

## Analysis of SMMGP Membership Consultation on the UKDPC consensus statement on Recovery



In July/August 2008, SMMGP conducted a consultation of its membership on their views on the UKDPC Consensus Statement on Recovery and its relevance to treatment services in General Practice.

The consensus statement is: **“Recovery is a process, characterised by voluntary maintained control over substance use, leading towards health and well-being and participation in the responsibilities and benefits of society”**

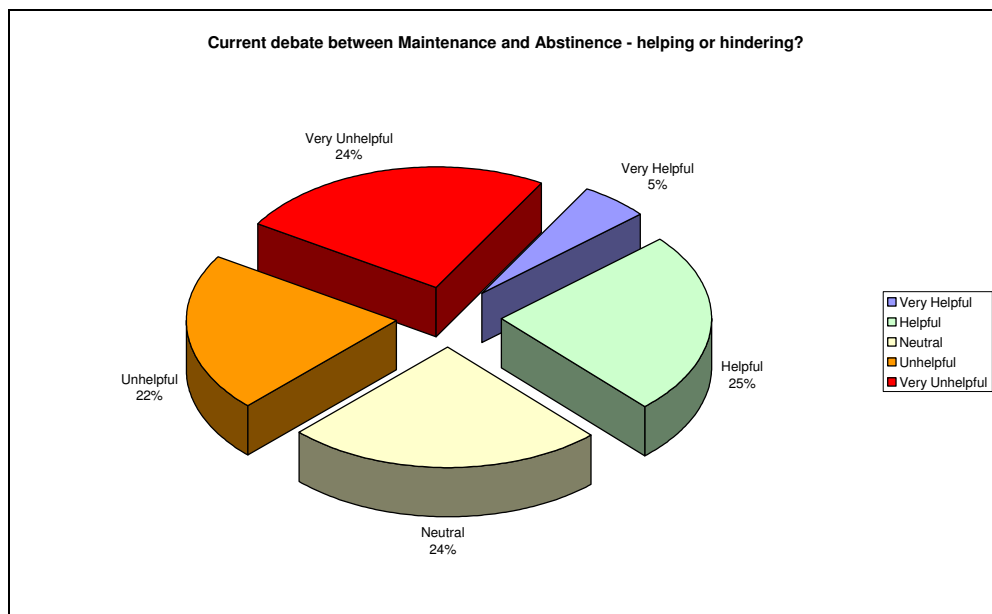
The consultation questionnaire comprised 5 questions:

1. Do you think the current debate between maintenance and abstinence is helping or hindering the delivery of better quality drug treatment service?
2. Do you find the debate relevant to treatment in primary care?
3. What is your reaction to the UKDPC consensus statement?
4. How do you think this debate fits in with the priority to deliver evidence-based medicine?
5. Do you think more research is needed on the delivery of abstinence-based treatments in primary care?

Responses were received from 40 SMMGP members; 26 GPs, 5 pharmacists, 6 community drug teams, 2 nurses and 1 psychiatrist.

### Results

#### 1. Does the current debate between maintenance and abstinence help or hinder the delivery of better quality drug treatment service?



Of the respondents, 46% felt that the current debate did not help, compared to 30% who felt that it was helpful. Only 5% felt that it was very helpful, compared to 24% who felt that it was very unhelpful.

**Comments against the recovery discussion:**

- Debate distracting from more important things (6)
- It is polarising opinions (8)
- Makes patients think there is an easy solution (2)
- Shouldn't be all or nothing and need to recognise individual need and not the attitudes of the professional or the politician (7)
- One size never fits all (3)
- Need to have a spectrum from harm reduction to maintenance and not a division (6)
- Biased reporting does not help

**Comments for the recovery discussion:**

- Healthy evaluation of what we are doing (3)
- Debate can only be healthy and a breath of fresh air (8)
- Challenging thinking that has become 'accepted' can cause a rethink and some change (5)
- It may help patients to achieve abstinence where appropriate (2)
- Raised the profile of the need for better services and not just maintenance (3)
- Allows for clear goals and outcomes (2)

**A few quotes:**

*'Surely it is what ever works – when did one size fit all?!'*

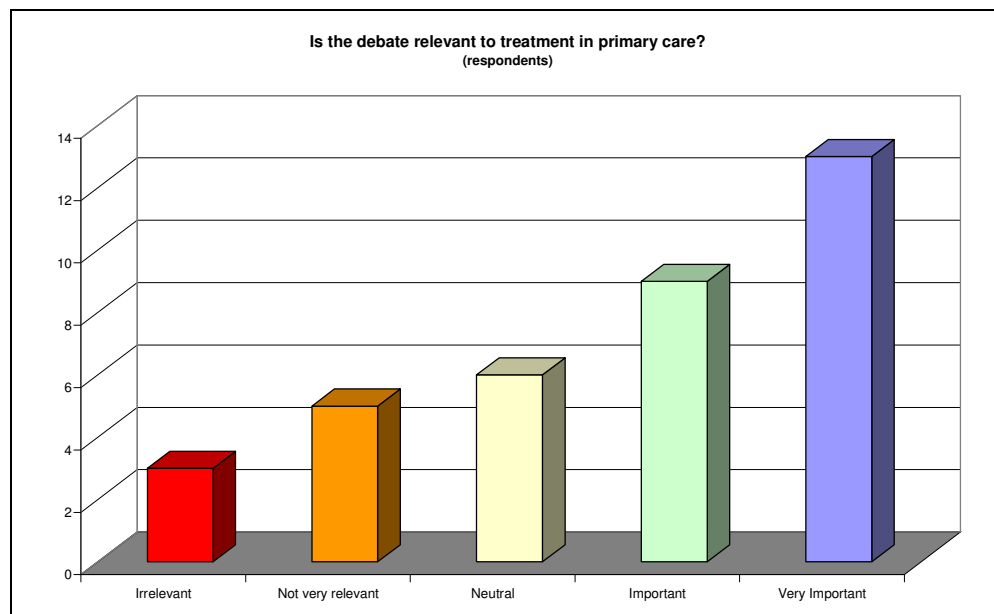
*'It's healthy to evaluate what we are doing when providing services and not get too comfortable with harm reduction being the best choice for all clients.'*

*'It's a spectrum, with abstinence and maintenance treatment included as part of harm reduction.'*

*'Those GPs outside of shared care are using their abstinence treatment ways of working again which is causing havoc for our advocacy service!'*

*'I think anything that gets practitioners thinking about what they are doing and what they are trying to achieve in conjunction with their clients is a good thing.'*

**2. Is the debate between maintenance and abstinence relevant to treatment in primary care?**



## Results

61% of respondents felt the debate between maintenance and abstinence was relevant to treatment in primary care, with 35% considering that it was very important.

### Comments for 'relevant to treatment in primary care'

- Knowing about this debate is vital (10)
- Wherever treatment takes place, an underpinning philosophy is needed (5)
- Important where currently detox and abstinence options are not offered commonly (7)

### Comments against 'relevant to treatment in primary care'

- It further stigmatises effective treatment (4)
- My treatment has not changed because of it (3)

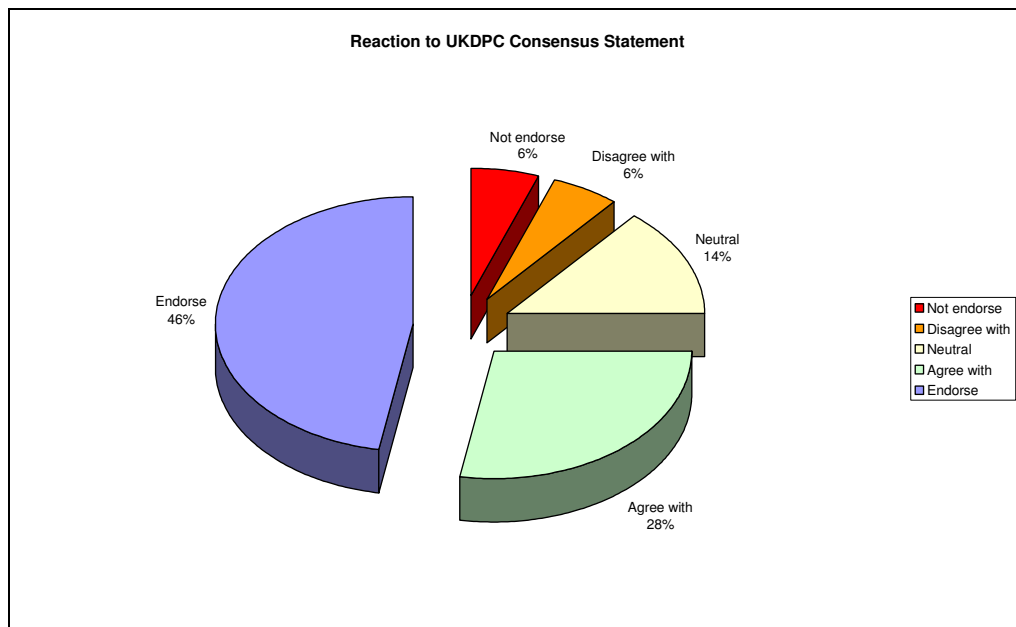
### Some quotes:

*'Particularly in light of commissioning pressures to "move people on" etc - we need to be on firm ground for arguing when this is not appropriate, or when more tier 2 support is needed to aid medication-assisted recovery.'*

*'Primary care is where so much care of substance misuse treatment and management goes on and the more GPs can be involved and aware that this is happening the better.'*

*'I fear general practice becoming a dumping ground where patients are just seen monthly for a script and there is little therapeutic intervention. Once someone is stable on a script in some ways that is the easy bit, the hard part is trying to restructure life, rebuild relationships, learn coping skills that don't involve drugs, get into training and employment. All of these can be achieved on a prescription'*

### 3. Reaction to the UKDPC consensus statement?



## Results

74% of respondents agree with the UKDPC consensus statement on recovery, with 46% fully endorsing it. 12% did not agree with the statement.

### Comments endorsing the statement

- Statement is well thought out, impressively summarises what is a complex area, but the discussion needs to continue (7)
- Statement captures all the concepts - the benefit to both the client and to society (2)
- Recovery is a process or a 'journey' (4)

### Comments against the statement

- There is absolutely no reference to abstinence, so not relevant (to us) as a description of recovery (2)
- Such a broad definition of recovery allows many (poor) services to carry on doing just what they are doing and call it 'recovery' (3).
- The issue over control is confusing given that loss of control is one of the defining features of addiction (4)
- It is so nebulous a statement as to be practically meaningless (2)

### Quotes

*'There is a big difference to coming up with this statement regarding recovery and being a drug user, living in a deprived area with seriously low chances of ever gaining employment or of moving out of your currently bad social situation.'*

*'The group seems to have forgotten that stopping using drugs is only a small part of recovery.'*

*'I think too many agencies are enforcing detox programs on clients because it ticks boxes rather than supports clients trying to integrate in society.'*

### 4. How does this debate fit in with the priority to deliver evidence-based medicine?

#### Positive Responses

- Consensus statement reflects a good evidence base (4)
- This debate will assist by setting up a framework to analyse performance and the improvement to the user. (2)

*'GPs are pragmatists-we work with the resources to benefit patients following best evidence, even when the resources don't always follow.'*

#### Negative Responses

- 'Political agendas are often not sensitive to evidence base and we should resist political meddling aimed at vote catching (4)

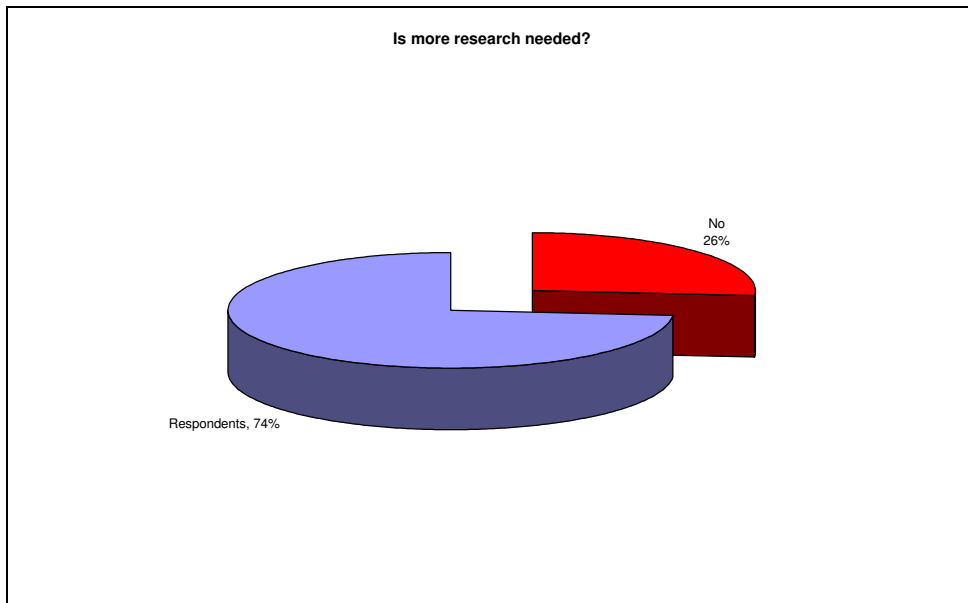
*'I've read several articles on abstinence and maintenance therapies....many are flawed on their interpretation of results and outcomes and ...this is largely due to the problem that we struggle to determine what is successful treatment and what is cure'*

*'There is a lot of pressure being exerted from senior level as particular treatments 'tick the boxes' more than other treatments.'*

*'Recovery in the sense described is what we all aim for; it is humanitarian aspiration and cannot in itself be evidence based.'*

*'Real patients do not always fit the evidence models available and there is a need to incorporate both evidence base and the patient's own situation to reach successful outcomes.'*

## 5. Is more research needed on the delivery of abstinence-based treatments in primary care?



### Results

74% of respondents considered that more research is needed

- More evidence needed regarding abstinence - particularly long term (9)
- More evidence is needed about a range of approaches to deliver abstinence, and whether abstinence is a desired outcome (5)
- Harm reduction is evidence-based. Abstinence lacks the research to back it up and certainly isn't a workable option for most people (4)
- Research is needed regarding enforced abstinence e.g. short term scripts, leading to a revolving door syndrome (4).
- The key focus should be on the 'voluntary' nature of control (2)

### Some Additional research questions posed:

**NB Why not put in a paper to the 14<sup>th</sup> Conference in Liverpool covering one of these?**

- How can GPs best support the attempts patients make to achieve abstinence? (Medical and/ or psychosocial treatments)
- We know that most have made at least 3 attempts to quit before entering treatment. Could primary care have assisted those attempts to achieve the desired outcome?
- What characteristics do those who have recovered have in common?
- What elements of residential treatment programmes are most likely to aid recovery?
- What is the place of mutual aid (self-help) groups in recovery?
- What are the attitudes of professionals in the field to the concept of drug-free recover?
- How can we make relapse safer?
- What do patients want from treatment?
- What is the difference in quality of life between methadone maintained patients and those in drug-free (abstinence) recovery?
- Long term outcomes for abstinence versus maintenance
- Relative results of residential v non-residential rehab
- Is naltrexone any use? Can we run relapse prevention groups in surgeries? Is it practical to deliver CBT interventions at a practice level?

## Quotes

*'Having worked with abstinence therapies for the past 7 years and suddenly changing to maintenance therapies it is clear that abstinence therapies are far more labour intensive.'*

*'The strengths of primary care research lie in attempting to answer questions about complex systems; e.g. persons imbedded in families and societies. Most of the patients I come across have co-morbid psychological problems and there is a lack of research looking at the impact this has even on current treatment in a UK setting.'*

## General thoughts on the recovery discussion

*'Recovery is defined by each patient. When they feel 'in control' they have 'recovered'. How this is defined for a population is a difficult discussion, but the statement from the UKDPC is a constructive one.'*

*'Pendulum has certainly swung firmly towards HR moment. We would like to see more attempts to engage mutual aid groups, such as NA, in this conversation.'*

*'It is important that the service recognises that different treatment options work for different types of people; there is no one size fits all!'*

*'Recovery is a spectrum that changes over time. We as clinicians should not be bullying patients into a single course of action that isn't right for them at that time and the current debate seems to be heading in that direction'*

*'...We've been doing things the same way for so long that we've forgotten how to do 'recovery'.'*

*'Abstinence should not be viewed as all or nothing. Someone on methadone who never uses other drugs is as 'abstinent' as a 'normal' person who drinks a bit more than they should and has an occasional line of coke. The focus should be on function, not drugs. We need to remove hidden moralising from the debate. Is 'total' abstinence even desirable, let alone realistic??'*

*'Whilst I am aware of the lack of good evidence my gut feeling that as a society it is more acceptable that we encourage abstinence and avoidance of drug use....Overall I think we should be consistently moving towards abstinence whilst accepting that it is not achievable or necessarily desirable for many people.'*

*'Recovery should be something that the individual should have some responsibility for. They should be able to make informed decisions about treatment and should be able to integrate back into society if necessary.' 'People are different. Doctors have different styles – what matters is having "competent compassion" – you need both to help someone get a better life i.e. enter into recovery.'*

*'Certainly as the moral basis for drug treatment has moved from a public health pragmatism to a more punitive/coercive criminal justice morality there has been little discussion about how our philosophical models have been affected by this – I think this discussion forms part of this and is a resurgence of the deserving/non-deserving dichotomy i.e. people can be helped if they're prepared to help themselves.'*