

Home detox: a step too far?

Dr Colin Brewer has just been struck off the medical register for 'irresponsible' practice. He was trying to bring affordable detox and maintenance to his patients, and has been punished unfairly, he tells DDN.



Last month Dr Colin Brewer, founder of a pioneering drug addiction centre, was struck off the medical register for 'irresponsible' practice. Central to the case was the death of a 29-year-old man who had died during the course of a home detox, prescribed by Brewer, that would have been continued with a naltrexone implant at the clinic. The patient's parents had misunderstood that they were meant to watch him for 24 hours around the clock, even during his sleep; the GMC ruled that the drugs were prescribed too freely and said Brewer had become 'over-confident' in his treatment.

A case had been building up around Brewer's addiction clinic, the Stapleford Centre, over the past eight years. Accusations had been directed not only at Brewer, but at six other doctors who worked at the practice, for their liberal prescribing policy. By the time the GMC delivered its verdict, the case had not only become the longest in the council's 145-year history; it had divided experts on the way drug-dependent clients should be treated.

For Brewer, his story contradicts any intention of over-zealous prescribing. Qualifying in the 1960s as a psychiatrist, he was drawn into becoming an alcohol specialist, 'maybe because everyone else didn't like alcoholics, and I didn't mind them'. He was impressed with the useful effects of using ant Abuse with his patients for detox and relapse prevention – which led him onto extensive trials of naltrexone, at a time when the drug was unknown in the UK. Using naltrexone for detox gave impressive results, says Brewer. He was surprised then when the NHS 'weren't interested in it... in fact they were actively uninterested'. Having 'more or less left the NHS' at that stage, he continued using it and believes the results justify his enthusiasm for it to this day.

Back in the 1970s, attitudes to addiction were at a crossroads. From the 'quite good prescribing programmes available in the 1960s, when it was easy to get methadone', the climate changed and abstinence became the keynote of drugs policy.

From his already busy practice, Brewer was not looking to become involved with heroin addiction. 'But when the NHS stopped providing methadone maintenance in the 1970s, patients were desperately looking for someone to continue their prescription. A doctor I knew called Dr Ann Dalley had gradually acquired a fair collection of patients on methadone maintenance and did very well by them,' he explains.

When Dalley was prevented from prescribing controlled drugs – the result of suspicion by a GMC 'rabbidly against maintenance' that medication was being diverted – Brewer came back from holiday to find a queue of patients in his waiting room saying 'we've been told by the Home Office that you treat addicts and thought maybe you'd continue our methadone'.

At first he was horrified. 'I'd never supplied methadone apart from to one or two patients, a week or so before detox.' But a phone conversation with the Home Office persuaded him to take the patients on.

The decision wasn't taken lightly, and Brewer adopted a meticulous approach to understanding methadone maintenance. His first few patients took him on a steep learning curve.

'The first thing I wanted to do was see whether patients actually took the amount of methadone they said they were taking,' he explains. 'The first guy I saw said he injected 70mg of methadone. I said "that seems an awful lot" – you can see how little I knew at the time! I told him I wanted to see him do this, as I'd never prescribed injectable methadone. He looked at me as if I was an idiot, rode off on his motorbike to a pharmacy and got some injectable methadone, rolled his jeans down and whacked 70mg into his femoral vein, and said "there you are doctor, there's nothing to it is there". It was just as if he'd smoked a cigarette for all the effect it had on him.'

From then on Brewer would make a point of getting everyone to demonstrate their claimed tolerance, either injecting or swallowing. He learned that most patients were 'pretty sophisticated' and knew roughly what their need was, so he carefully calculated the equivalent amount of methadone – a routine that continued 'for years and years without serious trouble' and 'certainly no deaths, because we'd have jolly soon heard about them if we had'.

What seemed a logical way forward to Brewer was taking him down a different path to that laid by the establishment. Practices which the GMC recently termed 'irresponsible', Brewer prefers to call 'a bit unorthodox', but he still believes strongly that that they did much more good than harm. The case has been a bitter blow to a man who believed so strongly in the value of individually tailored treatment that he set up the Stapleford Centre as the only way to provide it.

His motives related to filling a treatment void, he explains. By and large he was not dealing with middle-class patients with a reasonable income, who were covered by insurance and wanted a more deluxe service than the NHS. Rather, patients came to him because they had no other choice.

'At that stage there was very little maintenance, lousy detox facilities, and in many areas of the country nothing at all,' he says. 'There were waiting lists of months or even years to go into detox, with a high risk of failure.'

Brewer was also coming into contact with families who had spent all their money on a spell in rehab for their son or daughter – only to realise they may need several more attempts to detox. He tried concertinaing the content of a two-week stay into a detox lasting two or three days, which 'made it cheaper, even though the nursing was more intensive'. But some still couldn't afford that, he says, so he resorted to offering the alternative of a home detox, with 24-hour phone contact and advice. At around £250, the home detox was still a large amount for some families, but for many it offered the difference between treatment and resorting to a life of illicit drugs.

For patients wanting maintenance – and he is a strong believer that stabilisation can often be the best route to getting an out-of-control life back on

track – his mission was to provide accessibility and choice. He would involve the family wherever possible, which as a psychiatrist he had been used to doing anyway, but his trusting prescribing practice pushed his methods towards further scrutiny.

'If someone trustworthy came with the patient, I would say "you look after the medication, so there's no need for them to go to the pharmacy every day, or to come back and see me every day".' It made perfect sense to Brewer as his patients came from all over the South East of England: 'It was not like we were running a neighbourhood service where we could say "come back and see me tomorrow". Quite a few patients were desperately trying to keep a job and didn't want to take more time off work. Flexibility was combined with choice: some patients worked best with morphine, some preferred buprenorphine, others would be happy on a methadone programme.'

For 15 years Brewer offered his services 'without any serious problems'. The death of his patient was not only an isolated incident that left him so devastated he seriously contemplated suicide; he also feels that it gave critics who had been circling him for years the chance to pounce.

Whatever the personal toll on him, not least the blight to his distinguished career, Brewer has emerged still as passionate about certain underused forms of treatment. Naltrexone is still the great enabler, as far as he is concerned – the drug that 'does what it says on the tin'. His belief holds firm that the drug should be used within the criminal justice service, to give offenders chance to calm down and be receptive to the support they need.

'The lost opportunities with naltrexone make me weep,' he says. 'When I think of the number of people who could have been kept out of prison for useful periods and who are never even offered it...' He reflects on how things have changed since, not so long ago, the Home Office approached him about setting up a model treatment system for prison medical care.

His recent experiences have made him feel so far outside the system that he is convinced that government, the NHS and rehabs are going out of their way to put obstacles in the way of fair treatment.

'They're deliberately making it difficult for addicts, saying "we only want the ones who are really keen on treatment, so we'll give them lots of hoops to jump through",' he says. 'But you wouldn't do the same with psychiatric patients, would you? You wouldn't say to a schizophrenic patient, "we'll take you into hospital, but if you have one more hallucination we'll throw you out".'

'It's the same with rehab,' he adds. 'When addicts' urge for drugs doesn't disappear, they kick them out. It'd be laughable if it wasn't so serious.' It's clear that his experiences have left Brewer seriously disillusioned with the system. **DDN**

Should medically unsupervised detox be allowed? Vote at the DDN online poll, www.drinkanddrugs.net