Community Drug Summit

June 2001

Treatment For Drug Users And Reintegration Of Drug Dependent People Into The Community.

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1.0 Introduction

This examination of the issues concerning the treatment and rehabilitation of drug dependent people is commenced by highlighting a number of givens. These givens are specific aspects of the treatment and rehabilitation of drug dependence about which there is evidence of sufficient strength and diversity to make them indisputable. It is recommended that the reader reflect on the many and varied issues raised in this Issues Paper against the backdrop of these givens.

The givens have been derived from various sources, but three key references are provided as support:

Farrell, M. (2001). *What makes treatment programmes effective and what are the possible options for making them better?* London, UK: National Addiction Centre.

Hall, W. (2001). *Evidence based addiction treatment: Challenges and opportunities*. University of New South Wales, Australia: National Drug and Alcohol Research Centre.

National Institute of Drug Addiction (2001). *Principles of Effective Treatment.* Washington, USA: Department of Health.

Over the past decade there have been three major investigations into the treatment of drug dependence and these studies are extensively cited in the above reports. These studies, the British National Opiate Treatment Research Study (Gossop, M., Marsden, J. & Stewart, D., 1998), the American Drug Abuse Treatment Outcome Study (DATOS) [www.datos.org] and PROJECT MATCH studies (PROJECT MATCH Research Group, 1997) [www.commed.uchc.edu/match/public_data_set.htm], represent a core of knowledge about the effectiveness and efficacy of intervention.

1.1 Treatment and Rehabilitation 'Givens'

Simply expressed, the givens are:

- there is strong evidence of the impact of treatment. Treatment improves health outcomes, reduces criminal activity and reduces the use of illegal drugs;
- treatment 'works': consumers coming into contact with various forms of treatment do 'better' than those not coming into treatment contact;
- treatment is cost effective. For every dollar spent on treatment there is a four to seven dollar return in terms of health care and crime cost reductions. This return is higher than for law enforcement;
- there is no single treatment appropriate for all individuals: a smorgasbord of options is necessary;
- there is an overall equivalence of treatments. Programs of very different ideological perspectives appear to achieve very similar outcomes. So called 'non-specific' factors, such as quality of the helping alliance, therapeutic enthusiasm and adoption of a coherent theoretical model of treatment, all appear to be important;
- longer duration of treatment results in improved outcome. (This seems to be particularly so for rehabilitation where three months plus of care significantly improves outcome);
- for treatment to be effective it must be readily available, easily accessible and address the multiple needs of the individual;
- the appropriate use of medications (such as substitution, antagonist and psychotropic) in conjunction with counselling, improves outcome (see Section 3.1);
- detoxification is only the first step of treatment and is not, by itself, an effective intervention;
- treatment does not have to be voluntary to be effective; and
- recovery from addiction is a process not an event. Many non-treatment factors, including access to employment, housing and a sense of social inclusion are critical for recovery.

1.2 A Perspective on Treatment and Rehabilitation

The term treatment has been interpreted as being any intervention that has the potential of engaging drug users and drug dependent individuals either into health enhancing behaviours or more direct clinical contact. Within this framework such preventive interventions as needle and syringe exchanges, injecting rooms or heroin on prescription are viewed as falling within the rubric of a broad based definition of treatment.

The concept of reintegration into the community, while an absolutely vital aspect of successful treatment, relies on the implicit assumption that most drug dependent people were integrated in the community prior to becoming drug dependent and that it was drug use that caused their subsequent social exclusion. For many drug users and drug dependent individuals, especially younger people, this is not the case, in that they were marginalised or socially excluded prior to drug use. Their drug use could be seen as a way of coping with this social or psychological exclusion. It is therefore considered that for many people habilitation, as opposed to rehabilitation, or integration, as opposed to reintegration, should be the proper focus of intervention.

Granfield and Cloud (1999) discuss the concept of 'recovery capital', which they define as the existence of assets that the individual has to assist change. They have demonstrated that the more recovery capital a drug dependent user has the more likely there will be a successful treatment outcome. They note that recovery capital may be in the forms of:

- physical capital: literally tangible assets, such as houses, money, cars and employment;
- social capital: the relationships the individual has to assist him or her to feel they are attached to or belong in a community; and
- human capital: which is the individual's intrapersonal and interpersonal skills and capacities, such as psychological robustness, well being and personality resources.

It is recommended that the reader bear in mind the concept of recovery capital when considering the issues raised in Section 3 of this Issues Paper. Reference is drawn to the Western Australian Drug Abuse Strategy Office's (WADASO, 2001) paper entitled: Reintegration of people undertaking or leaving drug treatment. This paper which is available from WADASO, emphasises improving drug dependent peoples' access to assets, such as housing, education and employment.

2.0 The Western Australian Context

Any discussion of treatment and rehabilitation of people with drug related problems needs to be undertaken in the context of the previous Western Australian government's drug strategy, which involved, among other things, a reorganisation of drug treatment services. It included the introduction of 12 Community Drug Service Teams and the restructure of the then Alcohol and Drug Authority into a specialist drug agency called Next Step. In addition, greater emphasis was placed on improving the response of hospitals, the involvement of general practitioners and capacity building in service agencies such as the Ministry of Justice and the Department of Family and Children's Services.

The essential thrust of the strategy, that of making alcohol and drug problems everyones business, is sound, however, the overall effectiveness of the strategy, particularly in regard to implementation and appropriateness, is open to question.

2.1 The Extent of the Problem

Drug problems come in many guises and simply relying on measures of the number of dependent or even problem users has the likelihood of underestimating the extent of problem drug use. At any point in time the nature and number of drug problems are fluid. The notion proposed by Thorley (1980) that drug problems are better definds as problems of immediate use (problems relating to intoxication), problems that accrue from regular use (usually years of daily or near daily use that eventually causes medical problems) and problems of dependence (over reliance upon a drug or behaviour). These definitions provide a better basis for the collection of data and relevant intervention responses.

The best figures available concerning the number of people with drug problems or disorders come from data contained in the Australian 1997 National Survey of Mental Health (Hall and Tessem, 2001). In this survey 8% of all people aged 18 years and older had any substance abuse disorder (11% of males, 5% of females), out of which 6.5% had an alcohol related problem (ie harmful use or alcohol dependence).

An analysis of the WA data found 9% of all people (13% of males, 5% of females) had any substance abuse disorder, out of which 8% had an alcohol related problem. In relation to the 18 to 24 age group, it was found that 30% of males and 13% of females had any substance abuse disorder.

It has to be noted that survey data of drug use problems are always considered to be under representations, as people are loathe to admit alcohol problems and the illegal nature of drug use compounds this. Furthermore, Hall (2001) has estimated that there are approximately 30,000 individuals in Western Australia with comorbid presentations; that is they have reported the coexistence of drug and mental health disorders.

3.0 Issues For Consideration

3.1 Treatment and Rehabilitation

Given that a range of different treatment services are required (ie; a diversity of treatment options) an optimum mix of detoxification, counselling, psychopharmacological provision and rehabilitation services may not have been achieved in WA. In this regard, the marrying of the different components of the overall treatment and rehabilitation system may require further review and development.

Furthermore, it should be noted that the introduction of naltrexone based services has altered the overall balance of treatment provision in WA. Consideration should be given as to whether a review is needed of the overall provision and integration of the available drug treatment services. The lack of agreed and formal interagency collaboration and referral protocols is also seen as problematic.

In this context the following matters are raised:

- **Rehabilitation**
  Access to, and the availability of, residential rehabilitation is an important issue. An issue for consideration is whether the current provision of residential rehabilitation is sufficient. Residential rehabilitation involves participation in a structured residential program of counselling and other personal development, which participants may take part in for days or months. Evidence suggests the longer term programs of over three month's duration have greater success. Residential rehabilitation is recommended for patients with moderate to severe levels of dependency who have concurrent problems, such as homelessness or an unstable home and social environment;

- **Co-ccurring Mental Health and Drug Related Disorders**
  While recent initiatives in this area are viewed as positive, there is concern about the adequacy of the provision of services for consumers with co-occurring disorders. The need to better integrate mental health services with alcohol and drug services is an important issue that needs to be considered. Co-occurring mental health disorders are common in the drug treatment population, as are co-occurring drug use issues in the mental health population. In fact, the situation may be considered the norm rather than the exception in both groups. It is broadly recognised that neither sector has managed this issue particularly well, therefore, the development of suitable treatment responses is a priority;

- **Compulsory or Coercive Treatment**
  The previous State government developed proposals for the compulsory treatment of juveniles with serious drug abuse. One of the proposals developed was for the Childrens' Court to have the power to issue Compulsory Assistance Orders (Court Order) to young people who were considered to be at high risk of significant harm from their substance abuse. Under the proposal, a Compulsory Assistance Order would enable a young person to be coerced to undertake compulsory treatment and if necessary to be held at a secure treatment facility. With this proposal it would not be necessary for a young person to have been charged with a criminal offence. The basis for applying to the Childrens' Court for a Compulsory Assistance Order would be after a professional assessment had been conducted and a conclusion had been reached that a young person was at significant risk of harm from their substance abuse;

- **Accreditation and Licensing of Agencies**
  Concern has been expressed about the quality of some of the clinical treatment services currently provided. This concern relates to patient confidentiality, record keeping, gaining informed consent for treatment and the quality of counselling. Consideration should be given as to whether a statewide system of treatment agency accreditation and/or licensing of practitioners, plus the introduction of a clinical governance model is desirable. Currently in WA there is no legislative restriction on the advertising or provision of counselling services in general, including drug counselling. Furthermore, any medical practitioner can treat patients with drug use problems within the provisions of the Poisons Act 1964 (the Poisons Act 1964 restricts the prescription of Schedule Eight drugs, such as methadone, to doctors who have been trained and registered in its use);

- **Consumer Involvement**
  Drug treatment consumers have achieved a louder voice in recent years in the provision of more appropriate treatment services. The desirability of greater consumer involvement in the provision of treatment services is worthy of consideration;

- **Naltrexone**
  Naltrexone is an opiate antagonist. That is, it replaces the molecules at the receptor sites in the nervous system that respond to heroin and other opiates. Naltrexone binds to these receptor sites and prevents the opiate molecules from having any effect. As such, naltrexone also produces a withdrawal syndrome in addicted patients. The use of naltrexone addresses the physical phenomenon of heroin addiction, however social, emotional and other factors need to be addressed. The return to heroin use after a period of naltrexone treatment can carry considerable risk.

  The introduction of naltrexone as an aid to recovery from heroin dependence has added to the treatment options available for drug dependent people in WA. The actual delivery of naltrexone treatment services has, however, been the subject of widespread public debate. Consideration may need to be given to how best to provide naltrexone treatment in the context of other available treatment needs;

- **Methadone**
  Methadone is a pharmacotherapy and opiate agonist of proven effect. That is, it has the same effect as heroin and other opiates. However, methadone has a number of benefits over heroin, not the least of which is that it is legal. Methadone can be consumed orally, removing the need to inject, and has a longer duration of effect, meaning less frequent use. Research demonstrates that longer periods of treatment improve outcome. Methadone patients may stay in treatment for several years, during which time their social and emotional health is able to improve. At some point, the patient may feel stable enough

in their own life to be able to successfully remove methadone altogether. Other pharmacotherapies include naltrexone, buprenorphine, morphine, codeine phosphate and diethyl morphine (heroin).

A particular issue with regard to methadone is the disparity of cost to consumers of methadone in comparison to naltrexone (the latter being free). In addition, the desirability or otherwise of the extension of methadone prescribers is deemed to be an important issue worthy of debate;

- **Hepatitis Viruses**
  While Australia has an international reputation for responding to blood borne viruses very well, the level of infection in the community is still deemed to be unacceptably high. Consideration needs to be given as to how the pool of contamination can be better managed. The provision of free Hepatitis B vaccinations is also worthy of consideration. Hepatitis C is a particularly virulent virus that affects many injecting drug users. The prevalence of the disease amongst first time, occasional, regular and dependent users is alarmingly high and cause for considerable public health concern;

- **Staffing Remuneration**
  Inequities in the remuneration of government and non-government sector treatment staff is an area of concern that has the potential to impact on the quality of service delivery in this area; and

- **Training and Career Development**
  The skilling and personal development of staff in the treatment sector is an important area that needs greater attention. Drug trends and treatment options are continually changing and developing, and it is important that workers at the front line are kept abreast of such changes.

Important Questions

- With the current provision of treatment services, has an optimum mix of detoxification, counselling, psychopharmacological provision and residential rehabilitation been achieved?
- Is the overall structure, balance and diversity of treatment services appropriate?
- Should proposals be considered for the compulsory or coercive treatment of individuals who are at a risk of significant harm from their substance abuse?
- Should interagency collaboration and referral protocols be formalised?
- Is a statewide system of agency accreditation and/or licensing of practitioners, plus the introduction of clinical governance, desirable?
- Do the different costs incurred by patients being prescribed methadone as against naltrexone merit review?
- Should the prescription of methadone be expanded as a treatment option?
- Is the provision of free Hepatitis B vaccinations worthwhile?

3.2 Drug Specific Issues

A range of drug specific issues are identified as follows:

- **Polydrug Use**
  Polydrug use (use of more than one type of drug) and dependency is the norm amongst treatment consumers. It should be highlighted that the use of single substance pharmacological approaches is not the optimum response to drug dependence;

- **Alcohol**
  The widespread abuse of alcohol across the community and by people with illicit drug problems is noted and, as a consequence, treatment programs should deal with the abuse of alcohol as well as illicit drugs. Alcohol is a central nervous system depressant and interacts with other psychoactive drugs with unpredictable results. Mixing drugs in any combination is dangerous, however alcohol appears to be a particularly problematic agent in this regard. Alcohol along with benzodiazapines is usually present in cases of heroin overdose;

- **Amphetamines**
  Amphetamine dependence and misuse is a growing concern. An issue of urgency is a better response to the consequences of amphetamine use, especially the management of amphetamine psychosis and/or

paranoia, aggression and psychological disorganisation. The provision of community based services that have the capacity to accommodate amphetamine dependence and associated mental health disorders is an area of need.

Amphetamine is a stimulant drug that increases alertness and energy. In excess (which may include one off use for an inexperienced user), amphetamine frequently produces behaviour reflective of psychotic symptoms, including irrationality and aggression. Amphetamine is a popular drug of choice for young people seeking to party, however it is also frequently used in binge type patterns that produce unintended and unfortunate results;

- **Prescribed Amphetamines**
  There is considerable community concern with regard to the perceived over prescription of amphetamines to manage reputed cases of Attention Deficit Disorder. These drugs, which commonly include Ritalin and dexamphetamine, work to increase alertness and attention in affected patients. There is concern in the community regarding the perceived inappropriately high levels of diagnosis of this condition and treatment with the drugs;

- **Benzodiazepines**
  The over prescription of benzodiazepines to people with illegal drug dependencies is another practice that appears problematic. Improvements in the monitoring of both excessive using consumers and excessive prescribing doctors appear necessary. Benzodiazapines are depressant drugs that are commonly used in the treatment of conditions such as anxiety/stress and sleep disorders. They are particularly used by elderly patients and, in the vast majority of cases, are prescribed and used appropriately. Illicit drug users and others also access the drugs for recreational and other purposes. Mixing these drugs with others creates numerous problems, such as those illustrated in the alcohol section above.

- **Cannabis**
  The prevalence and debilitation of cannabis dependence has been understated. Consideration needs to be given to a greater focus and improved treatment response to cannabis dependence. Cannabis does not fit neatly as a depressant, stimulant or hallucinogenic drug, as its effects vary depending on the user, the dosage and 'other' factors. It is therefore classified as 'an other' in terms of pharmacological effect. Cannabis has typically been seen as a soft drug, perhaps because as many as one in two people have tried it at some point. Cannabis use is not without risk, and research increasingly points to numerous potential harms, including mental health, dependence and physical health problems;

- **Cocaine**
  Cocaine is not considered to pose a major challenge to treatment agencies in WA, at present. Nonetheless there is a need to monitor cocaine use by treatment consumers, especially the problems caused by very frequent injection, and to keep abreast of international treatment experiences. Cocaine is a naturally occurring stimulant drug, similar to amphetamine described above with similar problems and issues;

- **Ecstasy**
  Cases of ecstasy dependence are rare, however problems related to ecstasy use need to be monitored. Ecstasy is a popular recreational drug associated with the nightclub and party scene. It is chemically related to amphetamine and has stimulant properties, but also has depressant effects and is therefore also classified as 'an other'. Ecstasy has been associated with several deaths and studies indicate cognitive and other problems may follow regular use.

- **Heroin**
  Heroin is a drug of major concern, along with amphetamines. Innovative methods of managing heroin use such as injecting rooms or the prescription of heroin need to be considered. The extension of home detoxification programs and a clinical trial of the British drug Lofexidine (Britlofex) are also considered worthy of consideration. The current conflict over naltrexone versus methadone treatments is considered counter-productive. The development of agreed best practice guidelines for heroin dependence management may be a solution to this issue.

  A range of pharmacological options are available for heroin addiction, including methadone, buprenorphine and naltrexone. International experience has demonstrated that for those who do not wish to, have failed, or are unable to access other options, prescribed heroin has been a successful alternative. Studies in Switzerland and elsewhere have shown improvements to addicts' health, social adjustment, level of drug use, and reduction in crime, similar to that achieved in methadone treatment programs; and

- **Ketamine**
  Prevalence of this drug in Australia is rare, however its use in Europe is increasing with associated clinical problems such as hallucinations, delusions and violence. Monitoring for the use of this drug would be useful.

Important Questions

- How can better responses be developed for the consequences of amphetamine use?
- Should measures be put in place to restrict the perceived over prescription of Attention Deficit Disorder medications?
- Does consideration need to be given to the provision of improved responses to cannabis dependence?
- Would innovative ways of managing heroin use, such as the provision of injecting rooms or the prescription of heroin be helpful, in WA?
- Is an extension of home detoxification programs merited?
- Is a clinical trial of the British drug Lofexidine (Britlofex) a potentially important response to heroin detoxification?
- Is the development of agreed best practice guidelines for heroin dependence management useful?
- What is the nature and extent of the role of naltrexone in the management of heroin addiction?

3.3 Crisis Care and Access to Treatment

People with addiction behaviour often make attempts to resolve problems when under duress or in crisis. As a consequence, access to clinical services on an immediate, or at least a same day basis is very important. Delays in obtaining immediate service is considered to be problematic.

One of the reasons for the success of the Perth Naltrexone Clinic in attracting clients is through its provision of a walk in (no need to make an appointment) service. Consideration needs to be given as to whether other drug treatment agencies should follow this approach and provide a more immediate non-appointment based system, in order to make a range of treatment services more accessible.

Specific matters in regard to crisis care and access to treatment are as follows:

- **After Hours Contact**
  The provision of some form of acute after hours addiction service may be a valuable extension of existing services. While a number of agencies operate on an after hours basis, they do so by appointment only. Many crises occur outside of normal treatment agency hours and parents regularly express the need for support in such situations. Normal hospital emergency services which are available on a 24 hour basis are, at best, fitful in their response to drug dependent consumers. While such a crisis service may not achieve high rates of continuing engagement with clients, further consideration is warranted;

- **Co-occurring Mental Health Disorders**
  Consumers and families have expressed considerable reservations about the availability and quality of acute mental health emergency care. This is likely to reflect the difficulties in disentangling some of the effects of intoxication that may be accompanied by mental disorientation and more substantial mental disturbance. However, this is likely to seem immaterial to the consumers and families. The availability and quality of acute emergency care for this group of people is seen as an issue that needs to be addressed;

- **Amphetamine Related Psychosis**
  The area of most concern in relation to acute care is the response to an amphetamine related psychological disturbance. Amphetamine is the drug most likely to result in an acute psychotic reaction and apparent recent increases in its use mean that this problem is likely to be occurring to a greater extent;

- **Detoxification**
  Detoxification is the starting point of treatment, it is rarely effective on its own without continuing treatment and support. The need for user friendly, more immediate access and great availability of alternatives to detoxification services is an issue for consideration. Detoxification can be delivered through residential programs with either high or low levels of medical support; through outpatient arrangements with dedicated detoxification clinics or alcohol and drug agencies; or through home visiting services working in conjunction with local general practitioners. A full range of alternatives is the most likely to reach the widest number of people. This is particularly so as the physiological, psychological and social support needs and resources of drug users vary considerably; and

- **Crisis Care Accommodation**
  The lack of availability of crisis care accommodation is an important issue. Accommodation crises occur regularly among heavy and dependent drug users and do not always coincide with a decision to cease drug use. The desire for a service to accommodate young people particularly at such times is heard periodically, not least from families, and such a service would be likely to be well utilised. However, a crisis service which accommodates young people while they are using drugs would need to face a number of issues, such as whether the longterm interests of clients are being best served in this way, how such a facility could confidently stay within the bounds of the law and how the duty of care of the facility's staff could be met.

Important Questions

- How can access to clinical services be improved?
- How can after hours crisis management be improved?
- How can services for people who have acute mental health disorders and drug dependencies be improved?
- Are the needs of special groups adequately addressed?

3.4 Families and Special Needs Groups

While it is recognised that other Issues Papers more specifically address the needs of families and other special needs groups, it is important that they be considered in regard to treatment and rehabilitation. The following specific issues are worthy of consideration:

- **Dealing with Death**
  The grievous burden of losing a child to a drug related death has not received the attention and support that could be reasonably expected. There is a perception that the existing grief support services are inadequate, especially in regional areas. With regard to the Perth metropolitan area this perception may be a result of the inadequate recognition and marketing of the currently available service.

  Furthermore, the requirements for special sensitivity in the management of bereaved children should receive more attention. This applies both to the immediate grief process through which a child may need support, and later towards adolescence. At this time it may be necessary to again revisit these issues to ensure that the young people are not additionally vulnerable to developing a drug problem themselves. The phenomena of the children of drug users developing drug problems is beginning to be seen in alcohol and other drug agencies.

  In addition, the awareness of some counsellors as to appropriate grief management techniques is inadequate and an emphasis on grief and loss counselling skills as part of ongoing alcohol and drug counsellor awareness training is warranted. It is necessary and appropriate that all services should be sensitive and responsive to the needs of families and friends with respect to this issue;

- **Family Counselling**
  The provision of joint counselling for drug dependent people and significant others may well merit extension. This may be a strategy that is useful and necessary when partners both seek treatment even when the bulk of treatment may be delivered to each person as individuals. The skills of counsellors may need to be addressed in this area; and

- **Indigenous People**
  A particular concern is the high rate of incarceration of Aboriginal youth with drug related (often solvent related) cognitive impairments. The extension of services that deal with cognitive impairment is worthy of consideration. Additionally, treatment services need to be able to address solvent abuse. It is noted that the response to solvents necessarily extends beyond treatment and is likely to include alternative activities for young people, the local control of supply and mobilisation of all relevant sections of the local community.

Important Questions

- How can appropriate bereavement services be expanded for affected families and friends?
- What services are needed to meet the needs of children where a parent has died?
- With regards to families, is joint counselling of drug dependent people and family members or significant others warranted?

4.0 Summary

A wide range of issues have been identified in this Issues Paper. It is relevant to stress that key issues are:

- the overall distribution and nature of services provided;
- whether an optimum mix of complementary services has been obtained;
- the interrelationships between agencies;
- the role of the specialist drug treatment agency Next Step; and
- the vexed matter of access to treatment. This issue is especially significant for out of hours service provision and where drug use is associated with co-occurring mental health issues.

Inevitably there is an inherent demand for more and better service provision. A key response to this demand for greater capacity has to be initiatives that result in mainstream agencies working better and smarter with drug dependent people.

Notwithstanding any of the above comments it should be acknowledged that there is considerable dedication, expertise and commitment shown by service providers and that on going evolution, rather than revolution, of drug services is required.

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