Personal Paper

Abstinence or abundance—what goal?

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A recent slip of the pen prompts me to write about changes that have been taking place in drug prescribing habits. I work on a drug dependence unit and recently a referral letter arrived addressed to me as consultant in charge of the drug abundance unit. Whether the referring doctor had made the error unwittingly or humourously, it seems to me that in this error he was communicating his belief that drug units function as clinics for the free hand out of generous supplies of drugs to those who wish to ask for them. Such a view is not wholly unfounded as in the early days of the clinics in the late '60s and early '70s there was great confusion as to their true role, and indeed drugs were prescribed in quantities and form that would be seen as extremely generous and abundant by today's standards. Nevertheless, although drug units cannot ignore their own developmental history, it is surely time that the general medical profession and general public recognised the profoundly different orientation of such clinics today.

One major trend has been the move away of a substance preoccupation, so that problem drug taking may be recognised with a wider range of drugs and drug categories than was previously realised. It is also evident that mere identification of the substance taken does not inevitably identify problematic use. Thus the physical, psychological, and social problems associated with one person's solvent inhalation may on occasions be greater than those seen with another patient's use of opiates. What is required is a model that permits more individual assessment of the patient without being blinded by the substance. Just as with alcohol problems, clinicians have come to realise that patients may present with a wide variety of disorders under the mantle of drug dependence or alcoholism. Obviously, some disorders may occur more frequently than others, but an approach that catered only for patients with a fixed constellation of signs, symptoms, and pathology would not be providing a proper and comprehensive service. It would be demanding that patients fit in with the mould of the service rather than the service responding to the needs of the patient.

At the same time as this development, there has been increasing disillusionment with the long term prescribing of drugs as appropriate management of presenting problem drug takers. Contrary to popular belief, heroin addicts who present to services requesting help today are rarely (if ever) offered a "maintenance prescription." The service is now predominantly geared towards helping the drug taker to become and remain drug free, in much the same way as the service that is provided for problem drinkers. There are those who would question whether there is ever a medical justification for maintenance prescribing in which regular quantities of oral (or occasionally injectable) drugs are prescribed in the belief that by taking away the drug addict's "need" to commit crimes to obtain his drugs, the disorder can be "treated." This empirically derived approach, however, is too often linked with the belief that drug dependence is a discrete disease with a specific treatment.

The presence of medical complications of some drug taking (such as abscesses or withdrawal symptoms) does not indicate that the underlying process itself is a disease. If this were the case we would need to label as diseases such behaviours as cigarette smoking and

motor cycle riding. Even if it has proved itself to be the case that some drug users achieve a hitherto unfound stability when prescribed such supplies a blanket approach of maintenance prescribing was never (and was never intended to be) successful as an intervention for all those who presented. Over the past 10-15 years the pure medical component of therapeutic intervention has steadily reduced so that in many cases it could now be seen as offering a practical management for the physical complications that may accompany drug withdrawal, while permitting the more important personal, family, social, and occupational rehabilitation to take place. It is this concept of the heterogeneity of the population of drug addicts who present that explains why indiscriminate prescribing by any medical practitioner of short term (and especially long term) supplies of such drugs is inappropriate.

To provide figures to support this statement of changing practice in clinics, I have examined the prescribing habits and recommendations of this unit for the last 100 patients, for whom a decision was made to prescribe drugs. In 92 of the 100 cases, the drug of prior use had been one of the opiates (usually heroin or Diconal). Every one of these patients who received a prescription for drugs had discussed and agreed to a withdrawal regimen, which was to be completed within three to 20 weeks. In all these cases, only oral drugs were prescribed (91 received methadone linctus or methadone mixture, one received Diconal as a linctus). In essence, if we just look at the prescribing function of the clinic then the service is similar to an adapted and sometimes extended version of withdrawal regimens that are already frequently used by clinicians in their management of patients who depend on alcohol or barbiturates, etc. While responding to reasonable needs the service certainly does not pander to unreasonable demands.

This is in striking contrast to patients attending the clinic 10 years ago, when of the 54 patients who received prescribed supplies of drugs none was receiving such drugs as part of the preplanned documented withdrawal regimen; 48 were receiving drugs in injectable form or in a form now known to be frequently crushed and injected; and the recorded notes indicate an acceptance of the continuing drug use while awaiting spontaneous recovery or "maturing out," rather than an active intervention to bring about such a change.

It is ironic that the doctor who referred his patient to the drug abundance unit had in fact already been prescribing supplies of Diconal to his patient for many months before recognising that he had reached a therapeutic impasse. The drugs that he was prescribing were considerably more abundant than those which formed part of the consequent oral methadone withdrawal regimen constructed for his patient.

As much as anything else, it has been pragmatism that has brought about these changes. With the old model, the constant flow of new patients into the clinic system was not matched by any equivalent flow of patients out of the system. So with static or diminishing resources, the clinics found it necessary to look at shorter, more cost effective (and perhaps more appropriate) types of response. To date, little service evaluation has been conducted in this area to see how this pragmatically derived approach compares with other treatment options, and with the increasing awareness of cost effectiveness it is obviously important that such research is soon undertaken.

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