

# **Response to the Drug Strategy Consultation 2010 from SMART Recovery UK**

## **What is SMART Recovery**

SMART Recovery aims to help individuals gain control over their addictive behaviours, achieve recovery, a balanced lifestyle and lead meaningful and satisfying lives.

The tools and techniques are derived from Rational Emotive Behaviour Therapy, Cognitive Behavioural Therapy and Motivation Enhancement Therapy. The approach continues to evolve as the evidence for psychological interventions develops, under the guidance of an international advisory board which includes such luminaries as Alan Marlatt, Aaron Beck and Carlo DiClemente.

The SMART Recovery programme therefore uses some of the most evidence based methods available. What makes SMART Recovery different from treatment is the focus on mutual aid and peer led meetings. To put it in simple terms, SMART Recovery is a secular and science based alternative to AA / NA and other mutual aid networks.

The origins of SMART Recovery are in the USA, though there is a UK based charity which develops and promotes the movement in this country. After a strategic review earlier this year, we are pursuing a close partnership with treatment providers and commissioners. We believe this will allow SMART Recovery to make a valuable contribution to the UK drug strategy and support the growing recovery movement.

SMART Recovery meetings are run by a network of volunteer coordinators, nearly all of whom are in recovery themselves (a small number of professionals also volunteer their time). The organisation is supported by a board of trustees and a small central infrastructure. This consultation response is submitted on behalf of the organisation and may or may not reflect the views of all facilitators or meeting participants.

For more information see [www.smartrecovery.org.uk](http://www.smartrecovery.org.uk)

## **Section A: Vision for the new drug strategy**

### **A1. Are there other key aspects of reducing drug use that you feel should be addressed?**

SMART Recovery UK welcomes the increased attention to individual recovery and we agree with the sentiment that this has been somewhat lacking in the previous drug strategy.

We are however a little alarmed that the debate has become so polarised to a binary ‘abstinence versus harm reduction’ argument. This is very unhelpful, even from the point of view of an organisation that aims to support abstinence. Many of our network members would simply not be alive to pursue the opportunities afforded by abstinence if it were not for harm reduction interventions made available to them at a critical time of their lives. For most, the journey of recovery begins with harm reduction and ends with abstinence – these are not incompatible goals.

We therefore fully endorse the move toward greater ambition for abstinence, but urge the government to recognise that a range of treatment methods and interventions can be important steps on the path of recovery.

Also, we find no difficulty in focussing on helping people achieve abstinence but allowing the individual to define what that abstinence means for them. For example, many people achieve a meaningful recovery whilst managing their tendency to depression by using anti-depressant medication. For others, medication such as methadone is consistent with their vision of recovery and they are able to achieve stable employment and social stability. Most of our facilitators and long term proponents of SMART Recovery want to achieve a way of life that does not depend on substitute prescribing, but it is a sterile and unhelpful argument to make that a *sine qua non* of recovery.

## **A2. Which areas would you like to see prioritised?**

Greater ambition for individual recovery throughout the treatment system. This is not just the responsibility of abstinence based services, methadone clinics should be just as excited and ambitious about helping clients fundamentally change their lives.

It is also important that the treatment system is better integrated into the wider social structures that support recovery. Part of the hole that the treatment system dug itself was to see itself as providing an ‘intervention’ that stopped at the end of the script or 50 minute therapeutic hour. Particularly for people with serious addictions, recovery cuts across housing, benefits, employment, social support networks and so on. Re-aligning the treatment system to work in concert with all these services is possibly a more important priority than changes *within* the treatment system.

## **A3. What do you think has worked well in previous approaches to tackling misuse?**

The improved access to treatment has been a big success. Even though the treatment system has lacked ambition for recovery at an individual level, more people will have had opportunities to get their lives back on track because of treatment being more available. On aggregate there is a lot more ‘recovery’ than there was 15 years or so ago.

To put this from the perspective of our organisation, it is more likely that we can meet, talk to and make the case for recovery with individuals who are *in treatment*

than if they were on the street. In the case of severely dependent users, treatment is the gateway to recovery. It is not an end in itself, but it is a necessary step. The expansion in treatment has made possible that necessary step for probably hundreds of thousands of people. This is something we should praise, even if the treatment system did not encourage the next step with sufficient enthusiasm!

There has been some progress toward integrating the different support systems, even though overall the picture is still poor. In particular, the Supporting People housing scheme has helped many people take the steps back toward a stable lifestyle as they move toward the end of treatment.

**A4. What do you think has not worked so well in previous approaches to tackling drug misuse?**

One of the problems with the target culture has been simply that it was too successful! By this, we mean that commissioners and providers were effective at focussing on the targets, but the targets themselves were too blunt. They distorted the treatment system and made the lack of ambition run deep.

To give a specific example, the retention at 12 weeks mantra probably helped the treatment system improve. The problem was of course the un-intended consequences. The incentive was there to hang on to clients and not pay much attention to recovery of the individual and a successful exit from the treatment system.

We therefore share the view that there is a need for some 'rebalancing' of the treatment system, but also have some anxiety that the 'pendulum' could swing too far in the other direction. SMART Recovery meetings can be of immense help to people who are ready and willing to engage in their own recovery – but we do not want to be the dumping ground for thousands of people forced prematurely off substitute prescribing. That would be dangerous and does not reflect our own vision of a recovery oriented treatment system.

**Section B: Prevent Drug Use – Department for Education lead**

**B1. What are the most effective ways of preventing drug or alcohol misuse?**

This is not really an area we want to comment on at this time.

**B2. Who (which agencies, organisations and individuals) are best able to prevent drug or alcohol misuse?**

This is not really an area we want to comment on at this time.

**B3. Which groups (in terms of age, location or vulnerability) should prevention programmes particularly focus on?**

This is not really an area we want to comment on at this time.

**B4. Which drugs (including alcohol) should prevention programmes focus on?**

This is not really an area we want to comment on at this time

**B5. How can parents be best supported to prevent young people from misusing drugs or alcohol?**

This is not really an area we want to comment on at this time.

**B6. How can communities play a more effective role in preventing drug or alcohol misuse?**

This is not really an area we want to comment on at this time.

**B7. Are there any particular examples of prevention activity that you would like to see used more widely?**

This is not really an area we want to comment on at this time.

**B8. What barriers are there to improving drug and alcohol prevention.**

This is not really an area we want to comment on at this time.

**Section C: Strengthen enforcement, criminal justice and legal framework – joint Home Office and Ministry of Justice lead**

**C1. When does drug use become problematic?**

This is not really an area we want to comment on at this time.

**C2. Do you think the criminal justice system should do anything differently when dealing with drug misusing offenders?**

The criminal justice system could make greater use of Mutual Aid and Self Help groups such as SMART Recovery. There is a great deal of interest at the present time, but this is a new and welcome change.

In particular, there is no reason why SMART Recovery groups could not take place in prisons. By attending meetings and learning the tools and methods of Recovery that we teach, on release the ex-offender would have access to our network of meetings and an already in place social support network. Over the last few months we have had considerable interest from the prison sector and we are hoping to meet NOMS leads shortly.

It is worth noting that SMART Recovery is used extensively in prisons in Australia, Sweden and the USA.

**C3. Do you have a view on what factors the government should take into consideration when deciding to invoke a temporary ban on a new substance?**

This is not really an area we want to comment on at this time.

**C4. What forms of community based accommodation do you think should be considered to rehabilitate drug offenders?**

There needs to be a range of accommodation options, to create a pathway to normal social functioning and employment. We have facilitators and meeting participants caught in the same benefits / housing trap as many none ex users. For example being unable to take on temporary or low paid employment over the risk of losing benefits or housing. This is a barrier to recovery.

**C5. Where do you think we most need to target enforcement efforts to reduce the supply of drugs?**

This is not really an area we want to comment on at this time.

**C6. What else do you think we can do to keep one step ahead of the changing drugs markets?**

This is not really an area we want to comment on at this time.

**C7. Which partners – in the public, voluntary and community sectors – would you like to see work together to reduce drug related reoffending in your local area?**

We are getting a great deal of encouragement from local Drug Action Teams. As we are trying to expand the availability of our meetings in a local area it really helps that there is 'someone to talk to' rather than having lots of competing agencies to deal with.

**C8. What results should be paid for or funded?**

Increasing the incentives to help people get drug free would be a good thing, but not to the extent that lots more people die of overdose. If treatment services 'push' people out before they are ready they will relapse and be at a high risk of overdose. Recovery needs support and individual planning. Setting targets for this seems to be tricky.

**C9. What measures do you think should be taken to reduce drug supply in prison?**

This is not really an area we want to comment on at this time.

**C10. (if applicable):**

**What impact would the measure suggested have on:**

**a) offenders**

**b) your local community?**

n/a

**Section D: Rebalance treatment to support drug free outcomes – department of health led.**

**D1. Thinking about the current treatment system, what works well and should be retained?**

Aim to maintain the overall capacity. Try not to go back to long waiting lists to get into treatment. Have a good range of treatment options available as everyone's recovery journey is different.

**D2. Thinking about the current treatment system, what is in need of improvement and how might it need to change to promote recovery?**

Recognise the potential of self help and mutual aid. Research into mutual aid shows that something special happens when people with problems help each other. This is still a threatening idea to many in the treatment sector, perhaps because people think this devalues training and professional qualifications. Treatment and self help should be two complimentary sides of the same coin.

Encourage treatment providers to integrate Self Help and Mutual Aid models within the treatment journey. Referring someone to AA, NA or SMART Recovery only after they leave, as an alternative to aftercare, is not good enough. Even people on methadone maintenance could benefit from SMART Recovery and perhaps pave the way to a life beyond treatment.

Quite a number of our meeting facilitators got drug free with the help of residential rehab and there is quite a strong sentiment that these services have been under-valued.

**D3. Are there situations in which drug and alcohol services might be more usefully brought together or are there situations where it is more useful for them to be operated separately?**

In SMART Recovery we work with both together successfully. No view on how this should be handled in the treatment system.

**D4. Should there be a greater focus on treating people who use substances other than heroin or crack cocaine, such as powder cocaine and so called legal highs?**

SMART Recovery works with addiction to any substance of abuse (and also behaviours, such as gambling). From our point of view, there is a need for support around any substances to which people become dependent.

**D5. Should treating addiction to legal substances, such as prescribed and over the counter medicines, be a higher priority?**

This is not really an area we want to comment on at this time.

**D6. What role should the public health service have in preventing people using drugs in the first place and how can this link into other preventative work?**

This is not really an area we want to comment on at this time.

**D7. We want to ensure that we continue to build the skills of the drug treatment and rehabilitation sector to ensure that they are able to meet the needs of those seeking treatment. What more can we do to support this?**

Although we don't want SMART Recovery to be thought of as a job training scheme, it is notable that a high proportion of our Facilitators are successful at gaining employment in the treatment sector. It has been commented that our volunteers often have many more hours of solid therapeutic experience than professionals with years in the field!

**D8. Treatment is only one aspect contributing to abstinence and recovery, what actions can be taken to better link treatment services in to wider support such as housing, employment and supporting offenders?**

This is a big area and needs a lot of thought. It is about joining up treatment, mutual aid, user groups, housing, employment, benefits, education, mental-health treatment and so on. If these can be coordinated to create a 'package of care' far more people will be successful on their recovery journey.

**D9. How do you believe that commissioners should be held to account for ensuring outcomes of community-based treatments, for the promotion of reintegration and recovery, as well as reduced health harms, are delivered?**

This is a tricky area as targets can have un-intended consequences. Having just a target for abstinence would for example risk a large increase in drug related deaths, from overdose. Perhaps a basket of 'recovery' oriented goals as well as reduced drug related deaths could be considered?

**Section E: Support recovery to break cycle of drug addiction – Department for Work and Pensions lead.**

**E1. What interventions can be provided to better support the recovery and reintegration of drug and alcohol dependent offenders returning to communities from prison?**

As mentioned above, we would like to get SMART Recovery meetings in every prison, so ex-offenders are already versed in the tools and methods when they return to the community. The cognitive behavioural methods we teach are also applicable to changing offending behaviour and we are building up a network of meetings around the country that could provide effective ongoing support.

**E2. What interventions could be provided to address any issues commonly facing people dependent on drugs or alcohol in relation to housing?**

Make it easier to hold down housing but begin working for a low wage. Treat volunteer work as a valid route back into employment.

**E3. How might drug, alcohol and mental health services be more effective in working together to meet the needs of drug or alcohol dependent service users with mental health conditions?**

This is not really an area we want to comment on at this time.

**E4. Do appropriate opportunities exist for the acquisition of skills and training for this group?**

This is not really an area we want to comment on at this time.

**E5. Should we be making more of the potential to use the benefit system to offer claimants a choice between;**

- a) some form of financial benefit sanction, if they do not to take action to address their drug or alcohol dependency; or**
- b) additional support to take such steps, by tailoring the requirements placed upon them as a condition of benefit receipt to assist their recovery (for example temporarily removing the need to seek employment whilst undergoing treatment).**

Linking treatment to benefit sanctions is overly coercive, though more 'positive' inducements to support recovery might be worth exploring. At a certain point in the recovery journey it is much better to work than not work – but too much pressure, too soon can be counter-productive and might trip some people toward relapse.

**E6. What if anything could jobcentre plus do differently in engaging with this client group to better support recovery?**

This is not really an area we want to comment on at this time.

**E7. In your experience, what interventions are most effective in helping this group find employment?**

This is not really an area we want to comment on at this time.

**E8. What particular barriers do this group face when working or looking for employment, and what could be done to address these?**

**E9. Based on your experience, how effective are whole family interventions as a way of tackling the harms of substance misuse?**

This is not really an area we want to comment on at this time.

**E10. Is enough done to harness the recovery capital of families, partners and friends of people addicted to drugs or alcohol?**

A holistic understanding of recovery should take account of the recovery capital offered by others in the social network. The current treatment paradigm tends to exclude these people rather than seeing them as a positive resource. This does need to be considered on a case by case basis, however – as some service users have good reason for keeping away from their families!

**E11. Do drug and alcohol services adequately take into account the needs of those clients who have children?**

This is not really an area we want to comment on at this time.

**E12. What problems do agencies working with drug or alcohol dependent parents face in trying to protect their children from harm, and what might be done to address any such issues?**

This is not really an area we want to comment on at this time.