Risks from forced detoxification from heroin are being ignored, conference hears

- Mark Hunter

Changes of policy on provision of services to drug users risk forcing thousands of people into detoxification and abstinence programmes before they are ready, a primary care specialist in drug misuse has warned. The potential consequences could be fatal. Steve Brinksman, a GP from Birmingham and clinical lead of the support network on Substance Misuse Management in General Practice, told a meeting in Manchester that the recent shift in emphasis away from harm reduction and stabilisation towards a more recovery based approach should not be allowed to go too far.

“Detoxification is not a cure for anything,” he said. “It is a small step in the process, and if you do not do the preparation beforehand or the aftercare afterwards you are setting people up to fail and you will increase their risk of dying.

“Don’t get me wrong: I’m all for recovery, and the ultimate harm reduction is abstinence. But people are not Superman. It’s not a case of with one mighty bound they are free. There are a lot of steps. Harm reduction takes that on board.”

The “recovery agenda” was adopted as official policy in the government’s drug strategy last year (BMJ 2010;341:c7168, doi:10.1136/bmj.c7168). Although it stopped short of the abstinence based approach proposed in the Conservative manifesto, the policy emphasised a focus on helping addicts overcome their dependency rather than on providing maintenance methadone and clean needles.

Dr Brinksman acknowledged that nobody should be “parked” on methadone for years but said that he was worried that the pendulum was “swinging too far the other way.”

“At the moment we have a government and a media who seem to think that recovery is for everybody. They want to know why everyone isn’t in rehab — why aren’t they all getting better. Well, actually the problem is a bit bigger than that.”

He warned that if drug services became too preoccupied with abstinence they risked returning to the “revolving door” policies of 20 years ago.

“Patients used to come in for treatment, and six weeks later they’d be back again. And we had a prison system that was doing exactly the same thing. We don’t want to go back to that, which is where harm reduction comes in,” said Dr Brinksman.
A prescription of methadone or buprenorphine could give drug users valuable relief from “the chaos of their daily lives,” he said.

“Stability and hope is what gives people the ability to move on to recovery. And that’s what I hope we offer by prescribing. How long that takes depends on the individual,” he added.

Only once drug users had achieved that stability should they move on to the detoxification stage, he said. This should be followed by a structured programme of aftercare that includes structured support, psychosocial support, pharmacotherapy, support by family and carers, management of side effects of detoxification, and use of self help groups.

All this could be managed by primary care, said Dr Brinksman.

Louise Sell, a consultant addictions psychiatrist from Greater Manchester West Mental Health NHS Foundation Trust, told the conference that many patients taking prescribed methadone were given inadequate doses. The daily dose recommended by the National Institute for Health and Clinical Excellence is 60 mg to 120 mg. Most patients received doses either below or in the lower reaches of this range, she said.

“There’s a lot of evidence that an increased dose is associated with better avoidance of heroin. But it’s very difficult to raise the dose, because people often associate reducing the dose with making progress. There is a risk that many people for many months and years are being undertreated,” said Dr Sell.

Notes
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