BASIC PRINCIPLES

USE, PROBLEM USE AND DEPENDENCY

Not all substance use causes problems and only a small proportion of those who use substances become dependent on them. Illicit substance use is widespread amongst the general population with almost 50% of younger adults having used cannabis during their lifetime. Alcohol use is even more widespread, but only a minority of individuals will experience problems as a result. Both problem use and dependency may indicate the need for treatment, as may the particular risks or harms arising from the problem use or dependency.

Problems associated with substance misuse range from the biological (accidental overdose, viral infections, liver disease etc.) to the psychological (depression, psychosis) to the social (homelessness, deteriorating relationships, loss of work, financial problems, acquisitive crime).

The use of the term 'dependence' indicates the presence of a dependency syndrome as defined by the World Health Organisation (1981). This modern concept of dependence encompasses both the psycho-social and physical characteristics of addiction and includes a number of 'symptoms':

- **A stereotyped pattern of substance use.**
- **Prioritisation of drug-seeking and using behaviour over other daily activity.**
- **Craving.**
- **Tolerance to the effects of substances.**
- **Withdrawal symptoms on cessation or reduction of substance use.**
- **Use of substances to prevent the occurrence of withdrawal symptoms.**
- **Persistence of substance misuse despite awareness of harm.**
- **Loss of control over the onset, termination and amount of substance use.**
- **Rapid reinstatement of the syndrome after a period of abstinence.**

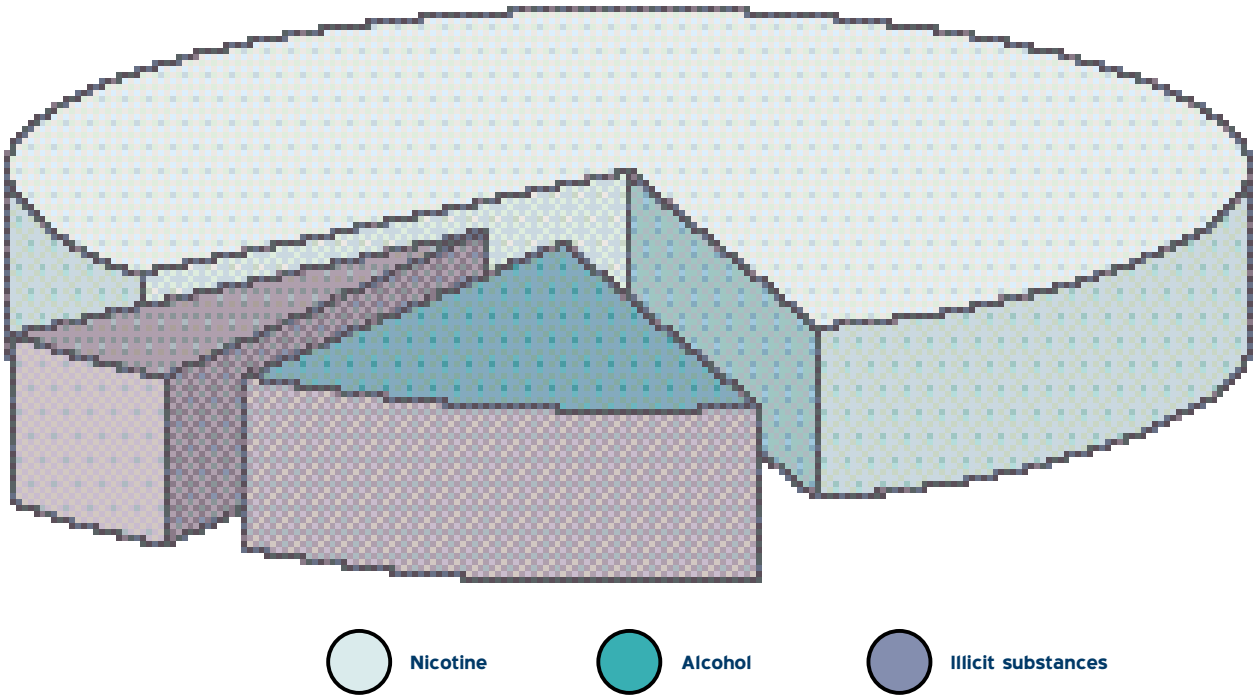
Not all of these symptoms need to be present to indicate the presence of a dependency syndrome, and it is often the case that an individual is dependent on a substance in the absence of a withdrawal syndrome. Equally, harm and dependency are not necessarily correlated, and some non-dependent substance misusers may suffer serious physical, psychological and social consequences of the misuse.

- Not all substance use causes problems and only a small proportion of those who use substances become dependent on them.
- Illicit substance use is widespread amongst the general population with almost 50% of younger adults having used an illicit substance during their lifetime.
- Alcohol and nicotine use are much more widespread, and are responsible for the large majority of substance-related disorders in the general population.

PREVALENCE OF SUBSTANCE MISUSE

There exists a confusing array of statistical data regarding the use and misuse of substances. The most important distinction to make when considering data is that between the prevalence of lifetime use and active problem/dependent misuse. For example, whilst roughly 50% of 16-29 year olds have used an illicit substance at least once in their lifetime, only 2% of the general population is actively dependent on an illicit substance. Many more, however, use substances in a way which causes harm to themselves and/or others (misuse). In fact by far the most common forms of substance misuse are legal and not illicit – nicotine and alcohol are responsible for the large majority of health, social problems and dependency created by substance misuse. Approximately 15% of the adult population experience problems as a result of alcohol misuse, whilst many more are dependent on nicotine.

DEPENDENCY BY SUBSTANCE



THE APPROACH WITH THE CLIENT/PATIENT

Substance misusing service users have both rights and responsibilities (*appendix 1*, page 114). They should be treated with the same respect afforded to any other patient. Non-punitive and non-judgmental styles are a foundation of good practice and support the development of an honest interaction between professional and patient. Nevertheless, judgements will have to be made in accordance with professional and other agreed criteria.

The very large majority of requests for help will be honestly motivated – the substance user who presents purely to supplement income through unnecessary prescribing and subsequent diversion is rare. However, preconceptions regarding 'what it is necessary to say' in order to receive treatment are rife and may lead to inaccurate statements of need. For example, it is common-place for heroin misusers to present requesting a methadone reduction prescription, when in fact they both desire and may be better served by a methadone maintenance prescription. Equally, unrealistic expectations of treatment are quite common and important to identify, so that the client can be guided in a more appropriate direction. Examples include the heroin user who expects a large methadone prescription immediately, or the heavily dependent alcoholic who wishes to plan for controlled drinking rather than abstinence. Assessment by the professional may be expected to identify previously unrecognized needs which are directly contributing to the substance misuse problem.

- Non-punitive and non-judgmental styles are a foundation of good practice and support the development of an honest interaction between professional and client.
- Where the reason given for presentation is realistic and appears accurate, it is usually wise to follow the patient's lead in terms of delivering interventions (whilst working with limited resources). Imposing unwanted treatments is likely to lead to resistance and poor compliance.

Where the reason given for presentation is realistic and appears accurate, it is usually wise to follow the patient's lead in terms of delivering interventions; imposing unwanted treatments is likely to lead to resistance and poor compliance. In cases where unwanted interventions have to be imposed (e.g. where there are child protection issues), the aim will be to motivate the client to accept such interventions.

A NEEDS-LED APPROACH WHICH INTEGRATES PSYCHOSOCIAL AND PHARMACOTHERAPEUTIC INTERVENTIONS

The two major forms of treatment for substance misuse, i.e. psychosocial treatments and pharmacologic treatments, have a number of differences in terms of mode of action, time to effect, target symptoms, durability and applicability across drugs of misuse. While each has specific indications and strengths, no counselling intervention or pharmacotherapy is universally effective, and both forms of treatment have some limitations, particularly when used alone. Outcomes can be broadened, enhanced and extended by combining the most effective forms of counselling and pharmacotherapy. Having said this, despite consistent findings which point to the effectiveness of counselling in this area, no particular technique has consistently emerged as superior to any other technique. One interpretation of these findings is that different types of patient may respond differently to different treatments, and by aggregating outcome data across different types of patient characteristics, differential treatment outcomes may be obscured. Whilst major programmes of research such as Project Match (Project Match, 1993) have failed to describe particular patient characteristics indicating likely responsiveness to particular treatment modalities, there remains widespread support for the effectiveness of a needs-led approach. People often seek help when they are locked into a chaotic life cycle, and effective treatment can only be achieved by addressing the whole range of needs.

In general, pharmacotherapies have a much narrower application than do psychological therapies for substance abuse. Most counselling techniques are applicable across a range of treatment settings (e.g., inpatient, outpatient, residential), modalities (group, individual, family), substances and populations. For example, Twelve Step, behavioural, or motivational approaches can be used, with only minor modifications, regardless of whether the client is an opiate, alcohol, cocaine, marijuana or barbiturate user. On the other hand methadone produces cross-tolerance for opioids but has little effect on concurrent cocaine abuse, while disulfiram produces nausea after alcohol ingestion but not after ingestion of illicit substances. A notable exception is naltrexone, which is used to treat both opioid, and more recently alcohol dependence.

- Matching substance misusers to the particular combination of treatment approaches that best meets their needs, may greatly enhance treatment outcomes.
- Often, the best indicator of need is the patient's own statement, although on occasions this will not be the case.
- There is substantial evidence in support of the enhanced effectiveness of combined bio-psycho-social approaches.

There is substantial evidence in support of the enhanced effectiveness of combined approaches. For example, McLellan et al (1993) demonstrated superior outcomes for patients randomised to methadone maintenance plus regular individual counselling, medical/psychiatric therapy, employment and family therapy as opposed to methadone maintenance alone or methadone maintenance plus counselling. The latter group had intermediate outcomes. Naltrexone therapy to prevent relapse to opiate misuse, has failed to live up to its early promise, with high early relapse rates. However, the addition of behavioural and psychotherapeutic interventions to naltrexone therapy has been demonstrated to improve outcome (Anton, 1981).