

Breaking Out of Procrustes' Bed—Services for Problem Drug Takers

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'Procrustes was a robber of Attica, who placed all who fell into his hands upon an iron bed. If they were longer than the bed, he cut off the redundant part; if shorter, he stretched them till they fitted it. [Any attempt to reduce men to one standard, one way of thinking, or one way of acting, is called placing them on Procrustes' bed, and the person who makes the attempt is called Procrustes].'¹

For services and service deliverers to be like Procrustes is not necessarily a fault, for it may be that all the visitors are of the same length. In a simple way, it may be that all patients with appendicitis are well suited to a bed of appendicectomy. However, any such reliance on a single bed-size presumes either that there is uniformity in the presenting population, or an acceptance of a frequently imperfect fit.

Recently there has been a pronounced shift of emphasis away from a substance-orientated approach to a more problem-orientated approach in the management of drug addicts,² with less dependence on a disease model for understanding problem drug taking, and more examination of the relationship between the drug and the individual, and of the meaning of the drug taking for that particular individual.³

Once we give up the idea of a uniform disease of drug dependence, we then need to examine the consequences of embracing an approach which acknowledges the heterogeneity of the presenting population—we need to come to terms with the imperfection of any one model, and recognize that we need different-sized beds for people of different sizes.

So how has there been any degree of 'fit' with the old model? Why did the old model have any merit? One explanation is that it seemed an appropriate way for explaining and labelling a deviant behaviour; and by doing so, most of us and society felt more comfortable. However, I would like to suggest that there is a more scientific basis for this change. When any such behaviour is only manifest in a few hundred or thousand people out of the whole British population, then it is likely that this population may be abnormal in a number of ways; and it does not necessarily follow that the abnormalities are causally related to the behaviour. If this behaviour then becomes much more widespread (as has happened with opiate abuse over the last decade), then the presenting population is likely to become much more 'normal'.

Criticism of the old framework for examining and understanding drug taking is all well and good, but it must go hand-in-hand with presentation of a new framework. The Treatment and Rehabilitation Report of the Advisory Council on the Misuse of Drugs² recommended adoption of a problem-orientated approach, but many clinicians feel that too little guidance has been given on how such an approach should be used in practice, (although *Guidelines on Good Clinical Practice* has recently been sent to all practitioners').

The new term 'the problem drug taker' may have got rid of 'drug addicts' overnight, but it demands that a more flexible

system of service provision exists so that the response can be tailored to the characteristics and needs of the presenting patient and not to the characteristics and needs of the service and the staff.

Increasingly we recognize that the list of drugs with which people may experience problems becomes progressively longer, and by scapegoating and then driving out one drug after another, we seem to be missing the point that there is no universality about different people's response to their own drug use. While benzodiazepines are undoubtedly a valuable group of drugs, there can be little doubt that some people become very dependent on them and have great difficulty coming off them. While heroin seems to be a particularly problematic drug, it remains a valuable medicine, and there are undoubtedly those who use occasionally and then stop, and those who use regularly but appear to experience little or no problem. Obviously we are unlikely to see people in this group, as they would have little reason to come our way; but it would be as wrong to assume that the clinic population is representative of drug takers as it would be to assume that those who attend an Alcohol Treatment Unit are representative of people who drink alcohol.

One helpful start comes from workers at the Lifeline Project in Manchester,⁵ suggesting that drug taking may be seen as either experimental, recreational or compulsive/dependent; and these categories apply to a broad range of drugs. Initial use of any drug is usually experimental, prompted by curiosity or peer-group influence. Such drug use will either cease or will become the more deliberate pursuit of the drug—pursuit after an effect that has been recognized and is deliberately being sought (in much the same way as a recreational drinker of alcohol will deliberately seek a particular pint of beer or wine as distinct from the inquisitive sortie into alcohol use by the novice adolescent). Some of this population who experiment with drugs or are recreational users will become casualties without becoming dependent (for example, developing physical complications such as liver damage or septicaemia; or psychological damage such as amphetamine psychosis). Others will become casualties by virtue of the fact that their drug use gets out of control and they acquire the casualty status by virtue of the dependence itself. In those whose use of drugs is compulsive/dependent, a disproportionate importance is attached to the ongoing drug use (and procuring ongoing supplies), frequently with reduced care and attention with regard to other areas of the life such as their physical well-being, their family or marriage, their work and savings, etc.

It is not necessarily the case that an individual using a drug at one particular level will necessarily progress to use at another level; and it seems likely that the lessons we have learned from the alcohol field are applicable to the field of drug dependence in general.

Much less emphasis is placed on such pharmacological characteristics or complications as tolerance and physical dependence, and it may be better to see them as practical complications that need to be considered in planning management and not necessarily the main issue of dependence itself. Russell⁶ has suggested that the central feature of dependence is the 'difficulty in refraining', and physical complications may obviously influence this without actually *being* it.

In trying to promote a broader approach, it is important to examine the pattern of drug use as well as just identifying the substance. It is necessary to look at the particular meaning of the drug use for that individual, and not to be blinded by the substance itself. There is a great danger that doctors will get fixated at the 'what' level and will progress no further. A wider examination of the patient and the drug taking is warranted in order to be able to look at the drug use in context—studying not only the 'what', but the 'how' and the 'why' as well. Of course the actual substance used makes a difference, but at the end of the day a drug is just a drug and it would be remarkable if special characteristics were associated with one drug that had no validity for all others.

Much can be learnt by looking at the 'how' of drug taking. Recently we have been exploring a system of assessment that encourages measurement along different paradigms or axes in which these axes seem reasonably independent, thus enabling the system to be seen as some sort of multi-axial classification.

Measure One—Usual route: Almost all drugs may be taken by more than one route with intravenous use being seen as a more deviant and worrying method of use whereas oral use would be of less concern.

Measure Two—Frequency of use: Even though the drug may be one of general concern to society, the one-off or occasional use of that drug will not be of such major medical significance as the daily use which is almost a necessary prerequisite for the development of physical dependence. In the absence of daily use of a drug, it is unlikely that too great a psychological dependence will have developed, as coping mechanisms will need to be able to operate in the intervening time.

Measure Three—Effect sought: Drugs of abuse are almost always taken initially in pursuit of some pleasurable effect (seen by the drug taker himself as positive), and recognition of the problematic nature of such drug use by the patient has usually been preceded by a loss of such positive effects from the drug use. By the time the patient presents, the drug is often being taken in a more chemical or medicinal fashion solely to relieve some negative quality such as physical withdrawal symptoms, or some inner pain such as a recent bereavement, marital problems or adverse social circumstances. It seems likely that this change from hedonism to symptom-relief is probably the component that patients themselves see as the key element of becoming dependent.

Measure Four—Level of functioning: Contrary to popular belief, there is no inevitable association between regular drug use and severe social and physical deterioration. Some problem drug takers appear to deteriorate very rapidly once they get involved in such drug use, while others seem unremarkable apart from their use of drugs. The extent of such impair-

ment will influence the treatment options that warrant consideration and will undoubtedly influence the extent of the concern experienced by the drug taker himself regarding the drug use.

Measure Five—Degree of dependence: Even when all other measures are equal there will still be considerable variation in the difficulty experienced by different patients when they give up their drugs. Some heavy cigarette smokers appear to be able to give up abruptly with little personal suffering; and the same is clearly true for benzodiazepines. Similarly with other drugs such as heroin, the difficulty experienced by an individual in giving up will vary for reasons other than the amount of drug being taken, the route or the duration of use. These are presumably characteristics of the individual and may be influenced by genetic and early developmental factors, as well as by the pharmacodynamics of the current drug use.

If drug takers comprise a heterogeneous population, then we must become better skilled at identifying different types of drug takers. Traditionally, this has been achieved by categorizing such drug users according to their drug of choice (e.g. heroin addict, barbiturate addict, etc). However, this does not do justice to the wide range of people who may present with drug problems and will fail to acknowledge the chaotic nature of one person's drug use if it is a legal drug, even though it may be more of a cause for personal concern than another's experimental use of an illegal drug. What is required is an ability to go beyond merely categorizing patients according to the particular substance they have been using, and this should encourage consideration of patients as people who have developed problems with their use of drugs rather than passive hosts to the drug of dependence. This more holistic approach encourages a more sensitive understanding of the personal meaning of drug use for a particular individual at a particular point of time. It should also encourage us to tailor our responses to the needs of each presenting patient, rather than forcing the patient to comply with our preconceptions of what a drug addict should require. In other words, it should help us to break out from the mould, and avoid becoming procrustean. Only in this way can we adopt an approach that permits the individual to have individual characteristics, and that permits the response to be relevant to the needs of the patient and not the needs of the service.

So what do we see as an appropriate system of services? Our aim should not be the pursuit of 'the perfect treatment' because this assumes the existence of a uniform condition. Rather, we should strive to establish a *network* of services which are sufficiently flexible to be able to adapt to the requirements of the individual. In practice, this is likely to mean a number of different Procrustes' beds of different sizes, with constant effort to retain as much flexibility as possible. The network of services should have several different options or avenues for flow in much the same way as the range of services being developed for problem drinkers. At this stage attention should be given to the importance of encouraging flow *between* units when a patient is inappropriately placed. Too frequently, the competitive and precious nature of those few units in existence results in them refusing to accept the possible greater appropriateness of the 'rival' unit—to the

detriment of the patient. Why complain about square pegs not fitting into round holes if square holes are available?

Examination of this model puts a specialist unit in perspective. It is not meant to be universally appropriate. It is, however, an essential part of the network, and in addition to providing a more intensive specialist treatment facility for more difficult cases, it may also function as an operational base for some of the other services, and a centre from which the network may be co-ordinated. It is all well and good to have a specialist centre—perhaps it is a particularly important size of Procustes' bed. However, it must not be forgotten that at the end of the day the task is to provide health care that is an appropriate response to the needs of the population, and as such it must be able to adapt to individual characteristics and not demand psychopathological conformity.

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The Management of Deliberate Self-Harm

New DHSS Recommendations

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These departmental guidelines at last revise advice of the 1968 vintage—that all parasuicides should be admitted to hospital and assessed by a psychiatrist. Of course this was never achieved, nor even attempted in many areas. It is a welcome set of new recommendations, therefore, which will help ensure that what actually happens is done well. It is great credit to undergraduate medical teachers that such confidence can now be expressed in newly qualified doctors carrying out these psychosocial assessments. It recognizes that suitably trained nurses and social workers can assess and manage aftercare of these patients quite competently.

Will psychiatrists abdicate or be pushed from taking any responsibility for overdose patients in the general hospital? The guidelines are emphatic that this must not happen. Each Health Authority is asked to define clearly a code of practice for managing these patients involving consultant psychiatrist with consultant physician in training, advising and supporting junior doctors and other involved professionals. There is economic as well as good clinical sense in this because left entirely to their own devices, house physicians and social workers tend to be more cautious, referring more of these patients for in-patient psychiatric care and booking more out-patient appointments with psychiatrists. You could find yourself spending more time at greater cost with patients who do not really need follow-up by a psychiatrist.

That this document anticipates a prominent role for the

consultant psychiatrist in the general hospital multidisciplinary team implies quite a lot about how working relationships between psychiatrists and physicians have matured since 1968. The liaison psychiatrist must influence attitudes and educate others in the team rather than just take the patients off their hands. Hopefully, therefore, the army of health service personnel skilled in assessing suicide risk and the detection of treatable depression, alcohol and drug abuse will grow in numbers. House physicians ought to have supervised experience in managing the suicidal since many will be general practitioners in the future. It surely must be right that this departmental advice asks psychiatrists to spread the word rather than corner the market. Forensic psychiatrists should take note that the Home Office is being asked to provide appropriate training for police and prison staff in the management of deliberate self-harm.

Predictably the guidance note ends with an appeal for more research 'to establish the most effective patterns of care for patients who have deliberately harmed themselves': this cannot be overstated for we still do not know of any effective means of preventing repetition of parasuicide. Whilst that is so, studies showing that patients dealt with by house physicians have the same repetition frequency as those dealt with by psychiatrists tell us nothing more. Future studies comparing different patterns of care should look at a wider range of outcome variables.

Register of UK Alcohol Research Projects, 1985-86

A register of current research into alcohol use, misuse and effects is being compiled by the Alcohol Research Group at Edinburgh University. The register will update an earlier publication covering 1982-83. For further information and

forms, please contact: Alex Crawford or Mrs Ray Stuart, Alcohol Research Group, Department of Psychiatry, Edinburgh University, Edinburgh EH10 5HF (telephone: 031-447 2011).