

SUBSTANCE MISUSE OPTION LECTURE 12

TREATMENT FOR SUBSTANCE MISUSE PROBLEMS IN THE COMMUNITY, PART II

GOALS OF TREATMENT

In the "Report of an Independent Review of Drug Treatment Services in England (1996)", the Task Force note that treatment agencies have a range or hierarchy of goals including:

- reduction of psychological, social and other problems directly related to substance misuse
 - reduction of psychological, social and other problems not directly attributable to substance misuse
 - reduction of harmful or risky behaviour associated with the use of drugs (e.g. sharing injecting equipment)
 - attainment of controlled, non-dependent, or non-problematic drug use
 - abstinence from main problem drug
 - abstinence from all drugs.
- These goals may be interrelated.

TYPE OF CLIENT

Treatment agencies can see a wide range of clients. Robertston (1998) points out that agencies "provide a range of services for drug users who can broadly be given one or more of the following headings:

- Experimental drug users
- Recreational drug users
- Controlled drug users
- Polydrug users
- Mature drug users."

There are other ways of describing the type of client who use the services of treatment agencies.

THE NATURE OF TREATMENT

- People present for treatment, advice and support at various stages of their drug and alcohol-taking career. Therefore, treatment agencies need to be able to respond to a variety of different situations.
- Some clients presenting with severe drug and/or alcohol problems require an extensive package of treatment and aftercare, sometimes involving medical, psychological and social interventions.
- Some people who use drugs recreationally may only require information and advice from a treatment agency.
- Others can be helped by a brief intervention. For example, a brief intervention may involve the assessment of alcohol intake and alcohol-related problems, followed by information about how to cut down on drinking and use a drink diary.

THE NATURE OF TREATMENT

- The difficulties for practitioners are compounded by the fact that people who misuse drugs and/or alcohol, and may be addicted to them, often present with a variety of other intimately related problems.
- Thus, a client may be homeless, jobless and experiencing problems with personal relationships, have a history of criminal activity, and have a physical and/or psychiatric illness.
- Practitioners must also be aware that an addiction to drugs and/or alcohol is a relapsing condition in some clients. Some clients may remain abstinent for many months or years, before initiating drug (or alcohol) use again.

THE NATURE OF TREATMENT

- Other clients may continue to periodically pop in and out of treatment agencies over long periods of time, whilst others may deal with their problems without visiting a treatment agency.
- Practitioners also face the problem of dealing with polydrug use. People today are much more likely to be taking a variety of drugs than they were 20 years ago.
- Use of heroin or amphetamine is often associated with use of benzodiazepines and/or alcohol. Some people will take whatever drug they can lay their hands on, which generally leads to a greater deterioration in psychological and physical health.

THE NATURE OF TREATMENT

- Treatment of substance misuse represents one of the most difficult challenges in the health field.
- Service users, their families, commissioners of treatment, and society itself expects more from treatment than just a reduction in, or elimination of, drug and alcohol use.
- Clearly, trying to reduce substance use, improve personal health and social function, and reduce public health and safety risks, is a daunting task for practitioners, particularly given that clients often present with severe and chronic problems at the start of treatment.

OUTCOMES OF SUBSTANCE MISUSE TREATMENT

- Despite these huge challenges, research has shown that various forms of substance misuse treatment are effective. In the U.S., scientific studies have shown that various forms of substance abuse treatment (e.g. methadone maintenance, therapeutic communities, outpatient detoxification) can be effective (cf. McLellan and McKay, 1998).
- Importantly, this research has shown that the benefits from treatment extend beyond the reduction in substance abuse, to areas that are important to society such as reduced crime, reduced risk of infectious diseases, and improved social function.
- This research has also revealed that "the costs associated with the provision of substance misuse treatment provide 3- to 7-fold returns ... within approximately three years following treatment."

OUTCOMES OF SUBSTANCE MISUSE TREATMENT

- An important study published in an October 2000 issue of the prestigious journal *Journal of the American Medical Association* compared drug treatment with treatment for asthma, hypertension and diabetes and showed comparable success rates and compliance.
- There has been a considerably lower level of investment in the U.K. to ascertain whether substance misuse treatment works.
- The National Treatment Outcome Research Study (NTORS), which involved tracking over 1,000 drug misusers after they entered one of four types of treatment intervention, showed that treatment for substance misuse in the U.K. does work and is cost effective.

OUTCOMES OF SUBSTANCE MISUSE TREATMENT

- For every extra £1 spent on substance misuse treatment, there was a return of more than £3 in cost savings associated with victim costs of crime, and reduced demands upon the criminal justice system (Department of Health, 1996).
- However, there were wide variations in the response to treatment of clients from different agencies.
- It is clearly evident that there is substantial variability in effectiveness of substance abuse treatment across different settings, modalities and programmes.

THE NATURE OF TREATMENT

- It is widely accepted that the best approach to treating a person with a serious substance misuse problem is to treat the individual as a whole (holistically), rather than just focus on trying to reduce his or her drug intake.
- Thus, treatment in some cases may involve use of a medication, behavioural therapy and/or counselling, and attention paid to necessary social services and rehabilitation.
- These might include access to housing services, mental health services, education and vocational training.

THE NATURE OF TREATMENT

Robertson (1998) states that "most agencies see themselves as providing a variety of support services which may be summarized in the list of headings below":

- Counselling
- Psychological therapies
- Psychiatric treatment
- Prescribing of methadone
- Harm minimization
- Welfare rights
- Medical referral
- Legal and advocacy services."

TREATMENT INTERVENTIONS

The specific interventions used for substance misuse treatment examined by the Task Force included:

- Self help networks (Alcoholics Anonymous, Narcotics Anonymous)
- Counselling (e.g. cognitive behavioural, 12-step based)
- Detoxification programme (residential or home)
- Methadone maintenance or reduction (may be other substitute prescription)
- Syringe exchanges.

Roberston (1998) summarises the "Management and treatment opportunities for drug users":

MANAGEMENT AND TREATMENT OPPORTUNITIES FOR DRUG USERS

- INTERVENTION STRATEGY:
Contact with drug taker
- COMMENTS:
May be educational input or attendance at a clinic or agency (the first major hurdle).

MANAGEMENT AND TREATMENT OPPORTUNITIES FOR DRUG USERS

- INTERVENTION STRATEGY:
Assessment
- COMMENTS:
May be first contact or one of many.
Degree of problems needs careful consideration, including living situation, family issues, and legal problems.
Important to determine any need for urgent medical or social care.

MANAGEMENT AND TREATMENT OPPORTUNITIES FOR DRUG USERS

- INTERVENTION STRATEGY:
Diagnosis
- COMMENTS:
Co-existing pathology (social, psychiatric or physical needs to be evaluated).
Referral to specialist worker in any or all of these areas may be necessary. Evaluation of presence and severity of opiate dependence and extent of other drug use.

MANAGEMENT AND TREATMENT OPPORTUNITIES FOR DRUG USERS

- INTERVENTION STRATEGY:
Therapy
- COMMENTS:
Various options depending on client choice, assessment and availability of individual therapies.

MANAGEMENT AND TREATMENT OPPORTUNITIES FOR DRUG USERS

- INTERVENTION STRATEGY:
Follow-up and long-term support
- COMMENTS:
Probably the most important, and neglected, area because of skills required, expense of worker time and frustration due to relapse and loss of contact.

SPECIAL NEEDS

Robertson (1998) also points out that certain drug using groups require special skills from the treatment system:

- women
- children of substance misusing parents
- co-morbidity clients
- co-dependent clients
- adolescents
- the elderly
- sexual groups
- ethnic groups
- the homeless
- health professionals
- the employed.

SUBSTANCE MISUSE TREATMENT SERVICES

- "It would be nice if services were planned on the basis of a needs analysis matched by the commissioning of service providers."
- Historically, this has not been the case; rather, the provision of substance misuse services has been reactive either to pressure from local clinicians or politicians, or to some perceived national crisis.
"Organisation of services: Putting it all together" by Gillian Tober and Duncan Raistrick, in "Working With Substance Misusers: A Guide to Theory and Practice", edited by Trudi Petersen and Andrew McBride.

'BRITISH SYSTEM'

- The UK approach to illicit drug use is usually considered to have been set by the report of the Rolleston Committee in 1926.
- The so-called 'British system' defined by Rolleston considered addiction as a medical problem.
- It acknowledged the prescription of substitute drugs (morphine or heroin) as a legitimate treatment for addiction:
 - > If the person was gradually withdrawn
 - > If, after attempts at cure had failed, the patient could lead a normal and useful life when provided with a regular supply, but ceased to do so when the supply was withdrawn.

'BRITISH SYSTEM' AND BEYOND

- Before the 1950s, there were so few opiate addicts in the UK that nearly all of them were known to the Home Office Drugs Branch Directorate, which periodically checked pharmacy records.
- These people were mainly middle class and middle aged, or elderly.
- In the early 1960s, reports emerged of a new group of opiate users, mainly in their late teens and twenties, who were misusing and advocating the use of prescribed drugs for 'kicks'.
- Amphetamines and other drugs were also being used on a recreational basis.

'BRITISH SYSTEM' AND BEYOND

- An Interdepartmental Committee on Drug Addiction chaired by Sir Russell Brain was set up to look at this matter, but reported in 1961 that there was little cause for concern.
- Following further media coverage, the committee was asked to reconvene.
- This second committee reported that " a new, young, unstable, non-therapeutic group of drug takers had emerged, and that although some illicitly produced drugs were sold on the streets, most of the problem was caused through overprescribing of therapeutic drugs by unscrupulous, uninformed or vulnerable doctors."

DRUG DEPENDENCE UNITS

- The second Brain Committee recommended that, where possible, prescribing should be taken out of the hands of GPs and instead carried out by specialist psychiatrists, who would work from special centres to be known as drug dependence units (DDUs).
- The DDUs were set up between 1968-1970, mainly in inner city areas.
- Since not all parts of the country were covered by these units, general psychiatrists and GPs, although discouraged, were not completely prevented from treating drug misusers. However, heavy penalties were put in place for any doctor who prescribed inappropriately or excessively.

DRUG DEPENDENCE UNITS

- The DDUs were set up with the good intentions of providing detoxification, substitute prescribing, psychosocial therapies, and social rehabilitation.
- However, these clinics were soon overwhelmed by demand and before too long were unable to deliver more than a substitute prescribing service.
- In a landmark report called "Treatment and Rehabilitation" (Department of Health and Social Security, 1982), the Advisory Council on the Misuse of Drugs (ACMD) recommended a broadening of the base of treatment agencies and professionals involved in delivering treatment.

COMMUNITY DRUG TEAMS

- The ACMD recommended the formation of non-medical multidisciplinary community drug teams (CDTs).
- It was envisaged that each health district, with populations of around 250,000 people, would have such a drug team.
- Their main role was not so much as direct provision of clinical treatment to a limited number of users, but the facilitation of treatment and rehabilitation by a wider network of professionals.
- The non-medical team would have links with a local consultant psychiatrist in drug misuse and their junior doctors, and primary care physicians, as well as with non-statutory drug agencies, probation, social services and other organisations in touch with drug users.

COMMUNITY DRUG TEAMS

- Over and above these CDTs, each region, comprising 10-20 health districts, would have a more specialised drug service with full-time consultants, bigger medical and multidisciplinary teams and additional facilities such as an inpatient unit.
- These services were expected to treat the more difficult cases, and were typically based where the previous DDUs had been.
- These recommendations were seen as formative in the de-institutionalisation of drug misuse treatment in the UK.
- This was important as with ever increasing numbers of drug takers it was important to involve GPs and other practitioners in tackling the substance misuse problem.

COMMUNITY DRUG TEAMS

- John Strang and colleagues (1992) assessed nearly a decade of the setting up and operating of CDTs.
- The original CDT concept implied a kind of 'triage' system, in which drug users with routine prescription needs could be treated by their own primary care physicians with guidance, some especially problematic individuals might need reference to a regional centre, and only a limited number would require all aspects of management from the drug service.
- However, Strang et al. (1992) noted that '[because] the extent of collaboration from generic colleagues (especially general practitioners) has been poor ... an unplanned abandonment of the original consultancy role for the CDT is widely evident, as CDT workers have become more actively involved in the delivery of care.'

COMMUNITY DRUG TEAMS

- Although the CDTs main role was originally considered to be the facilitation of treatment of others, they have been required to undertake a substantial amount of direct treatment themselves.
- Medical input has become more integrated within the multidisciplinary service.
- The services have had to become more self-sufficient, not only because of the uncertainty of generic involvement, but also because changes in the National Health Service have led to some dismantling of the originally recommended structure of which CDTs were a part.

VOLUNTARY SECTOR AGENCIES

- Many new voluntary sector treatment agencies have developed over the past 15 years.
- These agencies provide general advice and information, needle exchange, outreach initiatives, counselling, and general help with the variety of problems that can accompany substance misuse problems (e.g. loss of home, no social benefits).
- Many of these agencies work closely with GPs to provide substitute prescribing with psycho-social support. They can also provide a home detoxification service.
- Many voluntary sector agencies operate a 12-step programme which involves counselling and involvement in self-help groups such as Alcoholics Anonymous (AA) and Narcotics Anonymous.

VOLUNTARY SECTOR AGENCIES

- These agencies become part of multi-agency working in an area, and are as every bit as important as the CDTs.
- One advantage of these voluntary sector agencies is that it is easier to drop in and be seen (although waiting lists still exist).
- Like agencies in the statutory sector, voluntary sector agencies receive referrals from a wide range of sources.
- These include GPs, social services, mental health services, probation, police, and other substance misuse treatment agencies. Users may be referred by their family or refer themselves.

VOLUNTARY SECTOR AGENCIES

- There are a huge number of people who encounter people with substance misuse problems (e.g. GPs, social workers, probation officers, police officers, hospital workers, bar staff, workplace counsellors, magistrates, teachers, etc).
- Treatment agencies, particularly those in the voluntary sector, provide support and advice concerning substance misuse to people in a wide range of occupations.
- It is important to recognise that people from this wide range of backgrounds can influence positively people who have a substance misuse problem.

THE NATIONAL DRUG STRATEGY

- The UK has a ten year National Drugs Strategy which has four clear objectives addressing:
 - Help young people
 - Community safety
 - Improved treatment services
 - Reducing the availability of illicit drugs.
- Drug Action Teams (Drug and Alcohol Action Teams in Wales) and Local Action Teams have been set up to develop and implement strategies at regional and local level.
- Substance misuse has been very closely linked to the criminal justice system, and this has strongly influenced treatment policy.

ALCOHOL SERVICES

- Alcohol services have developed in a very similar to drug services, albeit driven more by a health rather than criminal justice agenda.
- In the 1960s, Regional Alcohol Treatment Units were set up with similar ambitions to DDUs.
- In contrast to drug services there was a stronger tradition of providing information and counselling to people with alcohol problems through local Councils on Alcohol.
- This tradition may have influenced the landmark "Pattern and Range of Services Report" (1978) to recommend a shift towards community-based services for alcohol problems as later happened for drug misuse services.

ALCOHOL STRATEGY

- There has, however, been no AIDS threat, no criminal justice agenda and no national strategy (other than in Scotland very recently) to fund and drive alcohol services forward.
- Unlike other parts of the UK, Wales incorporates alcohol into its National Strategy. However, there is no clear and coherent strategy for dealing with the problems that alcohol creates.
- England will introduce a national alcohol policy either this year or next, years behind the original intention.
- Some of the voluntary sector agencies work equally with drug and alcohol misusers (of course, some people misuse both substances).

TREATMENT SERVICES

- The terminology used to describe treatment services is confusing.
- "One way of getting around this problem is to use treatment programmes as means of bridging the gap between the broadly defined objectives of commissioner, tiers of treatment, and specific service agreements needed by providers." (is this statement confusing?)
- We can consider four tiers of service delivery:

TIERS OF SERVICE DELIVERY

- Tier 1: generic and direct access services providing information, identification, and first line interventions.
e.g. minimal or brief interventions in primary care
- Tier 2: addiction focused treatments provided by practitioners with some specialist knowledge
e.g. Addictions counselling and advice

TIERS OF SERVICE DELIVERY

- Tier 3: specialist services working with complex cases where multidisciplinary teamwork and cross-agency working is common.
e.g. a pregnant user's programme or structured methadone programme
- Tier 4: very specialised and usually intense forms of intervention.
e.g. dual diagnosis programme