The science of the mind: investigating mental health
Treating addiction

Narrator:
Emily Finch is a Consultant Addiction Psychiatrist. She works in a drug and alcohol clinic which treats clients from an area of London with multiple drug and alcohol problems.

Emily Finch
I think the biggest challenge is helping people decide that they actually want to stop using the drug that they're abusing. People present for treatment for a variety of reasons, sometimes because they feel absolutely ready to stop, to stop using. Sometimes because they're in trouble for a range of reasons, sometimes that's with the police, often it's because of physical health issues, they may have mental health difficulties, but they may not have necessarily made the link between that and actually stopping their drug use. And some people are frankly forced into treatment. We do also see clients who are, are very much pushed to come here by the criminal justice system, or by issues surrounding the care of their children. So the biggest issue is helping them feel they want to stop. The second I think is about them recognising the severity of the problem they have. Serious drug misuse, especially heroin use, is actually quite a serious problem, it's quite difficult to stop using, and people usually have to make very, very substantial changes in their lives in order to do so, and helping people come to that realisation is really quite difficult.

When you're considering what treatment to give a client at any one time, I think you have to decide what the client's ready for and what the client's prepared for. At the very basic level we have clients who don't want to stop using drugs, who are very happy with their lifestyles, but they need perhaps to be given clean needles so they don't catch and transit blood-borne viruses, and Hepatitis C and HIV are very harmful diseases that are easily transmitted through sharing dirty needles, they may need to be given social support, I mean if they're street homeless they may need to be given housing, and at that stage that may be the best we can do. One of the most useful things, for instance, we do for clients is vaccinate to get, vaccinate them against Hepatitis B, it's simple, it's cheap, even if they don't want to stop using, it will prevent long-term harmful drug misuse. Another tool for harm reduction is to give people Naloxone which they can use, or they can use on their friends if they're at danger of overdosing, because overdose is one of the most serious complications of heroin misuse, and it kills many people before they're ready to try and think about coming off. If they are beginning to address issues of stopping using their drugs, I think we then consider using some of the pharmacological treatments to replace the drug that they're abusing, and that's usually heroin, as I said. We then have to start bringing in all the other needs that a client has. All our clients have social needs, most of them have had majorly damaged lives that they will need, for instance, help with housing, help with benefits, help with employment, and before they can make progress with treating their heroin misuse and benefit from prescribing, we need to start working on those sorts of things. Many of our clients have long-term psychological difficulties, many of them have been abused as children, many of them have suffered trauma, and we need psychological help with that.

Many of them have a range of comorbid psychiatric illnesses, for instance, many of them are depressed and may need treatment for depression, or anxiety or a range of other problems, and we have a small number who have profound, serious mental illnesses, such as schizophrenia who also end up using heroin. So we, we may need to treat all those sorts of things. Then, if we've been able to stabilise their drugs on substitute medication, we then have to start considering actually getting them off the medication, and the moving into what we call recovery and actually beginning to think about how they need to lead normal lives, and pharmacology is useful for that but most important is clients looking at all the ways they

can be reintegrated into society, and for many of them it's about perhaps employment, it's perhaps about learning to live as a family, cope with their children, it's about maybe some voluntary work, and generally plugging themselves back into living a normal life, and at that point we can, for many people, start reducing the that they're taking and actually proceed to them living normal lives without drugs.

Narrator:
Many of Emily clients are heroin misusers.

Emily Finch
In some ways we're very lucky with treating heroin because we have, if you like, artificial replacement for heroin. It's a drug that is very addictive, it's profoundly dependence-forming, but it's not particularly harmful in itself. Opiates are used, are a naturally occurring drug, they're used in medicines, they're reasonably safe, so we can actually give people opiates that replace the heroin they're using. And there's in fact a whole range of drugs that we can use replace heroin. The commonest two that we use, the two that are licensed for use in heroin dependents are Methadone and another drug called Buprenorphine. There's a also a variation of Buprenorphine called Suboxone which is licensed. But it's also true that we can use any other long-acting opiate, and we very occasionally do. The most important issue about any pharmacological treatment for heroin use is that it usually needs to be easy to control abuse so we don't, for instance, like to use anything that involves tablets because tablets can quite easily be crushed and injected. We want a drug that is relatively long-acting because anything that's long-acting is less likely to cause the peaks and troughs of withdrawal that heroin users experience because heroin is very short-acting and they need to use very 4-6 hours, and also a drug that doesn't give quite as much euphoria perhaps as the heroin that they've started using, and really Methadone and Buprenorphine are the drugs that best satisfy those criteria. We do use other drugs but I think they're the ones that are most useful to understand very well because they're the most ones that are commonly used.

We use Methadone for two reasons. We use it for maintenance after detoxification. It's sometimes used for detoxification, and indeed the NICE guidelines which were published in 2007 are very clear that Methadone is a perfectly good drug to use for detox. What we do is we stabilise someone on a dose that stops them using drugs, and then we reduce their level of Methadone over a period that can vary. If they're an inpatient we do it over 2-3 weeks, and if they're an outpatient it can be over 3-6 months, those sorts of levels. What's most important to understand though is that detoxification is something that people can only do when they're ready for it, and ready in the terms of most heroin users often means their lives have to be perhaps moving towards a normal recovered lifestyle, and that's the time when they are going to be able to reduce their Methadone.

For some people who have very severe levels of dependence we would suggest inpatient treatment where they'd be detoxed over a shorter time which, but for them they would probably need to go on to long-term residential rehabilitation where they have a very intensive level of psycho-social support.

Perhaps it's useful here to talk about what we mean by detoxification, and I think often a better way of describing it is medically-assisted withdrawal. Detoxification implies sort of removing bad things from the drug, from the body, and it's not really that, it's a process by which we slowly reduce a substitute drug and allow people's normal brain functioning to return.

One of the things worth remembering about detoxification from Methadone is even after the last dose people continue to experience withdrawal symptoms for many months. The commonest, probably most persistent one is lack of sleep. People often don't sleep normally for months and months, and some people need a huge amount of support to help them get over that.

Methadone is most effective, however, in maintenance treatment. Most of the research evidence would point to the fact that Methadone maintenance is very useful in reducing the harm and probably returning people to normal life. People can live pretty much normal lives

on Methadone maintenance. It's not toxic long-term and for some people they may remain on Methadone for the foreseeable future. What's certainly true is that for many people they need a very substantial amount of support to get off Methadone, and they may never reach a stage that they can do that. Many clients need to spend two, three, four years on Methadone before they're capable of reducing the dose. Some people do it earlier, but for many of them it's that sort of level of time they may need before they're ready and before the rest of the lives are sorted out well enough that they can tolerate the difficulty of actually experiencing the withdrawal symptoms from Methadone. There is a 40, 50 year history of quite good quality research on the effectiveness of Methadone maintenance. What's interesting about it is that it's not a very politically acceptable treatment. The general public don't like the idea of somebody taking a drug for many, many years. It's an analogy that we don't really use here, but in the US people would talk about Methadone being as important to someone with a drug misuse problem as insulin is to a diabetic. I don't think we would go that far in the UK, but I think we would acknowledge that for many people they will find reducing the dose very difficult, and quite a good pragmatic solution is to keep them on it. It's not particularly toxic, there are some side effects but they're unlikely to attack them very severely, and for many people that's the best solution. An example I often give to clients is that I would talk about Methadone sometimes perhaps being a sticking plaster where it will solve most of the problems but it, it doesn't always deal with the underlying things, so often you may find that a client who has a very chaotic lifestyle, put them on Methadone and they do quite well, and that after four or five years only then are they ready to do some of the psychological treatments that they may need to do to address the other issues they have, perhaps a history of childhood abuse, so often it takes people a very long time, and maybe it takes them also a long time to develop the skills to live independently in a flat or go back to work. So Methadone pulls everything together, it's quite a short-term solution, but it isn't really enough but it, for many people they need it. It's also very effective very quickly.

The behaviour that it changes most readily is in fact criminal behaviour. A substantial minority of drug misusers are committing crime. Some of them don't, but a substantial minority probably do, and a good example of this is if you have a young man who's maybe injecting heroin four times a day, and in order to get enough money to buy that heroin he is burgling two houses a day. Put him on Methadone, even if he still continues to use heroin twice a week because he likes the high of heroin, that has probably reduced the number of houses he's going to burgle from 14 to one, and that is a hugely impressive benefit, and criminality is one of the first things we can change, and it's why the criminal justice sector is actually quite keen on Methadone because it solves the problems quite quickly.

Narrator
Talking therapies and self programmes can also be very effective.

Emily Finch
Talking therapies are hugely important. We know that there are some specific talking therapies that help with substance misuse. The two best known of these are probably relapse prevention, which is a type of cognitive behaviour therapy, which looks very practically and in a very focused way at misusing drugs, and a good example of this is ~~it,~~ we'll go through with a client the sort of things that are likely to cause them to relapse and will help them modify those, and it can be very basic, simple stuff like learning perhaps when you get paid on a Friday you tend to use, so can you do something different, can you give your money to someone else, can you make sure you don't have your cash card that day, can you do something that practically helps you, and we know that works quite well. The other technique is a technique that was developed by Miller and Rollnick in Canada, which is something called motivational interviewing, which is again really a modified form of cognitive behaviour therapy. That looks at people's motivation and one of the good examples of a technique that a keyworker would use, which is a motivational technique, if they would look at a decision balance analysis, so they would go through with a client what are the positives and what are the negatives of using, and they would help them work out what the benefits would be if they stopped misuse, using.

Self help programmes are the other really important treatment for drug misusers. The best known are Narcotics Anonymous and Alcoholics Anonymous, also known as NA and AA.

They essentially involve people meeting together as users usually, sometimes they meet every day, sometimes they meet twice a day, and sharing their experiences of using drugs and alcohol, and looking at how they managed their use and how they become abstinent in a very structured way. They're extremely effective and for clients who genuinely want to become abstinent, they are probably the single most effective thing that we can offer them. Interestingly, we can't prescribe it, they have to go on their own, so it's a really good test of motivation. The actual meetings, I think, have benefits but there's a whole social structure around NA and AA which clients find very useful because it's around meeting and socialising with drug misusers who are now abstinent, rather than meeting with people who are still using, so they're extremely useful. There are other programmes that are not directly NA and AA. We in the service have a very strong user movement, we listen very carefully to what our clients want, and we use that to plan services both for individual's treatment plans and also for the service itself, and that in itself has a therapeutic effect for the clients. The South London & Maudsley Trust has a highly developed user involvement programme where we have clients training other clients, we have clients actually being part of formal treatment programmes, so it's a very commonly used tool to help people stop using.

Narrator
But even with treatment, some people find it extremely hard to stop using.

Emily Finch
We have about 10% of clients who don't respond very well to treatment. They are a group who don't respond in a variety of different ways. One good example is those who continue drinking on top of a Methadone prescription, so they may have stopped using heroin but they start drinking large amounts of alcohol. That group we tend to try and see every day and we supervise their Methadone very heavily, we always watch them take it, we breathalyse them every day and we will only give them their Methadone if they're below a certain level so there's a strong incentive for them in the system to keep their drinking down to a reasonable level 'cos if they don't, they don't get any Methadone. There's another group who are continuing to use heroin, maybe continuing to inject, and for that group we've worked very hard at developing a new treatment which is giving them injectable heroin instead, legal injectable heroin. another group are probably people who continue to have quite severe psycho-social problems and some of that's very difficult.

A good example of this who's someone who we can't get rehoused, for a variety of reasons, and sometimes that's an issue and for many people it takes many, many years. If someone is street homeless it's almost impossible to treat their heroin use, and they're a group who continue to be resistant for reasons that are not to do with us. Most people eventually respond. I've just talked about injectable heroin and that's a treatment we've recently done a trial on where we compared clients being given injectable heroin, clients being given injectable Methadone, and clients on what we call enhanced oral Methadone - those people were offered many different psycho-social options on top of the Methadone – and we compared the three in three different sites in the UK over two years. We found that the injectable heroin, came out as dramatically the most effective of the three treatments, so we do know that in a group of treatment-resistant people if we offer them injectable heroin, in a very controlled way, they can respond to treatment eventually. The controlled injectable heroin is such that they have to come in every single day to get it. For many of them they have to take the drug twice a day, and they can make major changes to their lives in this treatment, so we hope that we'll be able to find funding to roll it out to be available in more areas for clients who are resistant to treatment.

Narrator
So what counts as a successful outcome?

Emily Finch
When we're looking at drug treatment we have to decide what we actually think the best outcomes are. One of the simple ones is criminal behaviour and, as a doctor treating drug misusers, I'm in rather the odd position of having non-health outcomes as some of my best outcomes.

We do know that drug treatment reduces crime, there's good evidence to show that. We know that drug treatment produce substantial health benefits. Achieving actual abstinence is much more difficult, and therefore if you used abstinence as an outcome the outcomes won't be so good. We know that getting people into work can be a good outcome, getting people off benefits may be an outcome that, at least at a policy level, people want to achieve.

One of the big issues for drug misusers is how well they parent their children, and we can substantially improve that in drug treatment. We're quite rare in a treatment section that we have a national outcome tool which we are monitored on and all clients who've had treatment are monitored on this tool, it's called the Treatment Outcome Profile, which looks across drug misuse outcomes in a series of domains, and it's criminality, health, drug misuse, and physical and psychological health, so we're quite well aware in our sector that outcomes is a multifactorial thing and a client can maybe not have reduced their drug use very much, but they can have changed many things in their lives for the better, and we try and measure that.