Home detox:
a step too far?

No to unsupervised detox, say readers

In our last issue of 2006 we asked on our website poll: Should medically unsupervised detox be allowed? Of 116 readers, 63 per cent voted 'no' against 37 per cent 'yes', and some of their reasons, thoughts and concerns about home detox are given below.

This fortnight we want to know:
Do you believe the Drug Intervention Programme has been a worthwhile initiative? Partners in Westminster City Council's DIP gave their verdict so far at a conference this week (page 5). Please visit www.drinkanddrugs.net and give us your vote. More detailed comments are welcome for the letters page; write to the editor at the usual email or address on page 3.

Qualified agreement

I voted yes... BUT, I think the drugs that are given for this should be carefully chosen as well as the families that are given this 'home detox' option.

Every addict, during heroin withdrawal will use any means necessary to get medication to stop the sickness. (I speak from experience here.) Giving these drugs to an addict's parents to administer 'when needed', whereby a combination of them could kill the patient, is slightly reckless in my opinion.

A parent might have a very hard time saying 'no' to a desperately sick and pleading son or daughter. And that addict could possibly have a stash of pills to add to the mix, 'just in case' the symptoms got bad. Addicts lie... a lot.

Giving the sole responsibility of a home detox (to administer the drugs and 'watch the patient 24/7') should not be given to an addict's parents. The responsibility should be shared by a home nurse, a case worker or even another addict who has been through it themselves... someone who could help the parents say 'NO, your next dose is in three hours and NO I won't give you all of them at once!'.

A comment on Dr Brewer: Thinking outside the box is a good thing when it comes to treatment. I believe Brewer meant well but just went way too far in what and how much he prescribed. It was almost as if the good doctor just couldn't say no, giving his patients whatever he or she wanted in whatever amount they could tolerate.

I feel for some of his patients, now that Dr Brewer's services are no more... these poor addicts with these 'huge' habits to maintain. Who will take them on now?
Ceane DeRohan, by email

It depends...

I was about to vote on your detox survey, but the answer depends upon what drug the person is requiring a detox from:
Alcohol – no
Opiates – yes
Benzodiazepines – possibly.
Derrick Anderson, mental health/ addictions specialist, Clouds

No supervision is dangerous

Our response to the debate is that a medically unsupervised detox is potentially dangerous. Though the unsupervised client will begin detox with the best intentions to strictly follow his or her doctor's instructions, we know the very nature of this disease can make self-detoxing almost impossible due to the addictive nature of many detox medications and behavioural patterns.

The weapons necessary in the earliest stage of the battle against this disease (the detoxification period) are in themselves a danger to the addict if not properly supervised. Further, friends and family members, even those with the strongest desire to help the client, generally do not possess adequate knowledge of addiction and certainly do not have the necessary medical training to act appropriately in emergency situations. However, due to the lack of financial and human resources in the NHS, statutory and voluntary sectors, most of the drug and alcohol users in this country are required to detox with very limited medical supervision.

The NHS is overstretched on budgets for substitute prescribing and for drug and alcohol workers to monitor the volume of clients on their caseloads. It is the age-old question of does one sacrifice quality for quantity? Having worked in the drug and alcohol field for over 20 years I am aware of the dilemma the statutory sector faces. It is because we ultimately believe that drug and alcohol detoxification should be medically supervised by trained professionals that my business partner and I founded Detox At Home Ltd, a private home detox service for people wanting a safe means to end their habitual intake of addictive substances. Our model ensures clients are supervised 24-hours per day and that detox medications are maintained and administered only by nurse specialists.

We did not set up the service in opposition to traditional treatment centres – quite the contrary – but we also understand that for some people this cannot be the only answer. Many of our clients have repeatedly attended treatment centres and feel that they a) cannot afford the time or money to repeat this process or b) have recently lapsed and simply need to reconnect with their support services once detoxed. We actively seek to re-engage clients with all their supports, including therapists, treatment facilities, community services and the fellowships. Our belief is that if we can supervise a safe detox, the client is then in a better mindset to absorb the vital therapeutic input they receive thereafter.

We also believe that the home environment – the client's family and support system – are critical elements in starting and keeping the client on the road to recovery. The in-home aspect of our model

allows our professionals to provide care and support not only to the using client, but also to the family and others involved in the client's life. Many times clients leave treatment in a good state of recovery, only to return home to the stressors that contributed to active addiction in the first place. Frequently, these stressors include the damage sustained by significant others during the client's using history. These stressors can result in feelings of guilt, shame and ultimately to relapse.

By providing support to the family during the detox period, work can begin immediately to alter dysfunctional patterns and dynamics. Having worked in many treatment centres I am aware that some family members find it difficult to address their roles in the addiction, believing it not to be their problem. We provide these family members with compassionate support, while educating them in addictive disorders.

Analysis of the most recent data from the National Drug Treatment Monitoring System estimates a 113 per cent increase in individuals making contact with structured drug treatment services between 1998/99 and 2005/06. This report states that 181,390 drug misusers sought help in England in 2005/06 and this data excludes the prison population. (Data from Manchester University, National Drug Evidence Centre.) These staggering statistics clearly indicate the need for a wider scope of detox and treatment services overall. The high morbidity and mortality rates make it particularly important that drug misusers remain in regular contact with treatment services.

In September 2004 the Department of Health published *Management of Medicines*, which is intended to support medicines management within the national service frameworks. Its main focus is on the involvement of the patient, family and carers in prescribing decisions and subsequent concordance with those decisions. Services such as ours recognise the critical importance of involving client, family and carer in building a solid foundation for recovery by beginning recovery in the environment that will need to sustain recovery: the home.

Moira Rothery, clinical nurse specialist, Detox at Home. www.detox-at-home.com

Issues of trust

As an addict, I voted 'no' – the reason being that detoxing is not only hard but it can be dangerous, and fatal if not properly administered. I have learnt this from my own experience, as well as from many others, including on the professional side.

More importantly, when we are addicted, although we want a detox because of how the illness and affliction affects our state of mind, it is so common for us to lie, deceive and abuse the trust of any drug worker or supervisor. It is very common for the detoxer to have a double hit – taking what they are given to detox, yet continuing to use their drug of choice.

It would be interesting to know how members of the profession voted, compared to addicts. Maybe this would back up my concerns!

Sean Rendell, by email

Reconviction a crude measure

Peter O'Loughlin ('Does anyone care?', *DDN*, 4 December 2006, page 9) implies that high rates of reoffending for people given DTTOs are to do with reluctance to use abstinence-based treatment with this group. As measured by the proportion who are convicted of another offence, the two-year reoffending rate is high (86.3 per cent of those given DTTOs in 2003).

But reconviction is a crude measure. It fails to take into account the characteristics of the offenders being sentenced. DTTOs were targeted at persistent offenders with a high probability of reconviction – regardless of what sentence they received.

Also, reconviction figures do not recognise reductions in the frequency of offending.

In our research on DTTOs in the QCT Europe study (published online recently in the *British Journal of Criminology*), we found significant reductions in the frequency of offending for people on DTTOs. These reductions were comparable to the reductions reported by people entering treatment at the same centres who were not on a DTTO.

We also found that people on DTTOs found it very difficult to adapt quickly to the requirements of abstinence-based treatment, and so tended to drop out very early where services insisted on abstinence from all drugs. This backed up the experience of the original DTTO pilots on the risks associated with abstinence-based approaches.

Treatment can offer an effective alternative to imprisonment for drug dependent offenders. The success of this alternative can be enhanced when it is offered as a genuine diversion from imprisonment (and not as an extra condition for offenders who would not otherwise have been imprisoned), when workers have the time and skills to build strong therapeutic relationships and when treatment is provided on the basis of clinical need, and not just on the preferences of judges and professionals and the existing pattern of local commissioning.

Some people on DTTOs/DRRs may need abstinence-based treatment. But there is no reason to suppose that insisting on abstinence for all would lead to a reduction in reoffending. It would be more likely to lead to an increase in imprisonment, as people have their court orders revoked for failing to comply with such treatment.

Alex Stevens, University of Kent, and Tim McSweeney, Institute for Criminal Policy Research

Erratum

I would like to apologise to Iain Armstrong and to the Department of Health for wrongly attributing Mr Armstrong's letter in our last issue (DDN, 4 December, page 8). Mr Armstrong made it quite clear when submitting the letter, that he was offering his personal view in his capacity as a freelance workforce development consultant and asked that it be so attributed. Mr Armstrong made it clear that, while he contracts with the Department he was not, in this case, representing the views of DH.

Editor, DDN