

SMMGP

Substance Misuse Management in General Practice Newsletter

With so much recent concern in methadone diversity, local and national debate on drug use and future policy we felt it appropriate to include Bob Scott's thought provoking examination on the expectations of treatment from the users, doctors and the public's perception.

**TREATMENT EXPECTATIONS for Drug Users: Bob Scott, Clinical Director of
Glasgow Problem Drug Service**

What is treatment? - the customary way of dealing with a particular type of person.

The word customary presents us with the concept of an established model of care. This might give a bit of a problem to those of us involved in the development of services for drug users - perhaps for us to be wary of straying too far from the established norms of health care delivery systems within our own cultures?

Expectations - awaiting, anticipation, it does not convey any idea of urgency. Perhaps expectation should read frustration.

Put treatment and expectation together, and it could be that if you are a patient, you might get what you want after a bit of a wait, but only once expertise has been built up in determining just what might be considered as a routine!

Other questions need to be considered: whose expectations are we talking about anyway, and how should any conflicting views be resolved?

There are three broad groups which can be regarded as having legitimate claims to expectations from the treatment of drug misuse: the patient, the professionals and the public. Obviously the most important group is the patients, if only because without them there would be no need for the other two to have any expectations at all!

Patient Expectations: When patients were asked what their expectations of treatment were, almost without exception they stated that the principle reason for approaching services was to obtain 'help'. On gentle probing help always meant a prescription for a controlled drug. This was followed by various personal gains which might be classified under the broad heading of social benefits - avoid prison, family reconciliation, repay debt etc.. None gave me improvement in their health as the main expectation from treatment and only one wanted to become drug free in order to look for work. Many expected to be treated badly, perhaps from previous contact with services or their self and / or societies image of drug users.

In a paper three years ago on drug users views on what the ideal methadone programme might contain (Jones S A et al Addiction Research:1994), 86% had previously experienced methadone. Just under half wanted oral methadone, but 62% received it. 26% wanted injectable methadone and 13% received it, and 23% wanted various combinations - oral plus injectable methadone, BDZ and heroin.

In this study, patients whose doctors were paid directly by them were more likely to receive what they wished, than was the case for those who received treatment under the publicly funded system. The authors also noted that the vast majority of patients felt that both urine testing for drugs of abuse and physical examinations should be an integral part of any treatment programme. In Glasgow

a similar survey found similar results. The drug users stating they could not trust themselves and needed the doctor to keep an eye on them. Patients do indeed have subtle needs and expectations from their professional carers beyond the receipt of a prescription.

Doctors expectations from treatment: not forgetting that many other professional's have involvement and expectations. The top priority is the prevention, diagnosis and treatment of disease. I believe that this objective is unchanging and must not be displaced by other priorities which might themselves suit current political or social policy. This is not trying to medicalise all aspects of drug misuse, but attempting to clarify the appropriate medical role in the care of drug users.

The treatment options must then be considered and then arrive at a judgement, based on the available evidence, as to what will best suit our patients. This will need that some interventions are rejected on the grounds that they are ineffective, too hazardous, or uneconomic which will upset some people.

It is also clear that there is an association between drug misuse and other markers of socio-economic deprivation such as poverty, family disruption, crime, debt, homelessness and despair. In the Glasgow Problem Drug Service 55% of the patients have previously been in prison, though a substantial reduction in criminal activity in patients who are receiving methadone is one of the most striking preliminary findings from a study, into the impact of methadone prescribing in Glasgow. An improvement in overall well-being can also be anticipated with better psychological adjustment and social functioning in patients where methadone is prescribed over another group of injectors. These go hand in hand with a reduction in death and disease, an end that all doctors hope to achieve.

I also feel that it is only right for doctors to expect to obtain professional satisfaction when caring for drug misusers. And why not? What other disorder is wreaking havoc with the health of our young patients, yet potentially is so amenable to medical intervention?

The Public's Expectations: The last group with expectations stemming from treatment is 'the Public' which include the community, politicians and the press. The 1980's and 90's have seen a world wide deluge in policy documents on strategies for dealing with drug misuse coming from government and their agencies, both national and international. A review of priorities over the past 15 years or so shows the greatest emphasis being put on stopping drug use, and the prevention of AIDS.

Now I do not wish to open up the debate on the differences between drug use, abuse and misuse, but it does seem that there usually remains an unwillingness on the part of the public to do more than barely tolerate the continued use of any drug, even if it were to be legitimately prescribed. Perhaps the public attempts to salvage its conscience with treatment programmes which offer substitute prescribing by expressing the aim of 'getting people off drugs' as quickly as possible, no matter how unrealistic and downright destructive to individuals the consequences of that policy on occasions might turn out to be. There are a number of possible expectations for this disquiet including a vague feeling of unease in making drug treatments available to people who have been damaged by substances taken, at least initially, in the pursuit of pleasure.

The public also somewhat naively expects treatment to result in a decline in the demand for illicit drugs and a consequent reduction in their supply. Theoretically this is an attractive prospect, though unfortunately the evidence is weak that this is actually achieved to any great extent. Given that the spectrum of drug taking ranges from experiment to recreation and then on to dependence, probably with fewer participants at each stage than the one before, is it really to be wondered at? Even though substances which alter our mood, behaviour and performance would appear to be fairly high up in human's catalogue of essential requirements.

In the early 80's HIV became a concern and put a considerable spurt into the pace of development of harm reduction measures. Needle exchanges and the substitute prescribing of opiates are now

almost universally accepted as appropriate interventions in this area, just as long as they are in your back yard!

The public also should be pleased that there is now an large amount of evidence to demonstrate that there is a reduction of crime, and although this may not be sustained to the level of people who are entering treatment it does not reach the pre-treatment levels. It is also intriguing that crime was unaffected by the dose of methadone, but that those patients who thought their dose of methadone was about right committed significantly less crime than those who felt their dose was too low. This benefit of the reduction in crime has previously been shown in several other countries, and may now be expected to be achieved from treatment programmes which are properly implemented.

In the US, treatment of opioid addiction methadone maintenance is effective in: reducing illicit drug use, reducing HIV transmission, reducing crime, improving social performance, improving health, reducing needle sharing and retaining patients in treatment (NIDA 1995 'Translating Research into policy'). Pretty impressive stuff !

However one word of caution. It would appear to me that the public also expects these gains to be achieved at no risk to people who do not misuse drugs, and at minimal cost to health care budgets. Accidental overdose deaths in those not known to be drug users, including children, as a result of illicitly diverted medication can be expected to result in a rigorous examination into the overall value of a substitute prescribing policy, and hopefully from the professions too, not just from the public. In my opinion the professional duty of care requires that all possible steps are taken, in the light of local circumstances, to prevent such diversion with all of its potentially disastrous consequences. It is no longer justifiable to weigh up the risks against the gains only for populations of drug misusers seen in isolation, an attempt must also be made to gauge the impact in all aspects of prescribing policies and practices on the community at large.

In conclusion, as drug problems appear and treatment services develop, the dynamic relationship between the expectations of the three groups will ebb and flow. I have attempted to show that these expectations, though somewhat different for each group as a result of their own particular interests, do overlap quite a bit. The extent they do so will vary from time to time and from place to place depending on the prevailing circumstances. It would be a queer old day, if all three had identical expectations coming from the treatment of drug misuse? Perhaps it is sufficient to recognise that diversity is inevitable, and for members of each group to try to develop tolerance to one another's needs, remembering when we do, the dangerous consequences which can result in this business from a loss of tolerance. **Bob Scott**

Research Network in *general practice and primary care* examining the care and management of drug users. If you haven't already and you are interested contact: Dr Berry Beaumont, 23 Jackson Road, London N7 6ES. Tel: 0171 607 4992.

Drug- users ~ Scapegoats or Activists?'A talk by Sam Friedman USA

Conference for drug users, please let your patients know, others also welcome.

- Working towards user activism not user consultation
- Can we learn from user organisations in the USA?
 - Can we move forward in the UK?
- How can we work together- Users and Drug Services?

Monday 27th October 1997 6:00pm at London Voluntary Sector Resources Centre

Details and application forms from Respect Users Union(Conference), Barkintine Clinic, 121 West Ferry Road, London E14 8JH, 0171.536.9079

Drug users are being scapegoated.

The world economic system has been going through a period in which corporations face serious problems since the 1960s. This leads to lay-offs, pressures to reduce government programmes and budgets, and a general attack on the lives of ordinary people and their communities. For the powerful, it poses a major political problem: How to keep their power. Part of their solution is 'divide and rule' through scapegoating. Many groups have been targeted in the States and one of those have been drug users. This has presented many problems for drug users, with hatred against them being official policy and the stable fare in the mass media. Hundreds of thousands have been gaoled. For both drug users' organisations and for harm reduction efforts, this situation poses many dilemmas. If 'drug related harm' is useful to many of the most powerful institutions and persons in society - as a way to foster division and to make it easier to cut back the lives of the working class - it is necessary for drug users and harm reductionists to consider what activities and alliances can help move us ahead and defeat the scapegoating and its negative consequences.

One example of the harm scapegoating does to drug users and to those around them is that it has made it much harder to organise appropriate responses to health threats such as HIV/AIDS and hepatitis C. Drug users are usually treated as incompetent at best, self-destructive and dangerous at worst. Thus, even many 'good' programmes of AIDS prevention of drug treatment set up advisory groups to consult users views rather than encouraging users to have real influence or power in their programmes. The concept of user activism is seen as absurd (since users are viewed as incompetent); when users nonetheless organise for harm reduction, this is sometimes seen as threatening even by well-meaning programme heads.

Drug user activism and organising has taken place in many countries - to some degree, even in the United States in the face of intense repression of drug users. We will discuss what can be learned from the experiences in many countries around the world, and how these ideas might help organising in the United Kingdom. **Sam Friedman**

A book not to be missed: 'Care of Drug Users in General Practice - a harm- minimization approach, edited by Berry Beaumont from Radcliffe Medical Press Ltd, 18 Marcham Road, Abington, Oxon OX14 1AA. Would someone like to do a book review for the next newsletter? Let us know.

Newsletter edited by Chris Ford, Brian Whitehead and Jean-Claude Barjolin. If you have contributions or suggestions please let us know. Or if you would like to join the mailing list for this newsletter, please contact: SMMGP Newsletter, Brent & Harrow Health Authority, Grace House, Harrovia Business Village, Bessborough Road, Harrow HA1 3EX P:0181.966.1109 Fax:0181.423.7314