Nursing by rote

Despite the rhetoric, is it still fit in or get out in Britain's inpatient drug units?

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ADVENT OF HIV and AIDS has led NHS community services to become more flexible, but what is the drug user faced with when they consider admission to an inpatient drug treatment unit?

It seems most units impose strict 'contracts' and discharge patients if they engage on the ward in the very problem they've been admitted for. While some wards are locked, others are proud of their openess. However, doors may be locked by rules as much as by locks. Random urine-testing is common, as is dismissal for programme 'non-compliance'. Even recreational alcohol use is usually an offence punishable by disciplinary discharge.

It adds up to treatment only for people at the end of their using career (essentially, ex-users) who are prepared to suspend some of their basic human rights to become drug free. Inpatient rest and recuperation is not available except by lying about one's intentions and motivations. Small wonder that most users leave early. They are, after all, only displaying the same behaviours that made them successful survivors in the hostile environment outside.

Drug units are only for people ready to suspend basic human rights to become drug free

Tough rules are a manifestation of the abstinence philosophy of such units. That they persist shows how little cross-fertilisation there has been between community and NHS inpatient services. The problem we face is how relevant such an approach is, not only post-HIV but also in the new social and political environment of the '90s.

It has been recognised that young users who chase heroin are a rather different group from older clients. Is it appropriate to treat this group in units which employ a psychotherapeutic method developed for older users?

HIV adds a separate ethical component to our review of treatment practices. For example, an in-patient unit which discharges someone for using on the ward and sends them back into an environment where HIV infection is a major possibility, is in marked contrast to another part of the same system providing a free needle exchange to help prevent such infection.

Inpatient units are generally staffed mainly by psychiatric nurses, and it is these workers who need to look most closely at their practice. Most nurses outside these units now work in a problem-orientated manner using individually tailored treatment plans. In contrast, nursing care in NHS drug units tends to be a highly structured, group-orientated affair with lengthy admissions to facilitate 'personal growth' into a drug-free lifestyle. Programmes are designed around a concept of the 'user', not the real individual, and people are expected to fit in. Such programmes are likely to be appropriate for an increasingly small percentage of users and have little to offer the adolescent 'chaser', those diagnosed HIV positive, or someone with AIDS.

One option would be to change NHS inpatient services so they admit clients for a wide range of purposes (detox only, rest and recuperation, maintenance, long-term rehabilitation) using treatment programmes designed around the individual — the system one would find in almost any other hospital ward. Alternatively, the units could stay as they are, accepting a more specialised role and allowing others to meet the needs of people who do not fit in. However, inpatient units would then risk becoming an increasingly marginalised arm of drug treatment services.

If these units did become more responsive to users' needs, should they be managed by psychiatric services? Would psychiatric nurses be prepared to staff units with a high degree of detox only or stabilisation admissions? Perhaps agencies run by ex-users or 'recovering addicts' would be more appropriate? General-hospital trained nurses may be better equipped to nurse users with AIDS or who have other general health problems, and who at the same time seek help for their drug use.

The changes required of NHS inpatient services do not just revolve around the 'prescribing debate'. For example, strict house rules may originate from an abstinence philosophy, but they also suggest a 'one track' approach to treatment in general.

The way forward lies in casting aside the shackles of standardised admissions procedures and treatment programmes and substituting individually tailored admissions of varying lengths for varying purposes. Users should be able to determine their needs and negotiate personalised objectives with staff. What must emerge is a recognition that people seek inpatient care for a wide variety of reasons, together with a commitment to provide facilities flexible enough to meet the user's needs, whatever stage they are at.

This is not to suggest a drug free-for-all, but a recognition, for example, that lapses during an inpatient stay may be a constructive therapeutic experience and should not automatically lead to discharge.

THE COMING OF HIV has added to our existing drug services; it has not yet caused us to look sufficiently hard at what we already do. It is now time to take into account not only the new needs of the post-HIV generation user, but the old needs we were not prepared to see. ■