REHAB UK: FULL HOUSE OR BLEAK HOUSE?

Back in the day, residential rehabs were pioneers in UK treatment provision and practice. However despite the recovery agenda, commissioning practice and the apparent failure of some rehabs to evolve mean further tough times ahead. By Harry Shapiro

Stop almost anybody in the street and ask them what they think addiction treatment is all about, chances are most will name check 'rehab'. But the image won't be an especially positive one. Rather than a place to get off drugs, the public perception of a rehab is of a celebrity bolt hole to escape from the paparazzi. Rehabs are seen as almost as exclusive, expensive luxury hotels for the rich and famous which fail to work: often within weeks of leaving rehabs celebrities are back in the headlines for falling off the wagon.

Yet despite the muddled public image of what rehabs are, they have an integral place in the history of drug treatment – long before we had anything that could be regarded as a genuine system for helping people addicted to drugs.

By 1968, concern over the growing heroin scene in London, fuelled by a small group of GPs who prescribed heroin (and cocaine) in eye-watering amounts, led to a ban on doctors handing out drugs to treat addiction. The new rules meant they could only do so if they obtained a licence from the Home Office. In practice, most doctors did not apply for the licence, they were only too glad to be able to tell users they were no longer allowed to prescribe to them. Instead, the licences went primarily to consultant psychiatrists, who were in charge of the newly opened 'drug clinics'. The clinics continued to prescribe heroin and cocaine (although in much lower quantitities) in the hope of turning users away from the illicit market in imported heroin which had just begun to emerge.

But it didn't take too long for the psychiatrists and the workers to realise two things. First, although the regime moved quite quickly from heroin and cocaine to injectable methadone and then oral methadone, there was growing unease that the clinics were little more than dispensaries. Second, while they were helping clients to detox and stabilise, it wasn't rehabilitation. They had no processes or methodologies for moving people towards a drug-free life. Looking for answers, drug clinic psychiatrists lighted upon the growing number of residential rehabs established in the USA. They were a particular type of rehab known as the 'therapeutic community' (TC).

Christian groups had been providing residential care for alcoholics in the UK since the 19th century. But the notion of the TC came from the mental health field in the 1940s and was developed by a small group of psychiatrists including Tom Main who first coined the expression in 1946. The TC aimed to

be a more democratic, user-led form of therapeutic environment, avoiding the authoritarian and demeaning practices of many psychiatric establishments of the time. The central philosophy was that clients were active participants in their own and each other's mental health treatment and that responsibility for the daily running of the community would be shared among the clients and the staff.

The American model was essentially the same, but with a crucial difference. The first TC, called Synanon, opened in California in 1958. It was founded by Chuck Diedrich, an ex-alcoholic who took his cue from the peer support approach espoused by Alcoholics Anonymous. The AA model was very supportive and unchallenging: you listened to somebody's war story and then applauded them for their courage to be up there and for their sobriety (however short a time that was). Diedrich thought, however, that all alcoholics and 'addicts' should be confronted, not comforted, and that they should take responsibility for their lives.

Synanon was run entirely by the residents on virtually military lines – a very strict hierarchy along which the resident could move up to positions of authority over the others, rigid timetables and duties which accounted for every second of the day, public humiliation for the smallest infraction of myriad rules and no-holds barred 'encounter' groups, again run by the residents where all anger, frustration and criticisms were aired. Looking to replicate the model, Daytop Village opened in New York in 1963 and in 1966 another New York-based TC, Phoenix House, was founded by a psychiatrist Efren Ramirez.

The pilgrimage to the States made by UK psychiatrists ended up with the opening in quick succession of a series of British-based rehabs in 1960s such as Alpha House (1968), Suffolk House (1969) and Phoenix House, initially called Featherstone Lodge (1969). The Coke Hole Trust (1968) was the first of the so-called 'Christian houses', while Cranstoun (1971) offered a less draconian, more 'democratic' environment.

But the TC model, which relied on non-professional resident therapists acting with none of the ethical standards demanded of professional mental health and addiction workers, was not without risk. At its most extreme, the charismatic Diedrich became the cult leader of 'The Church of Synanon' which engaged in all kinds of criminal activity to silence critics and ex-residents.

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In a much milder form, some of these problems were imported into the UK when two ex-residents of Phoenix US were brought over to run Featherstone Lodge. From the get-go there were conflicts between them and the professionals, who were unwilling to relinquish control of how the TC was run. However the Americans were edged out when a female resident, caught stealing food, was made to stand naked in front of everybody while she was verbally abused. Over time, Phoenix settled down, and in line with the general trend in TC programmes, the regime became less harsh. Under the leadership of ex-resident David Tomlinson, the first former user to sit on the Advisory Council on the Misuse of Drugs (ACMD), Phoenix adopted many of the business models that have stood the organisation in good stead ever since: becoming a housing association in the 1980s, for example, enabled Phoenix to draw on local authority housing budgets.

But the presence of rehabs also had an impact on clinical practice. As alluded to earlier, clinic staff wanted to do more than just hand out prescriptions. Eventually, as Dr Martin Mitcheson, the psychiatrist in charge of the clinic at University College Hospital later wrote, "the clinics collectively swung… away from maintenance and towards confrontation of continued misuse of drugs, with active intervention and emphasis on facilitating change". Decades before the current lexicon of 'recovery' and being 'ambitious for clients' was fashionable, the early drug clinics accepted the challenge of getting people drug-free, taking their cue from the working practices of rehabs which themselves were 'recovering' communities.

Custom and practice has it that in order for a stay in rehab to stand any chance of success, it is best if the individual is not only a good distance from old haunts, but also cut off from any nearby towns and all the temptations that this can bring. And so the tradition was established for the remote setting of premises – otherwise known in the drugs field as 'The House on the Hill'. But with the geographical isolation and the intense nature of the over-arching philosophies and daily routines of the rehabs, came a psychological insularity that stayed wedded to the founding principles of rehabs. As a result, they tended not to readily embrace change.

But by the early 1980s some profound changes were sweeping through the British drug scene. The number of heroin users in the UK was rising steadily through the 1970s, but not enough to raise any real concerns. Drug use was way down the political agenda. The arrival of smokable heroin changed everything. It broke down the taboo of injecting and opened up the world of heroin use to a mass of young people whose prospects (especially outside the south-east) had been battered by the collapse of Britain's heavy and manufacturing industries and the scourge of unemployment. Numbers of heroin users rose sharply, compounded by the advent of HIV/AIDS.

These climactic changes impacted significantly on the fortunes of rehab. First, most were not equipped to respond to the challenge of HIV: the very last thing an HIV positive user needed was to be pitched into a highly stressful therapeutic environment. Second, the establishment of harm reduction services and the drive to contain the virus meant that harm reduction including maintenance prescribing, became the primary treatment imperative. Third, in the wake of the

fresh demand for treatment, shorter (and therefore cheaper) 12 step programmes run by private companies and based on the 'Minnesota Model' sprung up.

This new landscape prompted the government to set up the Central Funding Initiative (CFI) in order to encourage projects to bid for new and innovative services. Of the pot of money available under CFI, rehabs won less than 10 per cent. TC champions like Rowdy Yates from Stirling University says they lost out "because they were unwilling to embrace harm reduction". Yet Professor Susanne MacGregor, who conducted an evaluation of the CFI, points out that if rehab did not benefit much from the CFI, it was not because of the ascendancy of harm reduction, but because "the aim of CFI was to develop new services based in the community and in places where services were previously few in number".

But not all rehabs lost out. Phoenix, for example, took the opportunity to expand its services to Sheffield. And this became the pattern of the future: organisations which began as single service establishments like Turning Point and Addaction (originally a parent support group called APA), grew and diversified, taking advantage of changes in policy and funding streams to become (with more recent providers like CRI) major players in what is nowadays a market-driven medium sized industry.

Through the 1980s, while funding was always an issue, the House on the Hill was in reasonably good shape, with a steady stream of clients referred from the growing network of community-based drug services and clinics from all over the country. And then came the NHS and Community Care Act 1990 (enacted 1993), a development which those from smaller rehab services still cite as the moment the rot set in.

Up until then, it was relatively straightforward to get into rehab – not much more complicated than a phone call from a service to a facility asking if there was any space. The money to pay for it came directly from the Department for Health and Social Security (DHSS), in the form of the resident's income support, plus any grant support that the rehab might have received from the local authority in which it was based. But as far back as 1968, the Advisory Council on Drug Dependence (the forerunner of the ACMD) had made clear in their report *The Rehabilitation of Drug Addicts* that rehabs should be funded by local authorities, not central government.

And so in 1990, the Conservative government introduced the Bill that created a 'marketplace' in the NHS. In a move currently echoed by the concept of 'localism', it transferred community care budgets down to social services. So, no longer would rehab fees be paid for through income support. Instead, community services would have to go cap in hand to social services for funding for money that wasn't ring-fenced and which would have to compete with all the other demands on social service expenditure. Except that wasn't how it was supposed to be.

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The drug sector swung into action to challenge the government on the issue of ring-fencing. SCODA (the Standing Conference on Drug Abuse) was the umbrella organisation representing voluntary sector drug agencies. Initially there was to be no ring-fencing, but as the then SCODA Director David Turner recounts: "SCODA, Turning Point and Alcohol Concern had a very secret meeting with civil servants and got an agreement that ring-fencing would be in the Bill. And then with no explanation, they suddenly back-tracked and it was out. We had another meeting, this time with Health Minister Virginia Bottomley and Social Services Minister Michael Portillo, but never got a clear explanation." Turner speculates that the reason for the government's decision was that the money to be transferred to social services was less than the total income support money previously paid to rehabs. But if they ring-fenced a budget, the government concluded that it would take the blame if local authorities couldn't make up the difference.

The upshot was that SCODA made a very public stink, going so far as to picket the first European Drug Prevention Week, held in London in 1993. But although funds were not ultimately ring-fenced, the much-touted meltdown of rehabs didn't happen. Some services closed, including Featherstone Lodge. Looking back, David Turner believes that ultimately the furore created by SCODA saved many rehabs. "We had made such a fuss that it was almost impossible for the government to take the risk that too many services would close," he says. Yet there were bigger changes to come in the way drug services were funded, with developments in local commissioning – and the creation of Drug Action Teams.

Since the 1990s, rehabs have knitted together finance through spot and block purchasing, housing benefit, and in some cases, the substantial fees paid by private patients – which helps subsidise the residencies of others. Supporting People, the housing-related funding stream started in 2003, provided a potential new pot of cash for rehabs, but only to the extent that they could demonstrate that they were 'supporting' people and not simply 'caring' for them. In this respect, Phoenix Futures CEO Karen Biggs feels that drug services missed opportunities for growth. "Money could have stayed within the sector if people had been a bit more savvy about how to produce the evidence of what they were doing," – meaning how you can present 'care' as 'support'.

Effectiveness is critical to the whole question of how marginalised some services say they feel. Those who campaign on behalf of the smaller rehab organisations are passionate in support of their belief in the virtues of rehab. A recent issue of *Addiction Today* declared 'A myth is doing the rounds that there is no evidence that rehabs work', but then cites plenty of evidence to the contrary, although not from the NTA who campaigners claim are 'anti-rehab' even though the NTA's *Models of residential rehabilitation for drug and alcohol misusers* (2006) states explicitly that rehab is "a highly effective form of treatment for drug and alcohol misusers who wish to achieve a drug-free lifestyle".

Rehab might be effective, but which

clients are likely to do best? Previous attempts to try and compare treatment effectiveness founder on the simple premise that you are not comparing like with like. There is a consensus that those clients who do best are likely to be the ones with the worst problems, those who have hit rock bottom. But is that because they are the ones most likely to receive funding – leading to another *cri de couer:* that rehab is always seen as a treatment of last resort. Would the drop-out rate from rehab be higher than it is if many more people with less severe problems – but who maybe were not ready for the tough rehab regime – were allowed in?

For rehab to demonstrate effectiveness beyond the front door is very difficult once the client leaves. The self-selecting group that stay in touch, start their own services or join the staff are in the minority. So commissioners inevitably fall back on simplified cost comparisons between community services (at around £85 per week per client) and rehab (around £500 a week), although some community service costs may be more diffused and opaque.

Why some commissioners are reluctant to refer clients to rehab probably goes deeper than cost, for as Karen Biggs says, "there are some DATs that don't spend all their Tier 4 budgets". It is possible that some commissioners are reluctant to send clients to whose regimes they feel are over-confrontational and harsh in an era when the professional ethos is supposed to be geared to showing more respect towards users and putting them at the heart of treatment. Because of personal relationships built up over years, some commissioners might only send clients to one or two rehabs, although

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if feedback from clients is positive, there is inherently nothing wrong with this, except it can sidestep more logical calculations on the relationship between quality, price and value across the range of rehabs available.

But it is by no means all bad news for rehab. Some providers have long demonstrated not only the value of diversification, but of being more responsive to the needs and expectations of clients in this day and age. For example, NVQs are being offered to residents engaged in house maintenance and catering. Some services offer a short induction stay for people thinking of coming into rehab, while residents at Phoenix can have virtual meetings with family through Skype. Others are working with new models of rehab, such as BAC O'Connor and Trust The Process, where the House on the Hill has given way to a much more systematic engagement with the community through professional link-ups and the physical siting of premises in town centres. Even that classic House can still do well.

Littledale Hall in Lancashire was opened in 2006 and may well be the future for rehab. According to Director Keith Robertson, the place is "full – with a waiting list". The programme fuses the models proposed by Tom Main and others, with contemporary addiction and psychological theories. Littledale Hall has manuals for all aspects of treatment, delivered by a multi-disciplinary team consisting of social workers, drug workers, clinical therapists and counsellors. The aim, says Robertson – who is asked to go into other Tier 4 services to advise on their programmes – is to "deliver a service grounded in a strong evidence base that is fit for practice and meets the demands of commissioners and service users looking for effective and quality treatment in the 21st Century".

Residential rehabilitation has come down a long winding road since the late Sixties. Some would say that the virtues of rehab have been oversold and no doubt the morally-uplifting abstinence focus has great political appeal. In the run up to the 2005 general election, then Conservative Party leader Michael Howard was promising 25,000 extra rehab places without any clear strategy for paying for them. Yet there is no denying the many stories of those who declare that rehab was the last chance saloon that literally saved their lives. However, in an era of swingeing local cuts and an increasingly market-driven health economy, the foundations of some rehabs are under serious pressure.