

SMMGP

Substance Misuse Management in General Practice Newsletter

The Case for Residential Treatment

by Dr Gordon Morse

There is an understandable predilection for topics at our conferences to be focused around methadone programmes of treatment, or "maintenance". Many of our group of interested practitioners come from areas where heroin using is on a large and enlarging scale, introducing vast physical, social, mental, and criminal damage into our practices. Methadone prescribing is a strategy which can be readily deployed to large numbers of people and the research work done in Glasgow and many other centres has shown unequivocal benefits across a range of measurable outcomes. Methadone offers probably the only strategy we have at present for beginning to manage on a large scale what is otherwise an unmanageable and chaotic problem.

But whereas methadone may offer a "containment" for a large group problem, I would suggest that abstinence based treatment, specifically residentially based, offers specific solutions to many individuals. As we begin our work with individual drug users we will inevitably begin with the offer of needle exchanges, health education and perhaps methadone replacement. We will go on to work within our teams to help address many of the issues that are common to drug users which affect their health, housing, crime, relationships and other issues. Many of our clients/patients will resist our interventions and many will abuse the help that is offered. But there will also be many who will at some stage come around to wanting to escape from the drug using culture for good. Abstinence clearly cannot be imposed on anyone, but there are thousands each year who make it their goal, and thousands more who would take the opportunity if it was made more accessible and realistic.

What is Residential Treatment?

There are many residential treatment centres in the UK. There are specific clinics, private or NHS hospitals, that offer detoxification alone. There are others that offer counselling and other psychotherapeutic services but without detoxification, and there are some that offer a package of care that combines detoxification and counselling. The periods of in-patient time vary considerably: there are some private clinics that offer rapid detoxification under heavy sedation for perhaps only 48 hours, and some secondary treatment centres that offer a "halfway house" facility, where counselling runs alongside re-integrating the patient into the community, which could take 6 months to a year.

Some centres are Christian based, some follow the Minnesota 12 Step model, and there are others that have their own particular ethos. Because there is so much diversity within residential treatment, workers need to be aware of what is available so that the style of treatment can be closely matched to the needs of the patient.

Detoxification can of course be carried out in the community, and abstinence achieved with the help of the Narcotics Anonymous fellowships, local counselling services and so forth. This is a cheap and attractive option and seems to be attempted on quite a large scale. Sadly, as in so many aspects of the addiction field, there is a real need for more research into the value of community treatment. I have no doubt that there are a number of patients each year who do achieve abstinence in this way,

but I am equally sure that there are many who fail, and successive failures harm the prospect of eventual success. There is on the other hand good evidence of the benefits of residential treatment.

What does Residential Treatment Offer?

A period of inpatient primary treatment, preferably of several weeks, offers many benefits that are essential to achieve abstinence and which are for the most part impossible to achieve in other ways:

1. - the patient is removed from his environment where cues for his drug use are most powerful.
2. - relief and protection for partners and children who may be at risk.
3. - 24 hour care, the management of coexisting health problems and nourishment and the support from peers and staff to prevent isolation.
4. - the opportunity to learn through the experience of group support.
5. - a concentrated period of time to focus without distraction on the single purpose of recovery.

Does it Work?

As I have already mentioned, the whole field of addiction and treatment of addiction is crying out for more and better research. In a world of scarce resources there is a compelling need for evidence on which to base treatment decisions. Furthermore the comparison of what data is available is fraught with difficulty because one is so often comparing what are essentially dissimilar data. The largest study of treatment ever carried out in the UK is the government sponsored National Treatment Outcome Research Study (NTORS). It is continuing at present, but bulletins have already been published. It is a prospective, multi-site outcome study of more than 1000 clients from all over England, and attempts to compare measurable outcomes from patients treated in different ways.

What has been published so far may be surprising to some: I quote from the second bulletin (6 month follow up) "clients treated in residential settings showed reduced consumption of drugs and alcohol, improved mental and physical health, and reduced criminal activity at follow up. The improved outcomes among residential clients represent gains that were maintained after leaving treatment." And from the third bulletin (at 1 year) "The clients who were treated in the residential programmes presented with some of the most severe problems and complex needs, and these clients made some of the greatest treatment gains."

Cost

Residential costs vary from expensive to very expensive indeed. In a world of short-termism, where we can see no further than the current financial year-end, and are only interested in the cost to our own particular slice of the pie, the cost of an individual's residential treatment looks hard to justify. But NTORS is already showing that for every extra £1 spent on drug misuse treatment, more than £3 is saved on costs on crime alone. The savings on costs to the health service and social provision have not yet been calculated, but will be additional to the crime saving, and of course the benefits to the patients quality of life, and that of his family and society around him, are impossible to quantify.

At the moment the Health Service is estimated to spend 70% of its entire hospital services budget every year on people who will be dead within 18 months. We spend tens of thousands of pounds on chemotherapy for patients whose life expectancy we know to be short, and indeed I would defend that. But by every criterion chemical dependency is a terminal illness too, it kills relationships, it kills intellects and it kills lives. However, the reason I enjoy working in the field is that it is the only terminal illness I know where with skilled intervention it can often be arrested and reversed. I work at a residential treatment centre and each year we hold a reunion for past patients.

I know of nowhere else in medicine where you can witness such a dramatic turnaround in peoples lives, a parade of healthy bodies with smiling faces enjoying a new lease of life.

A six week primary residential treatment package of detoxification and counselling costs about the same as a knee replacement, and normally the costs are split with social service community care funds. As we go into our Primary Care Groups, the ultimate aim is for these funds to merge. If we believe in residential abstinence based treatment as I do, it is incumbent on all of us to find out more about what residential treatment is available and to lobby hard for the ring fencing of funds for this very worthwhile purpose.

Gordon R. Morse, Clouds House, Salisbury, Wilts - 26.6.98

- Basic Guidelines Towards Standards, published by the European Association for the Treatment of Addiction, 375 Kennington Lane, London SE11 5QY
- There is a range of educational material, outcome analyses and discussion papers published by Clouds House, East Knoyle, Salisbury, Wilts SP3 6BE
- NTORS At One Year The National Treatment Outcome Research Study. Changes in Substance Use, Health and Criminal Behaviour One Year after Intake. Michael Gossop, John Marsden & Duncan Stewart. Can be obtained from the Department of Health, Richmond House, 79 Whitehall, London SW1A 2NS

Editor's Note: NTORS is a document worth getting and reading in total.

The study: In 1995 the study recruited over 1000 clients from four different treatment modalities:- inpatient units, residential rehabs and community-based methadone reduction programmes and methadone maintenance programmes cited over England. Heroin was the commonest drug used (87%), nearly two-thirds were injecting and over a third were using crack-cocaine. A quarter of the injectors were sharing equipment; more than two-thirds were drinking alcohol at worrying high levels. Physical and psychological problems were commonly reported and over a quarter had had thoughts of suicide before treatment.

Results: Nearly three-quarters of the clients were contacted one year later and there was marked reductions in problematic drug use across all settings. There was also reductions in injecting and sharing of equipment but only small improvements in psychological health and the large amount of physical health problems remained largely unchanged. Improvements in alcohol use were disappointing and many clients were drinking heavily at follow-up. The greatest improvement is the reduction in crime and as mentioned above there is a return of more than £3 in terms of cost savings associated with victim costs of crime, and decreased demands upon the criminal justice system. It confirms that treatment works, although the exact way it does help drug users is complex and difficult to interpret. You need the commitment of the client, not a passive patient and many may have a treatment career, which they pass through on the way to recovery. One result of the survey was perhaps more surprising which showed marked inter-agency differences, leading to huge variations in the changes in behaviour of clients who had been treated in different agencies. These differences may be greater than between different modalities. These differences need further analysis and I for one am fascinated to see these next results. **Chris Ford**

New Heroin Outbreaks Amongst Young People in England & Wales
Police Research Group: Paper 92, Crime Detection & Prevention Series

Howard Parker, Catherine Bury & Roy Egginton

Many areas in Britain were the sites of major heroin outbreaks during the mid '80s, the early '90s were dominated by the extensive 'recreational' use of drugs like cannabis, amphetamines and ecstasy, particularly by youth populations. Since 1996 indicators suggest that there is an increasing problems with heroin, especially in young people. This is being caused by increase availability of good cheap heroin world and nation-wide; an increase in dealing networks and the amount of money to be made at all levels through dealing; a drugwise young population in whom drugs have been 'normalised' through recreational use, dance drugs and cannabis but have no memory of HIV or previously heroin outbreaks. They do not see themselves as like the 'junkies' of the '80s and have little realisation of dependency. They have been offered and are using heroin as a come down drug after uppers. The groups using heroin have also increased. The majority are still the socially excluded but the spectrum of use now seems to be broader and include young people from all social classes and education. The age of onset has been falling for all drug initiation but it must be of particular concern that over a third of the under 19's age group were under 16 years old.

The report highlights how very few young people services there are and how it is important not to base services on the old 'DDU', '60s model, which is medically dominated and provides mainly methadone prescribing. It was also critical of GPs prescribing to young people, who they suggest are too keen to turn to methadone and benzodiazepine prescribing for young heroin users, before trying other methods. They suggest we should risk trying new models, which may be expensive to set up but 'cheap' in individual and community terms. Criminal justice and punitive solutions don't work and are also expensive. The new services need to be completely different; user friendly, open at odd hours and give good drug information. Perhaps we need to think seriously about what this report is saying and take up the challenge.

Any examples of different working practices?

'The 4th National Conference: Management of Drugs Users in General Practice'

Friday April 23rd 1999 London

Many people requested for it to come back to London on alternate years. It may be back in Scotland on the East Side for the millennium. Any offers for future years? The RCGP will continue to do the administration so there isn't an enormous amount of work to be done on the ground - honest! The programme for 1999 is already coming together and has taken account of the excellent comments on the evaluations forms of the previous conference, of which a staggering 80+% of us completed. Mike Trace has agreed to talk on the Government's 10 year strategy, with particular reference to primary care and how drugs and alcohol will fit into the new PCGs, both in the short and long term. John Tindall, who could not attend this year has agreed to give an overview of using complementary medicine in addiction. Some of the afternoon workshops are going to be practical demonstrations of different therapies. So far we have shiatsu, auricular acupuncture and hypnosis. Any offers for any others? Is there anything you would like to present, especially in the morning workshops or are there anything that you feel passionately we should not leave out? We are hoping to get someone to present the next round of NTORS results.

Are you happy with the format of the conference ? - One suggestion on the evaluation forms was to invite papers / abstracts from people working in primary care - what do people think ? Would this be a good way to support and encourage primary care research ? Would this be a better way of hearing what we are all up to ? Don't be shy - write to us at the address below !

Newsletter edited by Chris Ford, Brian Whitehead and Rima Chowdhury. 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, Harrobian Business Village, Bessborough Road, Harrow HA1 3EX P:0181.966.1109 Fax:0181.423.7314