service against new guidance on recovery-oriented drug treatment (RODT); I was the director of an NHS service providing DUD treatment for over 5 000 heroin users a year. The dominant culture in the service was one of 'reducing harm'. The service had good outcomes in terms of reduced opioid use and retention in treatment, but many service users dropped out after a year or so, and very few opioid users detoxified and sustained abstinence or gained employment. Initially, the staff reported that they already provided a service that promoted reintegration and recovery. In some ways, they were correct. We comprehensively assessed service users and provided needle exchange and hepatitis B virus vaccinations. Service users had care plans, received OST and were offered psychosocial interventions and liaison with health and social welfare services. Narcotics Anonymous ran weekly evening groups in the services. However, when we reviewed our service against the RODT audit criteria, our culture and interventions were not fully recovery oriented. Our focus was getting people stable on OST, retaining them and preventing harm, but we lacked focus on long-term goals and other domains. We did not assess services user assets as well as problems. We did carry out health screening, hepatitis B virus vaccinations and referred for blood-borne viruses and mental health treatment but did not have health improvement plans to help people stop smoking, increase activity and increase well-being. We referred people for help with housing and jobs but did not routinely focus on how service users could build their assets, meaningfully occupy their time and build supportive social networks. Staff were professional and busy but they were risk averse and not as optimistic as they could have been about service users' long-term outcomes. Critically, we did not routinely have staff or volunteers in 'visible recovery', 'modelling success' or helping co-deliver services. The audit and subsequent process of service change did lead to services becoming more vibrant and co-produced with service users and service user-led organisations. It was a journey and process of recovery itself.

Implications for OST in Europe: challenges of incorporating harm reduction plus reintegration and recovery goals

Drug policy is rarely evidence based and is frequently politicised. In the United Kingdom, a welcome focus on recovery-oriented treatment for DUDs brought an unwelcome attempt by politicians to implement a blanket policy to time-limit OST, as they incorrectly equated 'recovery' with abstinence. Services treating DUDs that were seen as 'successful' under a previous drug strategy for attracting and retaining heroin users in OST were denigrated as 'failing' to deliver abstinence outcomes in the context of what was perceived as a growing 'state burden' of a large number of people in OST. This view was challenged and overcome (NTA, 2011; ACMD, 2014), reminiscent of some hard-won battles in Europe for the recognition of the legitimacy of harm reduction (EMCDDA, 2010). Avoiding a simplistic polarisation of views in which abstinence goals are seen as 'better' is critical.

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 may 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.

Our field is hampered by a general lack of research studies on the long-term outcomes of the treatment of DUDs in Europe. Although there is some international evidence, it would be beneficial to invest in outcome research and avoid setting unrealistic performance targets around treatment for DUDs that can create perverse, non-evidence-based expectations.

Changing the focus in OST to longer-term outcomes and improving health, well-being and social functioning can be a challenge to professionals working in OST. It may require a change to working methods, with a focus on assets, with optimism and in partnership with experts with experience in these services, and with a wider range of stakeholders in local systems, including the community and families.

Many countries in the EU have a prematurely aged and ageing opioid-dependent population, among whom many are unemployed, have other long-term health conditions and are likely to die early. Therefore, achievement of health, well-being and integration goals with this group may be challenging, but speaks to our obligation to try to achieve parity of quality of life for a marginalised, stigmatised and disenfranchised group.

Opportunities

Opportunities may be created by a re-examination of OST goals and paradigms in the EU.

The studies mentioned above indicate that the pattern of OST use is often episodic with periods of OST interspersed with periods 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. Improving the quality and effectiveness of OST is important in all EU Member States.

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: they cannot recover if they die. 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 (health, social networks, meaningful activity).

There is potential to develop 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. This may be of particular importance in times of economic stress.

The potential role of mutual aid and 'experts by experience' may be underutilised in some European countries. Involvement with mutual aid increases service users' chances of achieving outcomes that include social connectedness and well-being. '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 (mental healthcare, managing long-term conditions, other 'lifestyle change' areas, etc.) and can update definitions and models with new thinking and evidence.

Implementing a recovery and re-integration approach may also provide opportunities for planners and providers to tackle local stigma and discrimination against people who use drugs and promote communities in helping those with drug dependence problems re-integrate through promoting visible recovery and positive impacts.

Conclusions

The heterogeneity of people who use drugs and the diversity in severity and complexity of drug taking and drug problems in Europe mean that a single goal or paradigm such as 'harm reduction', 'recovery' or 'abstinence' is no longer adequate to meet the diverse needs we face.

Harm reduction interventions are evidence based, and a harm reduction paradigm of goals is suitable for those at risk of harm due to occasional drug use, those who do not want to stop using drugs and those who are in treatment for a DUD. Harm reduction as an approach is wholly consistent with a public health approach of providing responses to acute health needs and is of fundamental importance. However, a harm reduction paradigm arguably neglects a longer-term or extensive focus on a range of outcome domains required to improve the quality of life of those with a long-term chronic health conditions attributable to DUD.

Recovery as a paradigm is focused on those who are dependent on drugs and is therefore not appropriate for those who use drugs or those with DUDs who are not dependent. A focus on recovery goals alone can lead to a lack of focus on people using drugs who are not in treatment for DUDs, on those using drugs occasionally but who are still at risk of acute health problems and on the critical interventions required to keep people alive (e.g. reduce the risk of opioid overdose deaths). While abstinence from drugs is a goal for some people who use drugs, it is not the desired goal for some and may not be achievable.

The paradigms of abstinence, harm reduction and recovery alone are therefore inadequate frameworks for goals and each brings its own bias and unintended negative consequences.

A more nuanced approach to goals for those with DUDs is required. This should consider the systems of services required to meet the diverse needs of those with DUDs, 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.

A more concerted focus on goals to prevent harm and the growing tide of opioid overdose deaths is required in many European countries (deaths are more common among those not in OST). This may also help 'futureproof' services against new opioid epidemics such as that caused by fentanyl and the synthetic opioids crisis in North America.

A new approach may be of particular importance for the EU's prematurely ageing population of people who use heroin and opioids. For those in OST, medication-assisted recovery models can provide an ambition to achieve wider health and social integration outcomes both for those who need continued OST and those who are able to overcome all opioid dependence, without trying to force change in those too vulnerable to achieve it.

Europe has led the world in harm reduction. Rather than focusing on old battles and a conflict-based approach to paradigms (e.g. harm reduction versus recovery), perhaps Europe can lead the way in developing a new integrated paradigm that recognises truly integrated systems of services with a range of goals for those with DUDs: a new paradigm that incorporates, without bias, a range of interventions and goals required to treat DUDs, from prevention of acute harm to management of chronic long-term DUDs to enabling people to overcome drug dependence.

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