Private alcohol detox clinics should be regulated

PersonaL VieW Anonymous

There exists a proliferation of establishments that purport to “detoxify” and “rehabilitate” extremely vulnerable people from dependency on alcohol and other substances. There are worrying absences of an evidence base, qualified staff, ethical standards, and ongoing support—and an even more worrying tendency to concentrate more on securing fees than on achieving success in overcoming these life threatening conditions. As a result, alcohol misusers are in danger of haemorrhaging as briskly from their bank balances as from their guts. Some of the residents in these facilities are funded either by the NHS or by their local authority, which makes the apparent lack of regulation a matter of public concern.

Treatment by the NHS of the most serious complications of chronic alcohol misuse, notably liver failure, is superb. NHS management of the underlying conditions of alcohol dependency, however, is abysmal. In the case of my son, there was, as so often, a potentially lethal mixture of alcoholism, depression, anxiety, and adverse social circumstances contributing to a pattern of recurrent drinking. To be fair, he underwent a period of 10 days’ detoxification in a distant NHS hospital, and a couple of brief psychiatric admissions locally, but in general, the upshot was that a full psychiatric assessment could not be undertaken while he was still drinking.

In the absence of ongoing NHS supervision of alcohol dependency (and possibly other substances), the private sector has expanded to fill the void. So called detox and rehab businesses are easily found online and often offer immediate residential treatment. Any statistical evidence of their effectiveness, as measured by maintenance of sobriety at one, two, or five years, is strikingly lacking. So parting with perhaps £3000 for one week’s detox or £4500 for four weeks’ detox and rehab is a leap into the all enveloping dark.

At my son’s first centre, which was highly recommended, daily instruction was carried out mostly by former alcohol or drug users who had become so called counsellors, but who had received little formal training. My son did well for four weeks, and his health visibly improved. Then he received some bad news and bought a couple of bottles of vodka, whereupon he was summarily discharged. My complaint that this constituted a breach of the institution’s duty of care and my request for reimbursement of some of the fee were dismissed.

He paid about £4000 for a further four week course elsewhere, which was successful for some weeks after his discharge, until another stressful event precipitated another relapse. This may have been because the centre had been too far away to arrange essential follow-up treatment. For this failure my son was entirely to blame, but this failure is characteristic of people in his situation.

His third experience was the worst. One evening, under the influence of alcohol as usual, he contacted a rehab organisation and booked a 12 week residential programme to begin the next day, paying £1000 deposit. I advised him strongly against this, because his work and personal problems required his presence at home. He went in the morning regardless, again considerably inebriated and agitated, but on arrival he had second thoughts.

Then, a so called counsellor phoned me to say that my advice not to attend was not in my son’s best interests and that he was too befuddled to make an informed decision. My son stuck to his guns and came home the same afternoon, issued with some chlordiazepoxide for the journey, but not before the staff had swiped a further £5990 from his debit card, the full cost of the programme.

They have refused to refund any of this, but have offered to reinstate the course of treatment. This handling of such a vulnerable individual amounts to exploitation: my son was not of sufficient mental capacity to make a valid contract, and, indeed, urgent psychiatric admission followed.

More recently, my son has engaged with another organisation to undertake a so called community detox—that is, at home—for £1600. The next morning, a locum GP from another town arrived and wrote a prescription for some chlordiazepoxide, diazepam, and metoclopramide. His telephone contact had promised a daily visit or at least a phone call from a nurse or a counsellor, but only one such visit occurred and nothing more was heard from them except an expression of amazement on being told that so little of the promised supervision had materialised.

My son is currently in negotiations with yet another organisation, but only one outcome is assured—the expenditure of £2000 to £4000 for a week or 10 days’ detox. The negotiations seem to be having a positive outcome. One clinic is so keen to secure his custom that they have sent a car to pick him up. While he is packing, a different clinic is repeatedly and insistently on the phone, claiming that they had spent more time talking with him than the first clinic, and that he had promised to spend the next 10 days with them.

The competition is clearly keen.

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Art on the inside

Prisoners’ participation in creative activities might provide mental health benefits and opportunities for self expression, finds Colin Martin, reviewing two exhibitions

Girls Behind Bars: Female Experiences of Justice
Rating: ★★★☆☆

Inside Art: Creative Responses to the Collection by Young Offenders
Rating: ★★★☆☆

Two exhibitions show how art workshops are currently being deployed in UK prisons to help inmates reflect on their lives, improve their wellbeing, and prepare for their release. The provocatively titled exhibition Girls Behind Bars: Female Experiences of Justice presents work by prisoners at Holloway Prison and other women, supported by the national mental health charity Together. It also includes work by female participants in a National Galleries of Scotland outreach programme at Greenock Prison. Girls Behind Bars focuses on the mental health of female prisoners. Pharmacopoeia, a collaborative group comprised of the general practitioner Liz Lee and the artists Susie Freeman and David Critchley, gained insights into the health problems of female prisoners from the prison medical service at Holloway. “We learnt that mental health and drug addiction are huge issues which eclipse everything else,” recalled Lee. “High proportions of inmates are prescribed antipsychotics and antidepressants, and use of pain killers and sleeping tablets is also high.”

Pharmacopoeia’s installation, Dose, which documents the health problems that might be experienced by a typical female prisoner and the prescription drugs she might take up to the age of 50, was first exhibited in the prison chapel. The pharmaceutical and medical narrative, noting “rather troubled teenage years with increasing family difficulties made worse when she takes recreational drugs,” seems tame compared with shocking actual memories recounted by prisoners in response to the installation: “First tried crack, age 13”; “Got shot in upper leg”; “21-24 (sic) ketamin-alcohol-EDMA-puff-DMT-speed-smack—got pregnant had my son.”

Pharmacopoeia subsequently ran art workshops for prisoners, using Dose as a stimulus for participants to produce works about themselves and their health and wellbeing. Those who wanted to sew and use textiles were encouraged to make self expressive bags. One was cut from a grey prison T shirt, reassembled, and restitched. External net pockets were added and appliquéd with the sobering details of prison routines, including the duration of nightly lockdowns (15 hours at weekends; 11 hours on weekdays) and an itemised list of breakfast provisions. “It illustrates an obsession with everyday things that arises when cut off from the outside world,” says Teresa Hoskyns, facilitator at the Pharmacopoeia workshops and architect at University College London, which funded the project. The prisoner had wanted to include methadone among the bag’s contents, “as that was the drug that was talked about constantly during the workshops,” but had to make do with fluoxetine (Prozac) and paracetamol, supplied by Lee. Other bags were poignantly titled, such as the To Put the Past Behind Me and the Future Before Me Bag.

Inside Art at the National Gallery in London exhibits work made by 30 men, aged 15 to 21 years, resident at Feltham Young Offenders Institution, during four week-long practical art projects, organised as part of the gallery’s outreach programme in 2010. The works exhibited by the young men are gentler because, unlike the women who were encouraged to explore their experience of imprisonment and how they feel about themselves, the men explored four subject themes represented in the National Gallery’s collections—the body, landscape, light, and perspective. They worked from large scale reproductions of works by seven artists rather than the originals. The quality of the work produced by workshop participants matters less than their creative engagement in sculpting, drawing, and painting with professional artists, which develops listening and communication skills and supports rehabilitation in preparation for their release.

“The most important thing I got out of this project was seeing things come together and actually achieving something,” said one participant. Heartening results from an evaluation of the 2009 project, presented at a seminar in April 2010, showed that participants had improved empathy and self awareness, and increased levels of teamwork, problem solving, decision making, and communication skills, all of which boost confidence in their ability to make positive choices and take responsibility.

The connection between confinement and creativity has had a long history, as evidenced in an exhibition on quilts held at the Victoria and Albert Museum last year. One quilt was made by women convicts during their long voyage to Australia in 1841, with materials supplied by the British Ladies’ Society for Promoting the Reformation of Female Prisoners, founded by Elizabeth Fry in 1816. Another was made in 2009, 168 years later, by men at Wandsworth Prison, with the support of Fine Cell Work, a charity that provides needlework lessons for prisoners.

Prisoners’ participation in regular creative activities not only relieves the tedium of incarceration, but might also provide mental health benefits, and an opportunity for self expression.

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Editorial: Health services for prisoners (BMJ 2011;342:d351)

Personal View: We should push for evidence based sentencing in criminal justice (BMJ 2011;342:d612)

Dose, 2009, detail with full ashtray
Do men choose philosophies, or philosophies men? A friend of mine, who has thought deeply about the question, thinks it is the latter: by which he means, of course, that it is one’s temperament rather than abstract considerations of truth that determines one’s world view. A cognate question is whether there is such a thing as the addictive personality, and if so, whether each drug has its corresponding personality. Or is it merely circumstances that addict the addict?

The German writer Hans Fallada (1893–1947, real name Rudolf Ditzen), was a man of multiple addictions, but principally to alcohol and morphine. In his Short Treatise on the Joys of Morphinism he describes, in terms similar to those of Thomas De Quincey, the pleasures and pains of opiate addiction.

Fallada did once shoot at his wife, though he missed—unlike William Burroughs, author of The Naked Lunch, and another morphine addict

The short story, written in the first person, describes his search for morphine when he has run out. He tries various doctors, one of whom eventually agrees to give him a dose on condition that he agrees to admit himself into an institution for withdrawal and cure. The doctor locks him in a room after he has given him some morphine and then searches for the keys to his car to take him to the institution. The narrator picks up one of the doctor’s books in the room and finds it stamped with his name on the flyleaf; he tears it out for later use as a forged prescription. The doctor puts him into his car but, revived by the morphine, our narrator jumps out and runs away.

Meeting up with a fellow addict who has managed to find a large supply of morphine, the narrator injects himself with some but spills the rest, and has to flee his fellow addict’s wrath. He then decides to inject himself with cocaine, under the influence of which he strangles his landlady: “I leap at my landlady and grab her by the throat. I push her blond bulk against the wall, her watery eyes are bulging out stupidly and offensively, her head makes a small, vulgar movement on to her right shoulder and she collapses in a soft pile, her sudden torpor pulling her clear of my hands.”

Actually, Fallada did once shoot at his wife, though he missed—unlike William Burroughs, author of The Naked Lunch, and another morphine addict. Burroughs shot and killed his wife and then used the family money, which he had hitherto affected to despise, to bribe his way out of prison in Mexico. In fact, Fallada had killed before. In 1911, when he was 17 years old, he had formed a suicide pact with a friend, arranged to appear as a duel. Fallada’s friend missed, but Fallada did not: his friend was killed. Fallada then shot himself but did not die. He was subsequently admitted for the first of many times to an asylum.

Clearly, Fallada was not what a normal person might call a normal person. But then he hardly lived through normal times. When he was 16 years old he was severely injured in an accident and started to take painkillers. His brother was killed in the first world war, he lived through the period of hyperinflation in Germany, and the rise and apogee of Nazism. He was courted and imprisoned by Dr Goebbels. He ended his days in the Soviet zone. Not an easy life, then, leaving undecided the question of the addictive personality. Although, personally, I think he had one. His books are marvellous.

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The importance of mistrust

We are not police officers; we have no undercover operatives, no batons or powers of arrest. Our relationship with patients is based on an old fashioned notion—trust. But the unspoken reality is that many patients are economical with the truth. This might stretch from exaggerating symptoms to improve welfare benefits, to applications for car disability badges. All this is perhaps no worse than exaggerating insurance claims or fiddling expenses.

Courses and textbooks on communication, however, never have chapters on scepticism.

Another area common for manipulation is medication. Drugs such as dihydrocodeine, tramadol, sildenafil, diazepam, zopiclone, co-codamol, and sip feeds can be diverted into the black market to be sold on. The scale of this problem is not known, not even studied. Doctors can be naive, but we are not stupid: we know this goes on. And this problem is greater than the odd buccaneering, bogus patient who presents late on a Friday evening with convincing stories of woe and “a taxi waiting.” Vast quantities of these drugs are dispensed monthly. How do these dependence forming drugs of diversion end up on our repeat prescribing system?

The process often goes like this. Patients present, for example, with symptoms of anxiety or pain—important symptoms, but symptoms that are subjective and difficult to measure. Often they attend with someone else. This adds emotional and occasional physical muscle to their story. We offer various alternative options. These are dismissed: “I have tried them all.” We might send them away with advice. They return, saying they have tried a drug from a friend that “really worked.” The easy option is to give them a small amount. You document “short term only” in the records.

Then they return grateful and explain how the drug has transformed their lives. You give them another small amount. You don’t see them for a while and then discover that they have seen other doctors to gain more prescriptions, claiming that, “you had said it was okay.” Worn down, you give longer prescriptions. They return again, again, and again. You are seeing them every few days and dealing with telephone queries about lost scripts. By this time they are being prescribed large amounts of the drug. The only solution is to put this “problem” out of sight, on to the repeat prescribing system. They stop coming. But the prescription requests are too frequent, often with conflicting excuses.

Broken, you call a showdown appointment, and the outcome is weekly dispensing. The original reason for prescribing is long forgotten: the drug has become the “problem.” Doing the thing we set out not to do. Some of this behaviour is absolutely legitimate; some is not. This is not cynicism; this is realism. How do you know when you are being manipulated? Only through the wounds of experience. Trust is great, but mistrust has a place too.

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What war is good for

“War—what is it good for?” asks the old protest song. Advances in surgery, if nothing else, might be the answer.

The patients of the French surgeon Ambroise Paré (1510–90) certainly benefited from his long experience treating the casualties of muskets and cannons in the conflicts that ravaged Renaissance Europe.

From humble origins, Paré was apprenticed to a barber before he enrolled as a trainee surgeon at the Hôtel-Dieu, Paris. After joining his first military campaign at the age of 27, he spent almost 30 years amputating limbs and excising musket balls on European battlefields, and applied the lessons he learnt to improving surgery for all. Despite his rise to the rank of royal surgeon to three French kings, Paré wrote his many books on surgery in French rather than the customary Latin. Decades of wading through blood did not inure Paré to the horrors of warfare.

Paré made his most famous discovery on his first outing as a rookie army surgeon during an expedition to Italy in 1536. Following standard practice, he was cauterising gunshot wounds with scalding oil, based on the common belief that this neutralised the supposed poison in gunpowder. When he ran out of oil, in desperation Paré applied a salve of egg yolk, rose oil, and turpentine to the wounds. Unable to sleep that night from guilt, he rose early the next day to discover those soldiers treated with the salve were healing while their fellows scalded with oil still writhed in feverish pain. Importantly, Paré resolved to apply the results of his unintentional randomised controlled trial to future practice, deciding that “neither I nor any other should ever cauterise any wounded with gun-shot.”

Paré popularised his finding in his Treatise on Gunshot Wounds, published in 1545. Always mindful to reduce pain and diminish suffering, Paré also pioneered ligatures in amputations, designed prosthetic limbs, and championed podalic version in obstetrics.

With a wit as sharp as his amputation knife, his works were dedicated to promoting rational medicine and dispelling superstition. His “rules of chirurgy” were simple and logical, beginning with the sage observation, “Health is not received by words, but by remedies fitly used.” Poignantly, Paré countered criticism from snobbish physicians in his Apologia, published when he was 75 years old, detailing his vast battlefield experience with clinical precision.

Addressed to Étienne Gourmelen, dean of the faculty of physicians, Paré wrote, “My little master, I wish you had been there.”

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