Drug and alcohol users: common needs, common services

Why integrating substance misuse services may be good for the clients

Last year a Welsh Office circular encouraged integration of services for drug and alcohol users. There are fears this could merely be a cost-cutting exercise and that drug users' needs will be overwhelmed by the influx of alcohol-using clients. But clients (particularly those using a range of drugs) may benefit from a properly resourced reorganisation that allows the common needs of drug and alcohol users to be addressed.

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IN DECEMBER 1990 the Welsh Office circular *Combating Alcohol Misuse in Wales: Next Steps* proposed two radical changes to the coordination and structure of drug as well as alcohol services. Despite different funding mechanisms, what's happening in Wales is unlikely to be divorced from general government policy.

Although primarily concerned with the future funding and development of alcohol services, the circular gave two strong hints that the Welsh Office wanted drug and alcohol services merged. First was the intention "that the respective national committees for drug and alcohol misuse are integrated into one substance committee within three years". The follow-on comment that "districts will wish to bear this in mind when reaching decisions" has been widely interpreted by county drug and alcohol committees as a green light to merge if they wish.

Of equal import was the second message: "It has also been decided to relax the constraints ... on drug treatment units funded under the central initiative to concentrate exclusively on drug problems". For drug specialists this appeared positively to encourage expansion to cover all substances; or, to put it negatively, to legitimise 'leakage' of drugs funding to alcohol services.

Attitudes to the circular varied. For instance, some feared that money now used solely to fund drug services would be diverted to alcohol services – a net decrease in drug funding. Alcohol specialists raised the spectre of 'street-wise', drug injecting clients 'contaminating' their socially more acceptable drinking customers.

In April 1991 we called a local conference to analyse these issues[2] (see below) and began a search for data, learned articles and research relevant to the question of whether integrated services actually benefited clients. Our search (see For More Information panel) proved disappointing – long on ideas, but short on data.

The debate on integrated services focuses on three overlapping issues, dealt with in turn in the following sections.

Are the customers different?

Conventional wisdom has it that there are substantial differences between the customers of drug and alcohol services. Problem drug users tend to be younger, more street-wise, and facing different risks. Involvement with criminality and the risk and stigma of HIV are also said to make drug users' problems different.

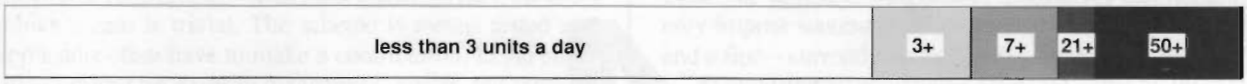
But there are commonalities. Brian Arbery has commented that the "history of services for alcohol and drug users is littered with the underused inheritance of well-intentioned proposals, whose main failing was that they attempted to classify clients into neat, well-defined categories based on the prevailing presenting substance."[3]

The age and sex profiles of clients presenting to drug and alcohol services are no longer widely different, and both groups have similar problems with dependence, finance, relationships, housing and employment. Attitudes to criminality associated with drug and alcohol misuse are beginning to converge: drinking and driving is no longer socially acceptable, but it is increasingly permissible for drug use to be used in mitigation for associated criminal activity.

A client's history of, for example, sexual abuse and multiple care orders as a child, may be more important for recovery than present drug of choice. Also it may not be of benefit to drug *and* alcohol using clients that help is only available from organisations funded to take clients with *either* of their drug problems, but not both. There is reason to believe (see chart) that these cross-over clients are a substantial proportion of drug agency attenders.

If services are to be 'people-centred', maximise client access, encourage holistic assessment procedures and pinpoint areas of change to enable recovery, it seems to

1 in 8 of Mid Glamorgan CDT's drug clients also drank a staggering 50 units of alcohol a day



Mid Glamorgan Community Drug Team recorded the past week's alcohol consumption for 319 consecutive 'drug' clients. Nearly 12% were drinking at least 50 units of alcohol a day – the maximum before serious risk of physical damage and dependence is 50 units a *week*. A further 15% were drinking at least 21 units per day, or over 70 pints per week.

make sense to offer services under one roof, whatever the substance used.

Are they compatible?

The prospect of mixed drug/alcohol treatment groups leads some therapists to fear 'contamination' of one group of users by another.

In 1984 the North East Council on Addictions (NECA) combined its alcohol and drug services and asked its clients how they felt about the change. At this service all clients enter by the same front door although the different groups meet in different places in the building. An informal enquiry among users of their Tranquilliser Project revealed no disquiet over the merger. On our behalf NECA recently updated this enquiry.[4] Two questions were asked:

- How do you feel about tranquillisers coming under the general term 'addiction'?
- As a user of the service, how do you feel about all addictions being under the one 'umbrella'?

Over 80 per cent said they felt positively in response to both questions – and this is a group that, if any does, can be expected to be unhappy about being lumped in with 'junkies'. We suspect that most users in similarly organised agencies would find few problems in using the same premises, but buying into a sub-service targeted on them.

But will compatibility carry over into the treatment process itself? The least flawed attempt to answer this question took place in a Pennsylvania hospital during 1979 using 50 alcohol and 50 drug patients referred to the clinic. The conclusion was that combined treatment programmes are no better and no worse than other programmes, but that they can result in considerable savings in resources and administration.[5] Given the US hospital setting and date of the study, the questionable relevance to Britain in the '90s will not need to be highlighted. But perhaps the saving in administrative costs will prove to be a general finding.

Combining services does not and should not mean pushing clients into combined treatment groups. Service choices should be maximised for the client whatever the substance of use, and should be organised to provide 'one-stop' shopping with a treatment menu geared not just to the substance they have in common, but also to other 'commonalities'.

Even a group on alcohol education will be relevant to many 'drug users'. If the focus is social skills or anxiety management, the drug used may be of little importance. Once the focus shifts from the substance to other commonalities, then treatment groups might be better constructed along the lines of the participants' age, sex, social and psychiatric history, rather than the drugs they use.

Service providers' attitudes

The fears of those attending our conference on integrated services were that:

- reorganisation would swamp drug services with alcohol clients;
- reorganisation would be a cost-cutting exercise;
- reorganisation would be administratively convenient and bureaucratic rather than 'people-centred';
- reorganisation would de-skill staff and service quality would deteriorate;
- reorganisation would ignore other drug concerns such as tobacco problems;
- reorganisation would weaken primary prevention and health promotion work.

Few were so 'anti' that they held all these views, and few so enthusiastic that they could easily shrug off the potential problems. In Wales, and probably elsewhere, potential alcohol clients greatly outnumber those with other drug problems. In the community drug team's recent survey of GPs in Mid Glamorgan, on average each GP said they would – if services were available – refer at least one alcohol client per month, or 3600 a year for all the GPs.

To argue that drug services could simply absorb this sort of referral load is unrealistic and the impact on developing drug services would be disastrous.

Funding levels for drug services' existing workload need to be maintained and additional work planned, costed and adequately resourced, before change can take place. With the purchaser/provider framework upon us, the emphasis will be on 'quality' services, measured by agreed standards based on client entitlements. Managers of newly integrated services would need to be able to identify priorities, control finances and take staff with them through the changes, to avoid one aspect of the service overriding the other.

Agencies, both drug and alcohol, would need substantial further training to pinpoint core, generic competences applicable to all problem drug users, and to improve specialist skills for each new client group. With integration, future priority and funding battles between competing alcohol and drugs agencies just might be avoided.

WE BELIEVE that integration is a viable option if resources are found, and that in Wales county drug and alcohol committees, and their equivalents elsewhere, can work together to plan, coordinate and implement future services to the benefit of people with substance problems, whatever the substance.

The first step must be for drug and alcohol services to meet and discuss the pros and cons of reorganisation for their clients. ■

FOR MORE INFORMATION

■ **EVALUATION OF COMBINED TREATMENT FOR ALCOHOL AND DRUG ABUSERS.** La Porte D.J. *et al. In*: Madden J.S. *ed. Aspects of alcohol and drug dependence*. Pitman, 1980, p.290-304.

■ **ALCOHOL AND DRUG SERVICES: THE CASE FOR COMBINING.** Dunne F.J. *et al. J. of Alcohol & Alcoholism*: 1989, *24*, (2) p.75-76.

■ **THE 'COMBINED APPROACH' – STILL AN IMPORTANT DEBATE.** Duncan Raistrick. *British J. of Addiction*: 1988, *83*, p.867-869.

■ **THE 'COMBINED APPROACH' – A COMMENT ON DUNCAN RAISTRICK'S EDITORIAL.** Pittman D.J. *British J. of Addiction*: 1988, *83*, p.871-873.

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■ **ALCOHOL AND DRUG DEPENDENCE: THE CASE FOR A COMBINED COMMUNITY RESPONSE.** Arbery. B. p.172-190. *In*: Stockwell T. *et al, eds. Helping the problem drinker*. 1987.

1. Welsh Office. *Combating alcohol misuse in Wales: next steps*. Welsh Office circular 5 December 1990, WHC(90)79.
2. *Integration of alcohol and drug services: for and against*. A conference organised by Mid Glamorgan Health Promotion Department on 25 April 1991.
3. Arbery B. "Alcohol and drug dependence: the case for a combined community response". *In*: Stockwell T. *et al, eds. Helping the problem drinker*. 1987.
4. NECA survey. Unpublished, April 1991.
5. La Porte D.J. *et al. In*: Madden J.S. *ed. Aspects of alcohol and drug dependence*. Pitman, 1980, p.290-304.