Middle Articles

CONTEMPORARY THEMES

Centres for Treatment of Drug Addiction

The Dangerous Drugs Bill, which received its unopposed third reading on 8 May, provides for the setting up of special centres for the treatment of drug addiction. In the Symposium below three consultant psychiatrists and a general practitioner discuss some of the problems in organizing these centres (see also Leading Article at p. 455).

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Advantages of Special Centres

From Dr. T. H. Bewley, Consultant Psychiatrist, Tooting Bec Hospital, London S.W.17

The recommendations of the Brain Committee on treatment centres and limiting the prescribing of restricted drugs are now about to be implemented. In the London area outpatient clinics are to be set up by the undergraduate teaching hospitals, and beds are to be made available for inpatient treatment in designated units to be set up in regional board hospitals. In the South-west Metropolitan Region there will be two such inpatient units in mental hospitals.

There should be several advantages from the setting up of special outpatient clinics for narcotic addicts. The number of these clinics will be limited,¹ and this should end the present practice where an addict can go from one doctor to another until he eventually finds one who prescribes for him what he desires (whether or not this is excessive). These outpatient clinics should have an up-to-date record of notified addicts (when addiction has been made notifiable). By working in conjunction with centres where there are inpatient beds for the treatment of addiction, it should always be possible to arrange for new referrals to be admitted for assessment. The centres could also provide a consulting service (whether or not a patient was an addict, or whether, and which narcotic, to prescribe for an addict who had a concurrent physical illness). As treatment is often unsuccessful, prevention is of importance, and case finding among contacts should be easier from a limited number of clinics. Again, if there is co-operation between the clinics it should lead to a standard practice in deciding which patients are otherwise incurable or untreatable, but thought to be capable of leading a more normal life with long-term drug-taking. Setting up a limited number of treatment centres provides an opportunity for systematic record-keeping and follow-up, and should facilitate research. Outpatient clinics could also be used for dispensing drugs, rather than prescribing, and this is discussed later.

The Ministry of Health in H.M. (67) 16, paragraph 8, on outpatient services state that their aim is to "curtail the spread of heroin addiction by continuing to supply this drug in minimum quantities," though this is qualified by saying "where this is necessary in the opinion of the doctor." What constitutes "minimum quantities" is not defined. If heroin is prescribed to addicts and not given in the form of an injection by the personnel of the clinic there are risks involved. Few addicts who have been admitted to hospital were concerned about cleanliness or antiseptic precautions. Some licked their needles as a routine before injecting themselves. There have been out-

breaks of syringe-transmitted serum hepatitis already among heroin addicts in Britain, and tetanus, septicaemia, right-sided bacterial endocarditis, and multiple abscesses are also seen. Three recent admissions to Tooting Bec Hospital had abscesses caused by breaking and leaving needles in themselves. Overdose of the prescribed drug (heroin) is the commonest cause of death in this group, and the death rate is 20 times the expected rate. If addicts are to have heroin the best method of providing it must be considered.

Previous attempts have been made to set up outpatient treatment clinics for heroin addicts. A number of prescribing clinics were set up in the United States between 1919 and 1923.² At that time under the U.S.A. Treasury regulations it had become impossible for doctors to continue to prescribe dangerous drugs to a drug addict without fear of prosecution. These clinics gradually fell into disuse and were looked on as a failure. Most of the addicts who attended the clinics were addicted to morphine or heroin, which are short-acting drugs (the majority of heroin addicts give themselves injections of the drug at 3- or 4-hourly intervals). It was not possible for the clinics which were set up at that time to provide a service where an addict was given an injection when necessary. They were given prescriptions, and this did not work. It was never possible to know the needs of an addict, and there was a tendency for addicts to get more than they needed and sell the surplus. Because of the short period of action of heroin, addicts oscillated between euphoria (feeling "high") and abstinence (feeling "sick"). There were also the problems from unsterile self-administration of drugs.

When similar clinics were set up in Israel³ an attempt was made to prevent people attending the clinics from obtaining narcotics on prescription, and then selling them, by giving drugs only by injection. It was found that to expect addicts to attend for each injection was impossible in practice, because of the need for frequent attendances. Hence, in my view, if drugs are to be given to addicts at clinics something different will be needed. Recent studies in New York,² using methadone, have offered a way out of this problem. Methadone is a long-acting morphine derivative which can be given by mouth and it is possible to give a single daily dose under medical control. If given in sufficiently large dosage it seems to relieve narcotic hunger, and patients in a New York trial who were taking methadone daily were protected against both abstinence and euphoria, and appeared to have lost the desire to take heroin.

At present the projected legislation will restrict the prescribing of only heroin and cocaine. As cocaine is not a drug that can produce physical dependence there is no reason to prescribe this drug in any circumstances. There may have to be an extension of the drugs restricted at a later date, as already many addicts who have taken heroin and cocaine in the past take intravenous methadone combined with methedrine at present. Prescribing methadone for addicts is not desirable. If there is to be medical control it is better dispensed and given orally under supervision. Whether patients of this type can best be

treated voluntarily or compulsorily will have to be considered. The most convincing follow-up studies up to the present have shown that a period of compulsory treatment followed by a probationary period on licence produced better results than purely voluntary or purely custodial methods of treatment.⁴

REFERENCES

- ¹ Ministry of Health, H.M.(67) 16:13 (a).
- ² Dole, V. P., *et al.*, *Arch. intern. Med.*, 1966, 118, 304.
- ³ Wislicki, L., *Brit. J. Addict.*, 1963, 59, 37.
- ⁴ Vaillant, G. E., *Amer. J. Psychiat.*, 1966, 122, 727.

Importance of Research

From Dr. P. H. Connell, Physician, Bethlem Royal and Maudsley Hospital, London

For the purposes of this short contribution I shall consider some of the recommendations of the Brain Committee under four main headings—namely, outpatient services, inpatient services, maintenance, and general considerations.

Outpatient Services.—It is generally agreed that outpatient services should be sited within the addiction prevalence areas, and that close contacts with the community served will be essential. In London this will mean that the teaching hospitals which serve the addict population may be involved. There are thus fears that large numbers of addicts will descend upon the general outpatient department, and not only overload it but also cause undesirable effects, such as spreading the addiction to other patients and disturbing the department by bad behaviour. Similar arguments are used when considering a psychiatric outpatient department. Moreover, it must be recognized that many hospitals have outpatient departments and psychiatric departments which are already severely over-extended.

In my view, therefore, there can be no hard-and-fast rule as to the siting of addiction outpatient services, which will have to be provided according to local conditions. In general terms, however, there is no direct evidence to suggest that there will be an influx of large numbers of addicts, provided that maintenance attendances are cut down to, say, once in two weeks, and provided that a large enough number of hospitals cater for addicts, so that the load is well spread. Nor is there any direct evidence that the presence of addicts in psychiatric outpatient departments necessarily causes distress to other psychiatric patients. In general, difficulty would not seem to be likely unless the addicts formed a group and settled themselves, for instance, in the canteen. The operative factor here would seem to be the proportion of addicts in relation to the other categories of patients seen. Thus some hospitals would need separate outpatient facilities for addicts, but others could cope without these.

Rehabilitation will be a central feature of the therapeutic spectrum, and without this the efforts of both inpatient and outpatient treatment may come to naught. It is likely that only the exceptional patient will be suitable for the general psychiatric rehabilitation service, and hence I think that there should be urgent provision of a few hostels—on an experimental and exploratory basis—in the London area linked by joint staff to the main centres of treatment. The role of the hostel would be to provide support and supervision for the addict, and gradually to introduce him to and integrate him into the community and to prevent him going back to the addict sub-culture, which has previously provided psychological sustenance and support of a deleterious nature. For example, "industrial therapy" at a hostel or from a hostel could be provided, while

other methods of rehabilitation (such as boarding out with families) should be explored.

Inpatient Services.—Urgent admission of the addict may be needed either because of physical illness or because he has reached the stage of wishing for treatment, and it is essential to admit him while he is in this frame of mind. In general, apart from physical illnesses which cannot be nursed in a psychiatric ward, I think that the general medical ward is not a suitable place for the addict, and it is rarely possible to provide adequate supervision. Moreover, admission to general psychiatric beds on a "dilution" principle has, in my view, proved to be unsatisfactory, firstly because the problems of the addict are different from general psychiatric problems, and secondly because the addict draws to him antagonisms from the other psychiatric patients as well as from nurses and doctors because of the difficulties he produces. Thus, provided it is small enough (say, 10–12 beds), a separate unit for addicts would have a number of advantages, including the development of a team approach to the addict; providing the opportunity to study methods of treatment and control; and cutting down the danger of spread of addiction to other psychiatric patients. This does not necessarily mean closed units, but does mean very close relationships between the staff of the addiction unit and the staff of the rest of the hospital.

Withdrawal from the narcotic is in my view best done in the addiction unit rather than elsewhere, since it is an advantage therapeutically for the same nurses and doctors who are to treat the underlying problems to have also helped the patient through the withdrawal crisis.

I believe that the case for compulsory admission or compulsory detention in a crisis has not been made. There are many reasons against compulsory admissions of addicts, and I feel that the whole question should be kept under review so that adequate data may be obtained.

Maintenance.—The prescribing of heroin to an addict is anathema to many doctors. Nevertheless, in my view the case has been well made for attempting such an approach, both to contain the spread of addiction and to try to prevent the development of large-scale criminal activities in this field. Acceptance of the maintenance method does not necessarily mean acceptance for all time, and it will be important that yearly reviews be made to assess the impact of this approach and to think again if the method has failed to influence events.

There are certain provisos to this approach:

1. It is essential that a uniform scheme of maintenance should be used in all maintenance centres, and that the scheme is rigid enough to debar prescription of heroin to an addict because he has lost his drug or sold it or given it away. If an addict comes