



Bedfordshire and Luton  
Mental Health and Social Care Partnership NHS Trust



# Defining ourselves as specialists

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Consultant Addiction Psychiatrist

SCAN Addiction Psychiatry Meeting for trainees and newly-  
appointed consultants  
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Francis Hotel, Bath

Imagine, if you will, becoming ill with appendicitis. Who would you want to take out your appendix? A surgeon who has taken out 100 appendices or a postman who had his appendix removed yesterday?

We can joke that the answer is the postman, but the truth is that we know that we would want the operation to be performed by a surgeon. A suitably trained surgeon has knowledge of the clinical presentation of appendicitis, of the anatomy of the abdomen, experience of performing the right steps to achieve the operation successfully. The surgeon does not have to have had appendicitis to know how to diagnose and treat it. A postman has knowledge of what it feels like to have appendicitis and to be subjected to the operation, but that in no way qualifies him to perform appendicectomies.

And similarly with addiction. It is possible to have objective knowledge of the symptoms and signs of heroin addiction, its aetiology, its pathology and effective treatments without having experienced addiction.

And that is what a specialist is. Someone who has a specific body of knowledge about a topic. And in the case of a medical specialist, it is someone who has a specific body of knowledge about a particular medical condition or group of conditions.

You become a specialist by studying and mastering the subject matter of the topic, not by some brief personal experience. (The Legal Dictionary)

This, however, is a practical definition and appears not to be a legal definition in the UK or Europe. (MTRAC 2004)

*But are the addictions illnesses?*

Some people question whether the addictions are illnesses. If they are only lifestyle choices, then the NHS has not basis for providing treatment.

The addictions are illnesses. Not because methadone prescription is followed by some people stabilising their lives and perhaps committing less crimes, a notion from the 1960's (Dole & Nyswander 1965, Dole *et al* 1968). Not because of the dependence syndrome (Edwards & Gross 1976), which we have known since the 1970's to be a *consequence* of heavy alcohol or drug use. But because addictive behaviour meets 4 criteria for an illness:

- Mortality – people with the condition die at a greater rate than people without the condition
- Morbidity – having the condition feels unpleasant
- External aetiology – it is caused by some external agent or agents
- Pathology or pathophysiology – there are abnormal changes in the body's structure or the way it functions

Having an addictive disorder is associated with significant mortality – smoking was considered to have caused 18% of deaths in the UK in 2004 (ic, 2006); in 2000, 22% of deaths in the United States were attributed to tobacco (18%), alcohol (3.5%) or drug use (0.5%) (Mokdad *et al* 2004). (Slide 2) Gruer *et al* (2009) in a 28-year follow-up of smokers in Scotland showed that more social class 1 smokers died than social class 4-5 non-smokers, indicating that it is smoking, not social class that kills you. (Slide 3)

It is associated with significant morbidity. (Slide 4)

It has external aetiology, with the aetiological factors being biological and psychological, often but not always in response to factors in the social environment. I have given the example of smoking in Table 1, but a similar picture is obtained for the other drugs. Many of the causes of tobacco use and nicotine addiction are not within the control of the individual, indicating that nicotine addiction is not a self-inflicted condition.

Genetic predisposition
Congenital predisposition
Low social class
Parental and sib smoking, esp with conflict
Poor academic record
Advertising
Easy availability of cigarettes
Major social stress (hurricane, terrorist attack, war)

Table 1: Aetiological Factors for Nicotine Addiction

Addiction has a biological basis, involving the reward pathways of the ventral tegmental area, the nucleus accumbens and projections to the orbitofrontal cortex, and the insular cortex, in this case a pathophysiological disorder rather than a pathological one. My own definition is that addiction is a neurobiological response to resource deprivation (Slides 6-9)

In summary the addictions are diseases. (Slide 10)

There is an escalator of illness that doctors use (Slide 11). Initially, the doctor may have to treat a symptom, with no attempt to understand a cause. An example would be a doctor prescribing paracetamol for a headache. Sometimes, a collection of symptoms are united into a syndrome. But ideally, doctors should treat identified anatomical or physical pathology. As we have concluded earlier, the addictions are pathology based diseases

### *Competences required to treat addiction*

So what do you need to treat an illness like addiction? You need knowledge, experience and expertise.

You need to know the clinical pictures of addiction, the substances used, the types of presentation, the patient treatment groups, the degrees of severity, the assessment of motivational state, the neuroanatomy, the neurophysiology, including the large number of

neurochemicals involved, the opposed neural pathways of the reward and stress systems and the way that drugs of addiction return these pathways to balance when activation of the stress pathways puts them out of balance; the way that addiction does not only occur in adolescents, but also in adults (which I distinguish by my own terms primary and secondary addiction, primary addiction being when people use drugs in an addictive fashion before undertaking adult roles, and secondary when people have taken on adult roles and then developed an addictive disorder), the natural history, prognosis and complications. (*Slides 12-23*)

You need to know which currently known treatments are effective in improving the prognosis, both at the population level and for the individual patient (*Slide 24-25*), and you need to be able to derive from your understanding of the pathology potential new clinical, biological, psychological and social treatments (*Slide 26-29*).

There are two types of knowledge – formal knowledge obtained by the observations of countless people round the world, either as observations of what the person says or does, formal clinical examination or by a variety of different types of research studies, such as ethnographical studies, case studies, epidemiological studies, double-blind, randomised, trials and a variety of other types. And informal knowledge obtained by experience of a situation and seeing something again and again and again. And this knowledge is used to diagnose clinical states, recognise the prognosis and select treatments that will benefit the individual patient. (*Slide 30*)

Expertise is the capacity to carry out the assessment effectively (even in complex cases), to carry out the intervention appropriately and to monitor the efficacy of the treatment. It includes being able to help less expert people to perform these tasks more effectively. It also includes the capacity to design an appropriate response that has a good chance of being effective to a novel clinical situation. (*Slide 30*)

It should be understood that protocols and guidelines are provided for the benefit of the inexpert to use in the absence of more qualified people.

Who has the skill mix to meet the needs of patients?

There are a number of skills sets that various clinicians, including addiction psychiatrists, general psychiatrists, physicians, general practitioners, psychologists, RGNs, RMNs, social workers, pharmacists, drugs workers and users in recovery bring to aspects of the knowledge, experience and expertise required for comprehensive addiction treatment.

It is the doctors, nurses, psychologists and pharmacists who make study of the basic sciences. (*Slide 31*)

Most non-addiction healthcare professionals are very limited in which drug addictions they can treat. Workers in NHS addiction services, nurses and drug workers can deal with heroin, cocaine, alcohol (a bit), as required by the Government strategy. Only addiction psychiatrists can treat outside this. (*Slide 32*)

Again it is the addiction psychiatrists who are best placed to manage complex cases (*Slide 33*).

Most drug workers can manage patients who are still using (*Slide 34*)

Drug workers can manage simple detoxification, but addiction psychiatrists and nurses can manage complex ones. (*Slide 35*)

It is those working in drug treatment who can help patients remain abstinent. (*Slide 36*)

All drug treatment workers are sympathetic to drug users, which is not always the case for general doctors, nurses and pharmacists. (*Slide 37*)

Drug workers provide general skills, with the addiction psychiatrists better trained and placed to carry out audit and research (*Slide 38*)

This set of tables makes it clear that Consultant Addiction Psychiatrists (CAPs) have a large number of skills and competencies that other clinicians do not have and that removing CAPs from services will deprive patients of care, including professionalism, comprehensiveness of services, and up-to-date services. It is the patients who will suffer, not the doctors who, after a period of anxiety, will find jobs in other parts of psychiatry, medicine or the non-medical workforce.

There is evidence that patients suffer if only simple levels of treatment are used. We are used to the idea of low threshold methadone treatment and reasonable caseloads for key workers. (*Slide 39*) But caseloads are increasing and we should note that the probation officer detailed to look after Dano Sonnex had a caseload of 127! (Scott 2009) How much intervention did each of his clients get?

And after the smoking ban, the level of smoking dropped from 2% in the first 9 months, although there was a slight rebound after that (West 2009). (*Slide 40*) This is good for those who stopped, but a recent report from the Office of National Statistics concluded that it was the lighter smokers who wanted to stop (ONS 2009). This left heavy smokers, who did not have access to treatment that would be effective for them, carrying on. Thus simple treatment is good for people whose illness is mild, but people who are more severely ill need a greater intensity of treatment by people who are more knowledgeable and expert. Addiction psychiatrists.

So how have we come to the current pass and what can be done to prevent impending meltdown of services, especially with the end of the drugs strategy and the anticipated reduction in NHS funding over the next few years?

There are three different type of 'player' involved in the state's delivery of addiction treatment services, each with different philosophies, ways of thinking and goals.

Politicians in the UK (including healthcare politicians, such as senior management staff in the NTA), responding to the concerns of the general public, see addiction as an issue of crime committed to fund mainly heroin and cocaine use. There is now some awareness of alcohol being involved in public violence and wavering concern about cannabis use and schizophrenia. There is almost no significant concern about the fact that up to a half of general hospital spending is accounted for by tobacco or alcohol induced conditions and that significant savings could be made to the NHS by addressing these addictions seriously. The addictions are seen, incorrectly as it happens, as 'self-inflicted' conditions and addicts are seen as undeserving of treatment.

Business-minded people, now including NHS managers, respond almost exclusively to financial stimuli. It is a reality of business that if you don't make a profit you go out of business. Businesses produce and provide what people want, not what they need. Wants and needs often do not coincide. There is no doubt that the introduction of the market, with monopolistic purchasing but plural providers has distorted priorities away from the clinical needs of patients.

Clinicians are only interested in getting people better. With the disjuncture of treatment from payment in the NHS, there is a tendency for clinicians to disregard costs when recommending or instituting treatment. Medicine is also an incredibly large subject, and many clinicians tend to focus only on what they see, rather than the whole picture of patient needs, leading to the sad, unedifying and ultimately spurious 'harm-reduction' versus 'abstinence' debate.

Currently, the three types work almost independently of each other. The result is that service delivery is less than the sum of its parts. There is a need for the three groups to try and link up to address each of their goals, needs and aspirations. If we as a society see addiction as an illness, then we must implement the pathology based model as the basis of our discourse, not the symptom based model that is the basis of the two Models of Care strategic documents. We must help politicians to realise that if they want a reduction in drug-related crime and if they want to reduce NHS costs, they must utilise the skill and knowledge of clinicians, using the leverage of financial stimuli to managers, to devise a suitable treatment system and provide the highest quality and most cost-effective treatment services within the finances available. If the politicians, the NTA, and the managers in the NHS fail to acquire the highest quality care by accessing and exploiting the specialist skills of the Consultant Addiction Psychiatrists, it is the patients who will suffer from receipt of unnecessarily suboptimal care. (*Slide 41*)

References

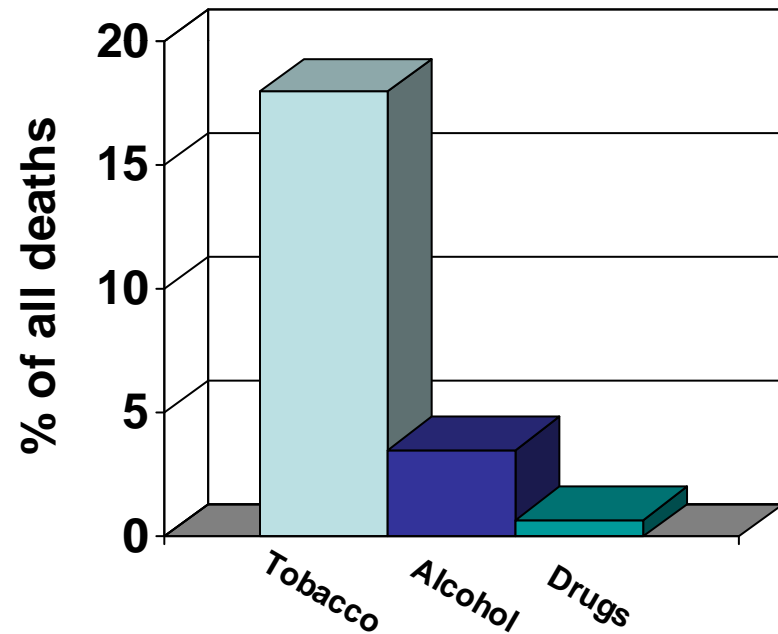
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- West R. Smoking and smoking cessation in England: Findings from the Smoking Toolkit Study. Powerpoint presentation dated 10 May 09 (<http://www.smokinginengland/ref/smokinginengland.ppt>, accessed 21 June 2009)

# Mortality

Smoking considered in the causation of

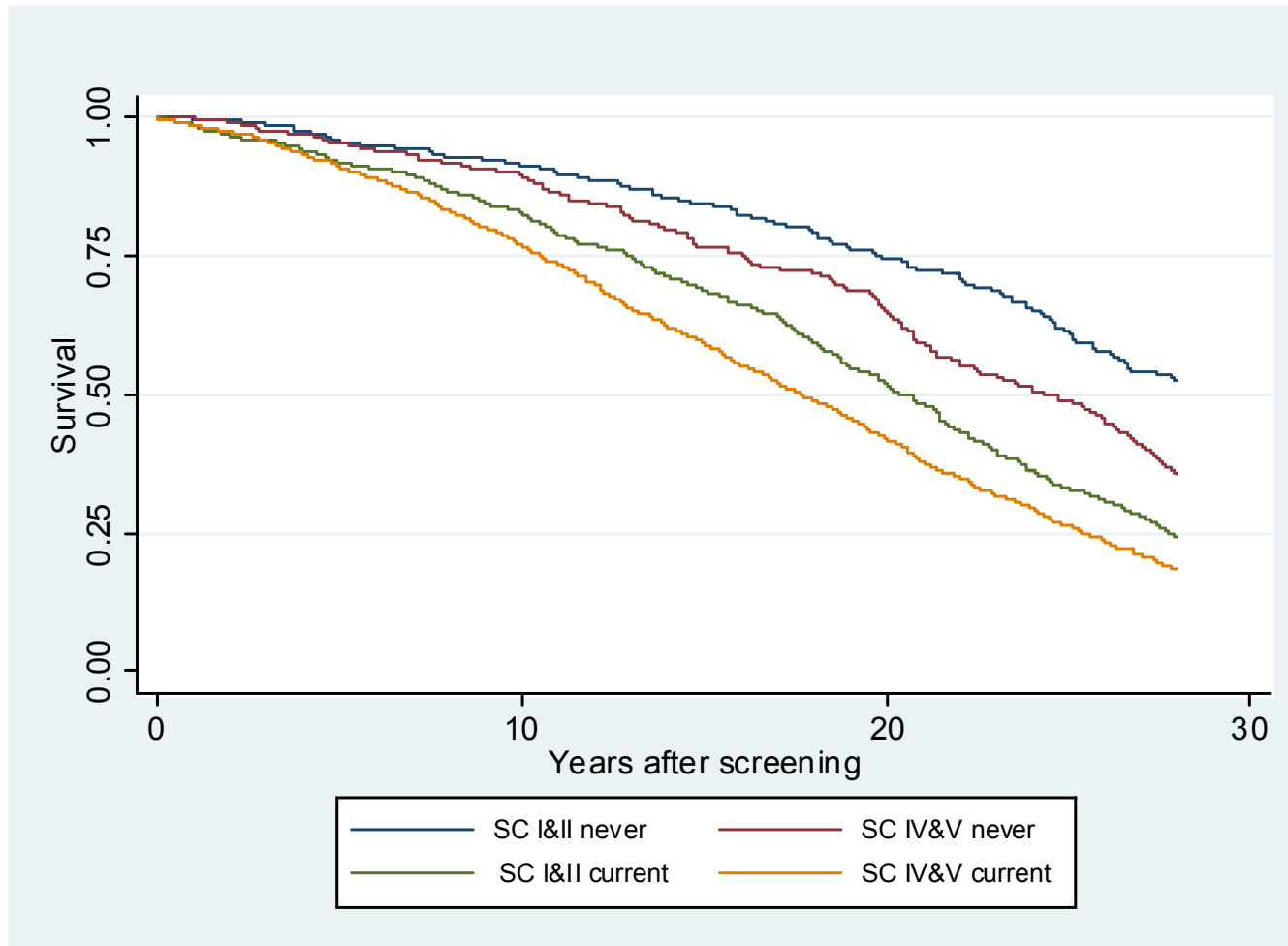
- 18% of deaths in England & Wales in 2004 (ic.nhs.uk, Statistics on Smoking 2006)
- 18.1% of US deaths in 2000 (JAMA 2004;**291**:1238)

Drugs as cause of deaths in US 2000





## Survival of most and least affluent men



Dr Laurence Gruer OBE, Scottish Health Inequalities in context

[www.thpc.scot.nhs.uk/Presentations/TIIPconf/Ig%20-%20Tayside%20inequalities.ppt](http://www.thpc.scot.nhs.uk/Presentations/TIIPconf/Ig%20-%20Tayside%20inequalities.ppt)

18/06/09

R Cohen - Defining Addiction  
Specialists

3

# Morbidity

## URTI *(for comparison)*

- Malaise
- Feel hot / cold
- Sore throat
- Headache
- Runny eyes

## Drug Addiction

- Low mood
- Anxiety / stress
- Low self-esteem
- Desire and longing for tobacco / alcohol / heroin / cocaine
- Difficulty concentrating
- Withdrawal symptoms

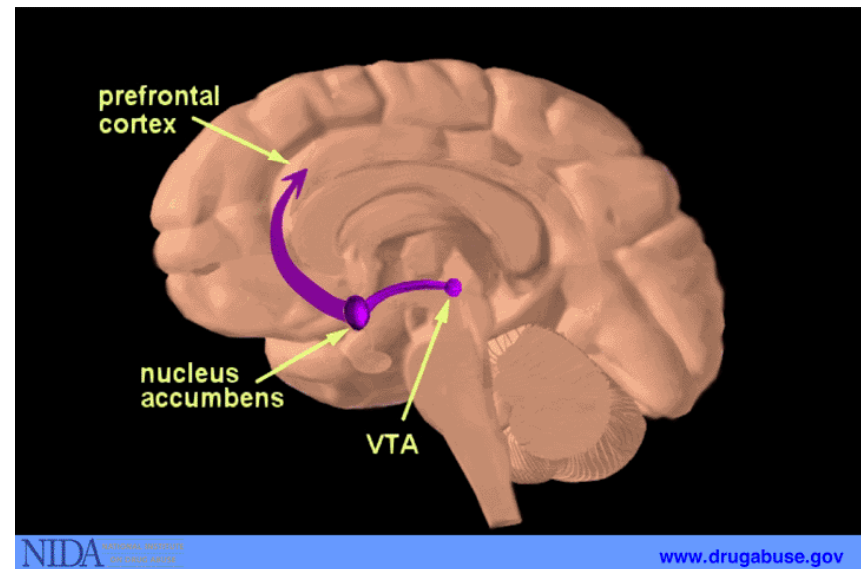
# Comment on aetiology of smoking

## *Aetiological Factors*

- Genetic predisposition
  - Congenital predisposition
  - Low social class
  - Parental and sib smoking, esp with conflict
  - Poor academic record
  - Advertising
  - Easy availability of cigarettes
  - Major social stress (hurricane, terrorist attack, war)
- The majority of these factors are not in the control of the patient
  - ***Smoking is therefore not a self-inflicted disease***

# Function of reward pathway

- Hunger
- Thirst
- Sexual desire
- Stroking
- Smiling
- Enjoying listening to music



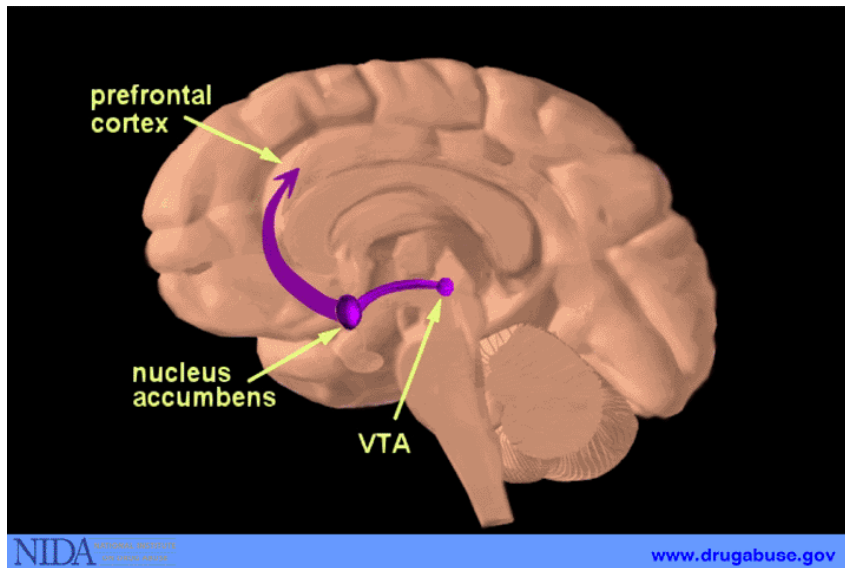
# Reward pathway in addicts

Hyperresponsive

*because*

Understimulated

- *Drugs, including nicotine, act on reward pathway and cause a hugely pleasurable response*



# Neurobiology of cocaine and experience of pleasure

- Reduced dopamine release in striatum (site of N Acc) in cocaine abusers
- Increased response in thalamus, assoc with craving
- Reduced D2 receptors in orbitofrontal cortex and cingulate gyrus
- Reduced D2 receptors associated with pleasure from cocaine, normal levels associated with feeling cocaine as unpleasant

Volkow *et al*

- *Nature* 1997;**386**:827
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# A 21<sup>st</sup> Century Understanding of the Addictions

*“Addiction is a neurobiological  
response to resource  
deprivation”*

Robert Cohen 2001

# The addictions are diseases

Mortality	22% of deaths annually (smoking, alcohol & drugs)
Morbidity	Cluster of unpleasant symptoms
Pathophysiology	Hyperreactivity of reward pathways
External aetiology	Multiple external causes (genetic, congenital, environmental)



# Escalator of diagnosis



Headache,  
drowsiness,  
vomiting,  
neurological  
signs

Brain  
surgery

Secondary  
care

Headache,  
nausea,  
flashing  
lights

Paracet-  
amol  
Triptans

Primary /  
Secondary  
Care

Headache

Paracet-  
amol

Primary  
Care

# Clinical pictures of addiction – substances and behaviours

## Substances

- Nicotine
- Alcohol
- Cannabis
- Ecstasy
- Amphetamines
- Methylamphetamine
- Cocaine
- Heroin
- Benzodiazepines
- GHB, LSD, poppers, PCP
- Anabolic steroids
- Khat
- Betel
- Salvia divinorum

## Behaviours

- Pathological gambling
- Morbid obesity
- Exercise dependence?

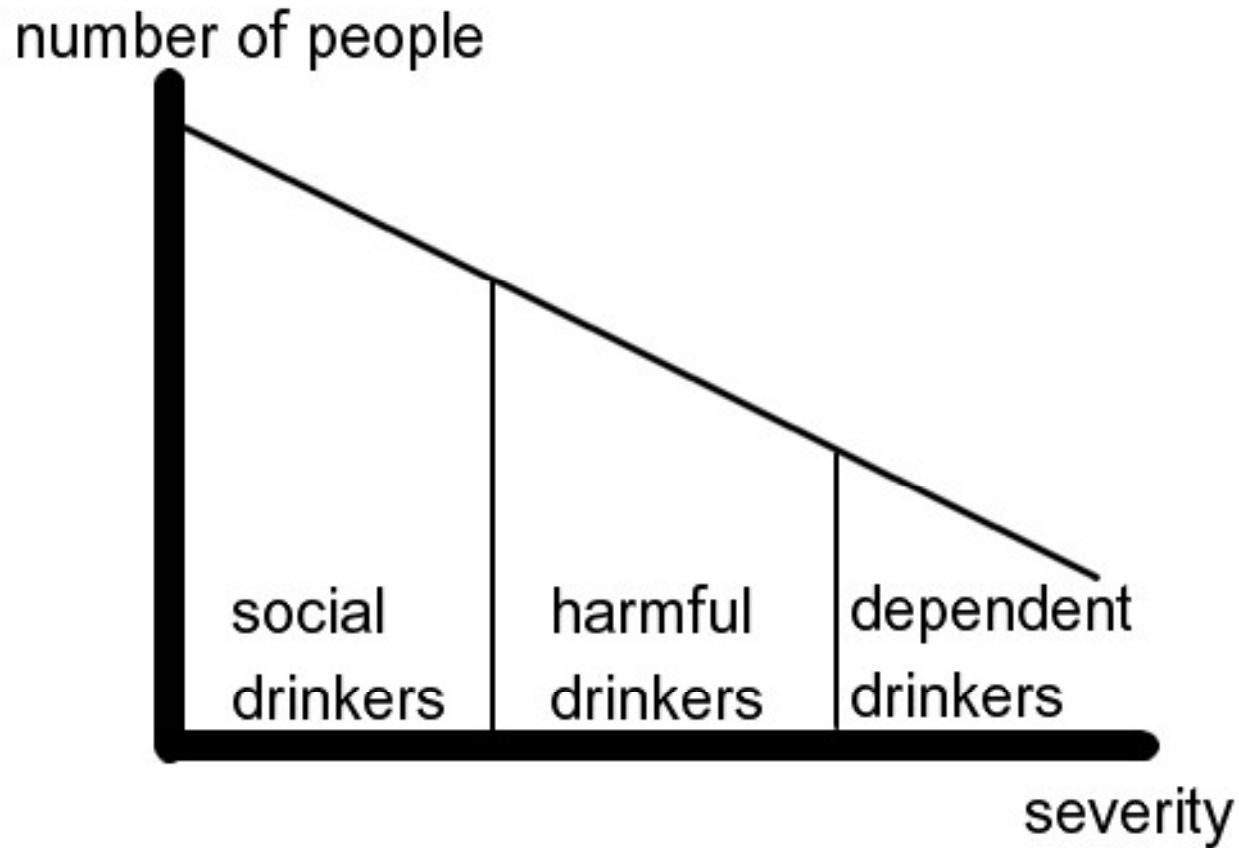
# Clinical pictures of addiction – presentations (some examples)

- Street heroin / cocaine addiction (treated if associated with criminality)
- Addiction as a response to social abuse ('mothers' little helper')
- Addiction as a response to life stress, especially acute (e.g, post twin towers)
- Addiction as a response to serious physical illness (Crohn's; colostomy reversal, metastatic carcinoma)
- Addiction as an ante-mortem grief reaction

# Clinical pictures of addiction – patient treatment groups

- General addiction
- Child & adolescent addiction
- Old age addiction
- Addiction in primary care (nb, not the same as ‘shared care’)
- Liaison addiction
- Addiction & mental illness (‘dual diagnosis’)
- Forensic addiction

# Clinical pictures of addiction – severity of illness

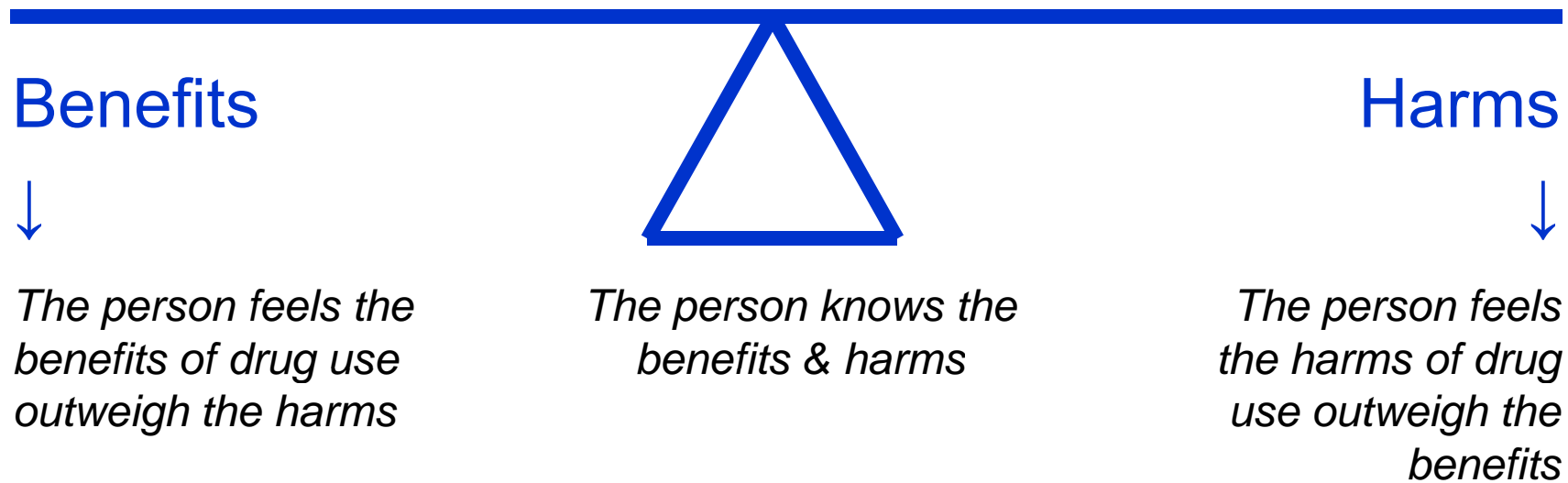


# Clinical pictures of addiction – motivational state

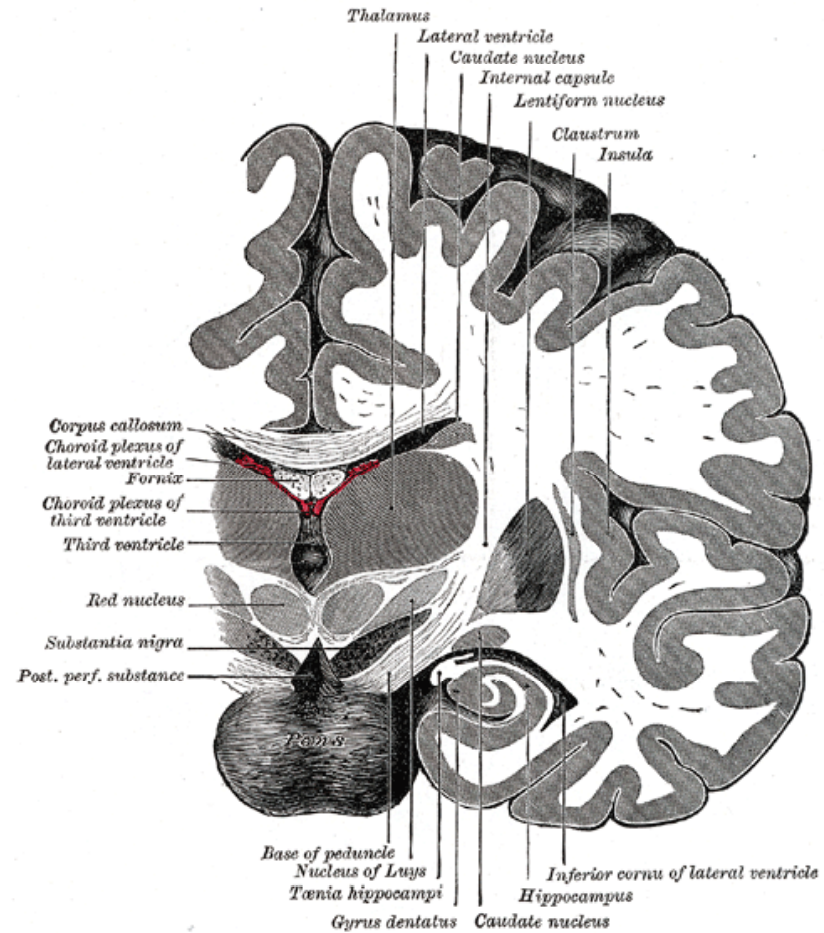
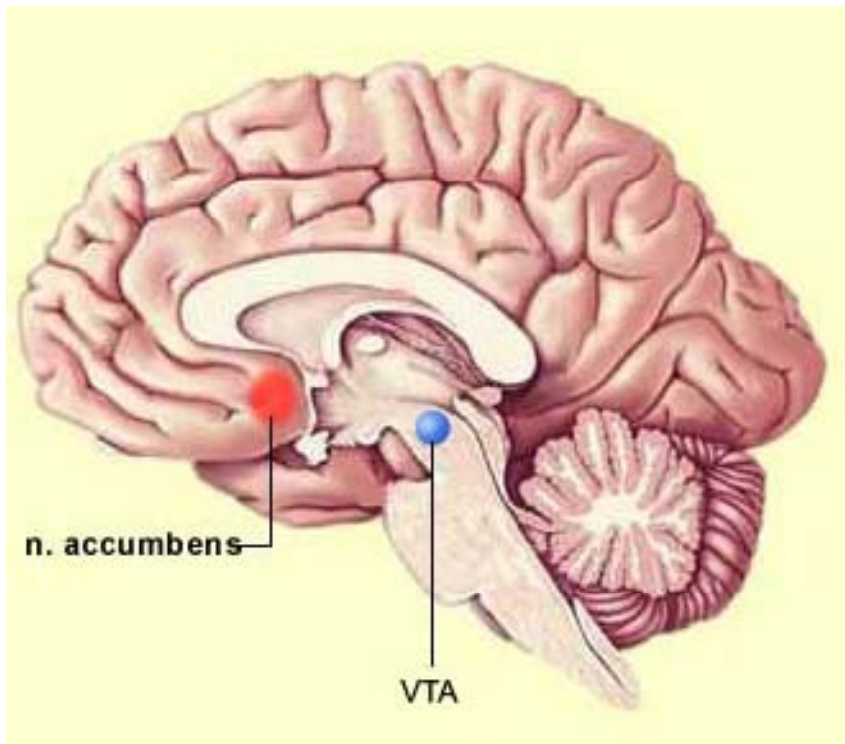
Motivated to  
continue

Ambivalent

Motivated to  
stop



# Neuroanatomy – known involved areas



Reward pathways

R Cohen

Insular cortex

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# Neurophysiology – known neurotransmitter involvement

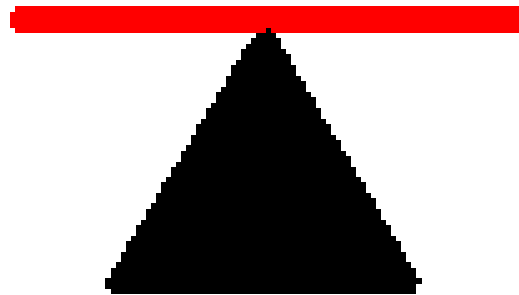
- Acetylcholine
- Adiponectin
- Adrenaline
- Agouti-related peptide
- Anandamide
- Brain-derived neurotrophic factor
- Corticotrophin Releasing Factor
- Dopamine
- Dynorphin
- Enkephalins
- Endocannabinoids
- Endomorphins
- Endorphins
- GABA
- Galanin
- Glutamate / NMDA
- Insulin Receptor Substrate 2
- Leptin
- Neurokinin 1
- Neuropeptide Y
- Nicotine
- Noradrenaline
- Oestrogen
- Phospholipase C $\gamma$
- Resistin
- Serotonin
- Substance P



# Neurophysiology – balance between reward pathways and stress pathways

**Circadian  
rhythm**

Balance of  
resource  
gain and  
utilisation /  
storage



**Stress**

Excess  
resource  
utilisation to  
meet a threat

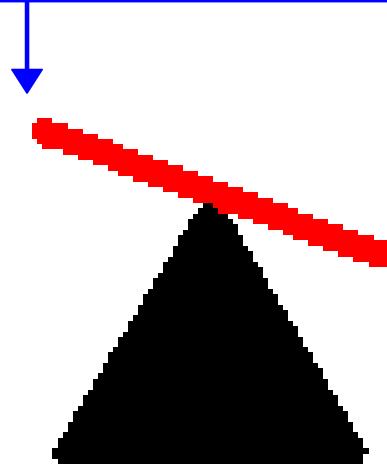
# Neurophysiology –

balance between reward pathways and stress pathways

*Further drug use to reduce effect of stress and enhance reward pathway*

**Circadian rhythm**

Balance of resource gain and utilisation / storage



**Stress**

Excess resource utilisation to meet a threat

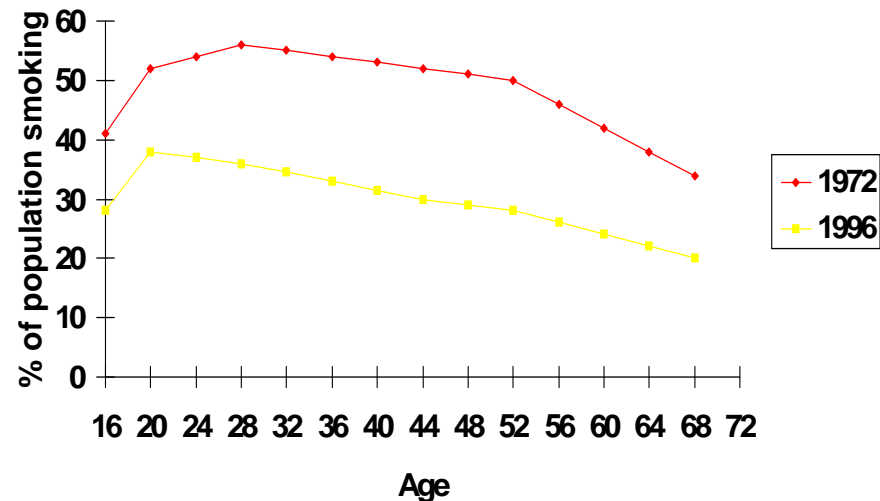
# Forms of addiction

- Primary addiction
  - Addiction develops before the person has taken on adult roles
    - Typical drug use of unhappy child starting drug use in teenage and then developing addiction career
- Secondary addiction
  - Following the successful attainment of adult roles, the person reverts to more dependent forms of behaviour, including drug use, following major social stress or trauma
    - e.g., development of cannabis and/or heroin dependence in Vietnam, but complete remission on return to US
- *nb, this is my definition – it is not in general use*

# Chronic psychoactive drug use, abuse and dependence

The natural history of drug abuse / dependence (*nicotine, alcohol, stimulants, opiates*) typically shows

- start in adolescence
- problems in 20's
- help-seeking in 20's / 30's
  - & behaviours showing dependence on therapist
- continues unless there are psychological changes



# Complications of addiction

- Numerous - *Much more than Hep C and HIV*

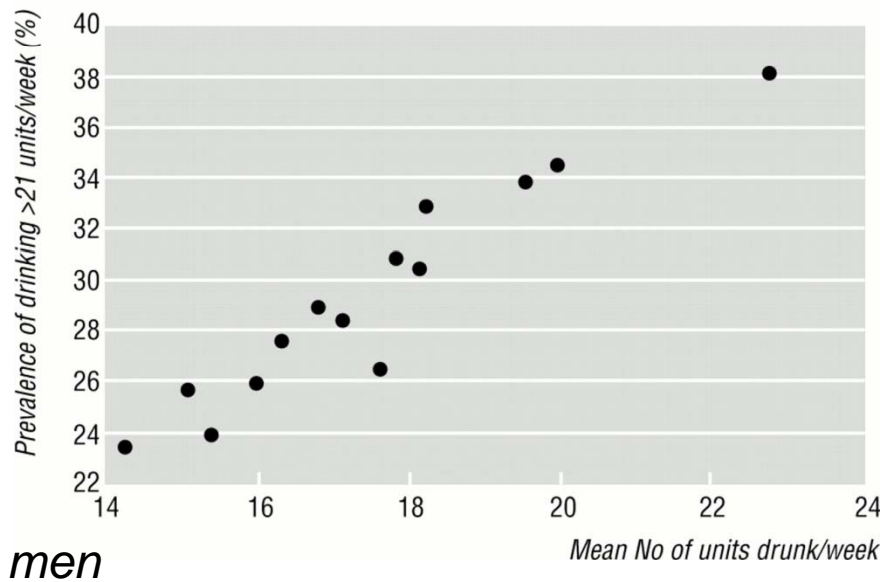
Physical

Psychological

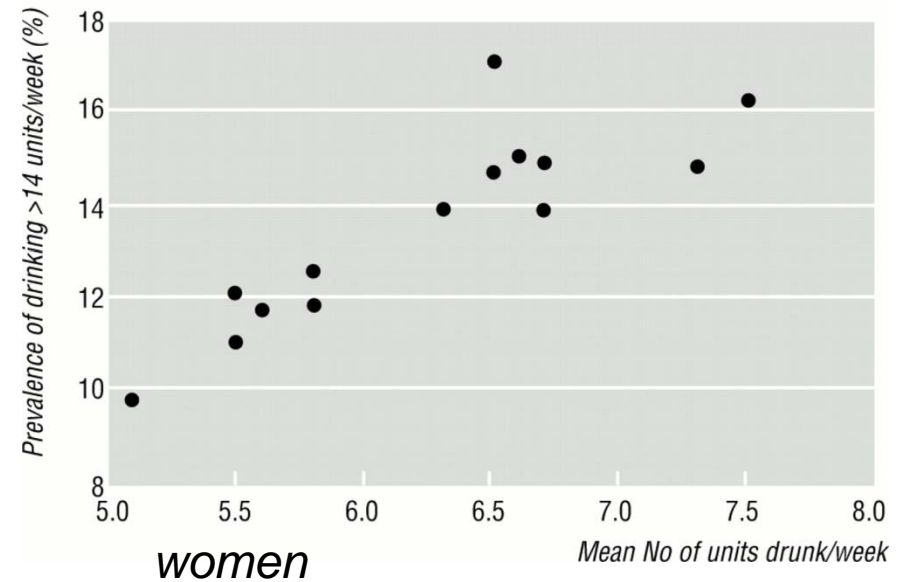
Social

# Single Population Theory

Colhoun *et al* *BMJ* 1997;314:1164



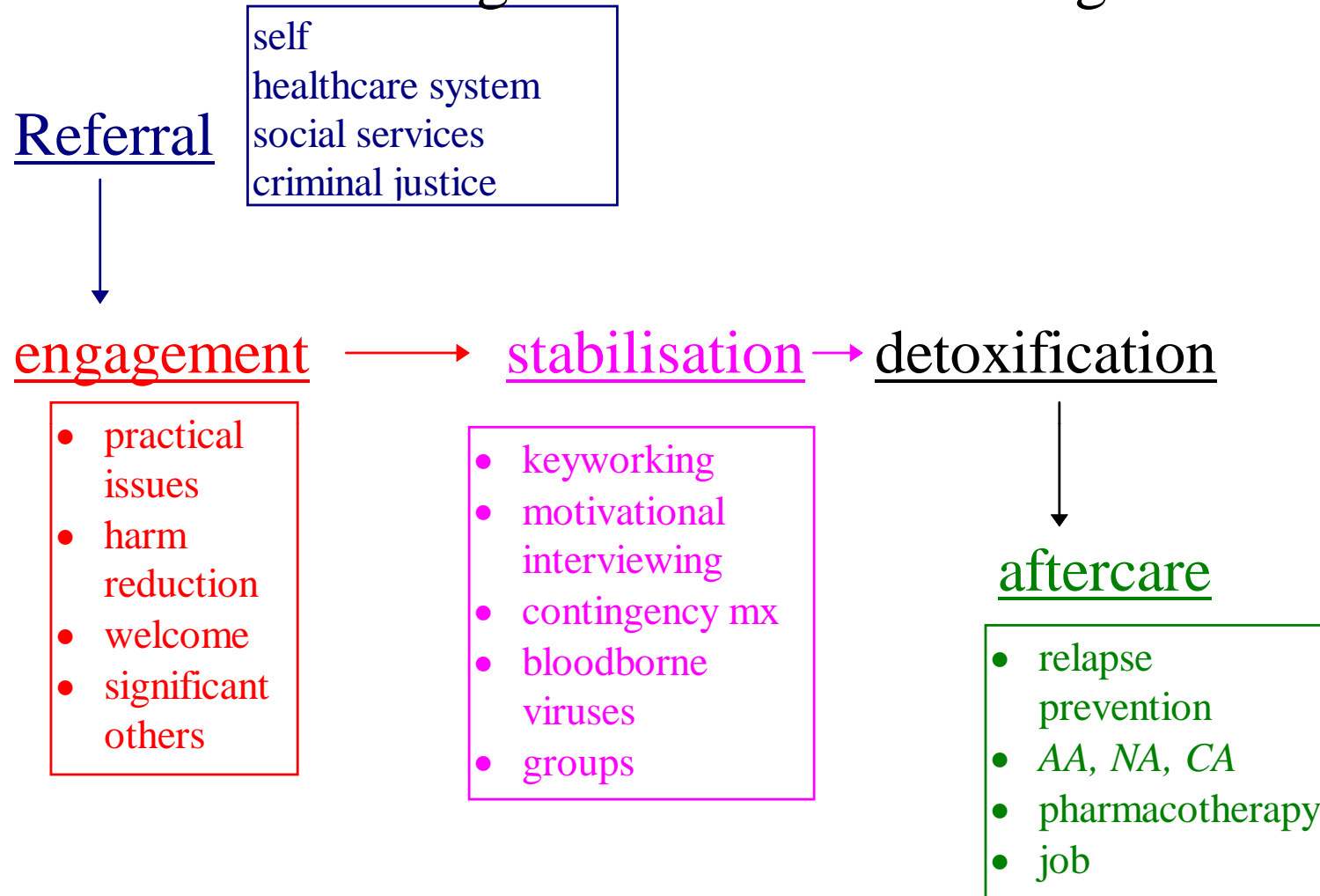
men



women

- Evidence that as the mean number of units of alcohol in a population increases, the number of people drinking over the recommended limits increases
- This is the basis of the notion that restriction of a drug, e.g., by increased taxation, smoking ban, will be followed by reduced numbers of problem and dependent drug users

# Schema of stages of treatment of drug abuse



# Areas for exploration for new treatments - clinical

- Punctuality as a clinical (not moral!) issue
- Lexical
  - Drug user language and its manipulation
  - Drug therapist language and its correction
    - e.g., The term 'admit' is used by therapists with limited understanding of the clinical disorder
- Physical issues
  - e.g., evaluation of respiratory status in a crack user
  - Infectious diseases, such as *C. novyi*, *B. anthracis*
- Introduction of new treatments
  - Contingency management



# Areas for exploration for new treatments - biological

- Overall view of addiction
  - Orexin
- Engagement facilitators
  - Oxytocin
- Stress pathways supports
  - DHEA, neuropeptide Y, substance P, lithium?, aspirin / cytokine therapy (monoclonal antibodies, e.g., infliximab)?
- Medications in development
  - Resveratrol, orlistat, rimonabant
- Physical exercise

# Areas for exploration for new treatments - psychological

- Social cue reading
- Trust (trusting & being trusted)
  - Develop from work of E Fehr
- Social status
- Delayed gratification
- Other behavioural
- Risk taking
- Identity as a drug user

# Areas for exploration for new treatments - social

- Social ecology
- Networks
  - adjustment,
  - intervention of existing pathoplastic networks already occurs, though patchy
- Culture and family

# Requirements to be able to treat

- Knowledge
  - Formal, objective
  - Other's observations (& own research)
- Experience
  - Own observation of clinical situations
- Expertise
  - The ability to assess and provide treatment effectively
  - *Protocols & guidelines (eg the Orange Guidelines) are second-best to help inexperienced therapists provide a minimal service in the absence of experts*

# Skill sets derived from training – Basic Science

	A	P	M	G	Ψ	N	R	S	C	D	U
Pathological Anatomy	√	√	√	√	√	√	√	x	√	x	x
Pathophysiology	√	√	√	√	√	√	√	x	√	x	x
Psychological Pathology	√	√	x	x	√	x	√	x	x	x	x
Other biological aetiology	√	√	√	√	√	x	x	x	√	x	x
Pharmacology	√	√	√	√	x	√	√	x	√	x	x
Sociology	√	√	x	√	x	x	√	√	x	x	x

Addiction psychiatrist (A); Gen Psychiatrist (P); Hosp Medic (M); GP (G); Psychologist (Ψ); RGN (N); RMN (R); Social Worker (S); Pharmacist (C); Drugs Worker (D); Recovering User (U) 31

# Skill sets derived from training – Scope of drug of choice treatment

	A	P	M	G	Ψ	N	R	S	C	D	U
Alcohol	√	√	√	√	√	√	√	√	√	√	√
Tobacco	√	x	x	x	√	x	√	√	√	x	x
Solvents	√	x	x	x	√	x	√	√	x	√	√
Cannabis	√	x	x	x	√	x	√	√	x	√	√
Ecstasy / stimulants	√	x	x	x	√	x	√	√	x	√	√
Benzodiazepines (1°)	√	√	x	x	x	x	√	√	√	x	x
Heroin	√	x	x	√	√	x	√	√	√	√	√
Cocaine	√	x	x	√	√	x	√	√	√	√	√
Anabolic Steroids	√	x	x	x	x	x	x	x	x	x	x
Gambling	√	x	x	x	√	x	x	x	x	x	x

Addiction psychiatrist (A); Gen Psychiatrist (P); Hosp Medic (M); GP (G); Psychologist (Ψ); RGN (N); RMN (R); Social Worker (S); Pharmacist (C); Drugs Worker (D); Recovering User (U)

# Skill sets derived from training – Management of Complex Cases

	A	P	M	G	Ψ	N	R	S	C	D	U
General addiction	√	x	x	√	√	x	√	√	√	√	√
Primary care addiction	√	x	x	√	√	x	√	√	x	x	x
Liaison addiction	√	x	x	x	x	x	x	x	x	x	x
Obstetric addiction	√	x	x	x	x	x	√	x	x	x	x
Dual diagnosis	√	x	x	x	√	x	√	x	x	x	x
Child & adolescent addiction	√	x	x	x	x	x	x	x	x	x	x
Old age addiction	√	x	x	x	x	x	x	x	x	x	x
Unusual presentations	√	x	x	x	x	x	x	x	x	x	x

Addiction psychiatrist (A); Gen Psychiatrist (P); Hosp Medic (M); GP (G); Psychologist (Ψ); RGN (N); RMN (R); Social Worker (S); Pharmacist (C); Drugs Worker (D); Recovering User (U) 33

# Skill sets derived from training – Management of Predetox Patient

	A	P	M	G	Ψ	N	R	S	C	D	U
Engagement	√	x	x	√	√	x	√	√	√	√	√
Needle exchange	√	x	x	x	√	x	√	√	√	√	√
Bloodborne virus treatment	√	x	x	√	x	x	x	x	x	x	x
Motivational interviewing	√	x	x	x	√	x	√	√	x	√	√
Opiate substitution therapy	√	x	x	√	x	x	x	x	√	x	x
Keyworking	√	x	x	x	√	x	√	√	x	√	√
Contingency management	√	x	x	x	√	x	x	x	x	x	x

Addiction psychiatrist (A); Gen Psychiatrist (P); Hosp Medic (M); GP (G); Psychologist (Ψ); RGN (N); RMN (R); Social Worker (S); Pharmacist (C); Drugs Worker (D); Recovering User (U) 34



# Skill sets derived from training – Management of Detoxification

	A	P	M	G	Ψ	N	R	S	C	D	U
Alcohol detoxification – IP	√	√	√	x	x	x	√	x	x	√	x
Alcohol detoxification – OP	√	x	x	x	x	x	√	x	x	x	x
Nicotine detoxification	√	x	x	x	x	x	x	x	x	x	x
Heroin detoxification – IP	√	x	x	x	x	x	√	x	x	√	x
Heroin detoxification - OP	√	x	x	x	x	x	√	x	x	x	x
Benzodiazepine detox	√	√	x	x	x	x	√	x	x	x	x
Complex detoxification	√	x	x	x	x	x	√	x	x	x	x

Addiction psychiatrist (A); Gen Psychiatrist (P); Hosp Medic (M); GP (G); Psychologist (Ψ); RGN (N); RMN (R); Social Worker (S); Pharmacist (C); Drugs Worker (D); Recovering User (U) 35

# Skill sets derived from training – Management of Abstinence

	A	P	M	G	Ψ	N	R	S	C	D	U
Pharmacology	√	x	x	x	x	x	x	x	x	x	x
Relapse prevention	√	x	x	x	√	x	√	√	x	√	√
12-step	√	x	x	√	√	x	√	√	x	√	√
Residential Rehabilitation	√	x	x	x	√	x	√	√	x	√	√
Day programme	√	x	x	x	√	x	√	√	x	√	√
Underlying psycholog probs	√	√	x	x	√	x	√	√	x	x	x

Addiction psychiatrist (A); Gen Psychiatrist (P); Hosp Medic (M); GP (G); Psychologist (Ψ); RGN (N); RMN (R); Social Worker (S); Pharmacist (C); Drugs Worker (D); Recovering User (U) 36

# Skill sets derived from training – Attitude

	A	P	M	G	Ψ	N	R	S	C	D	U
Non-judgementalism	√	√	x	x	√	x	√	√	x	√	√
Empathy	√	√	x	x	√	x	√	√	x	√	√
Positive regard to addicts	√	x	x	x	√	x	√	√	x	√	√

Addiction psychiatrist (A); Gen Psychiatrist (P); Hosp Medic (M); GP (G); Psychologist (Ψ); RGN (N); RMN (R); Social Worker (S); Pharmacist (C); Drugs Worker (D); Recovering User (U) 37

# Skill sets derived from training – General skills

	A	P	M	G	Ψ	N	R	S	C	D	U
Referral to related services	√	√	x	x	√	x	√	√	x	√	√
Attention to social issues	√	√	x	x	√	x	√	√	x	√	√
Case overview	√	x	x	x	√	x	x	√	x	x	x
Audit	√	x	x	x	√	x	x	x	x	x	x
Training	√	x	x	x	√	x	√	√	√	√	√
Research	√	x	x	x	√	x	x	x	x	x	x

Addiction psychiatrist (A); Gen Psychiatrist (P); Hosp Medic (M); GP (G); Psychologist (Ψ); RGN (N); RMN (R); Social Worker (S); Pharmacist (C); Drugs Worker (D); Recovering User (U) 38

# Does it matter if patients get less skilled services?

NTORS 5-year outcomes

Figure 1: Drug use outcomes - residential

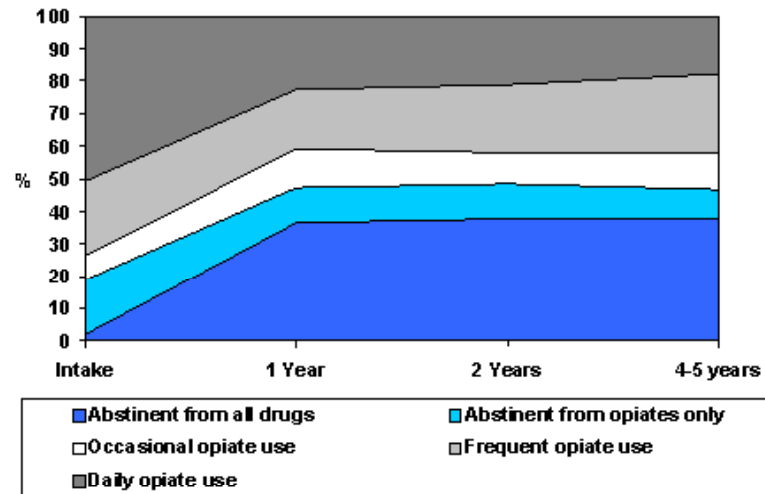
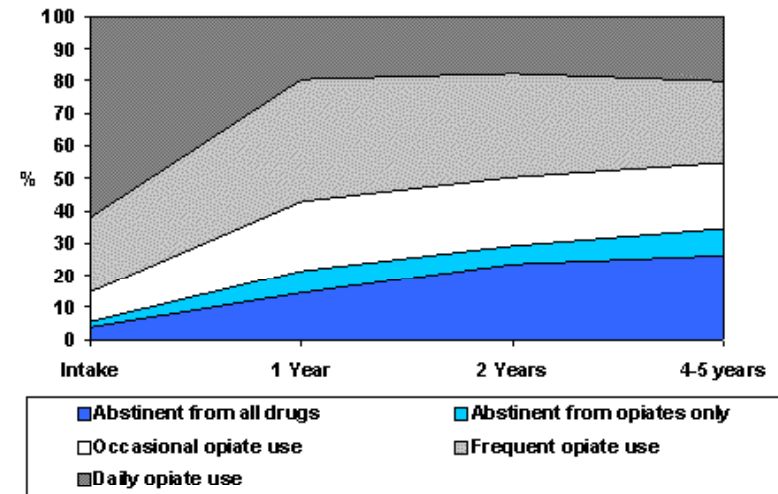


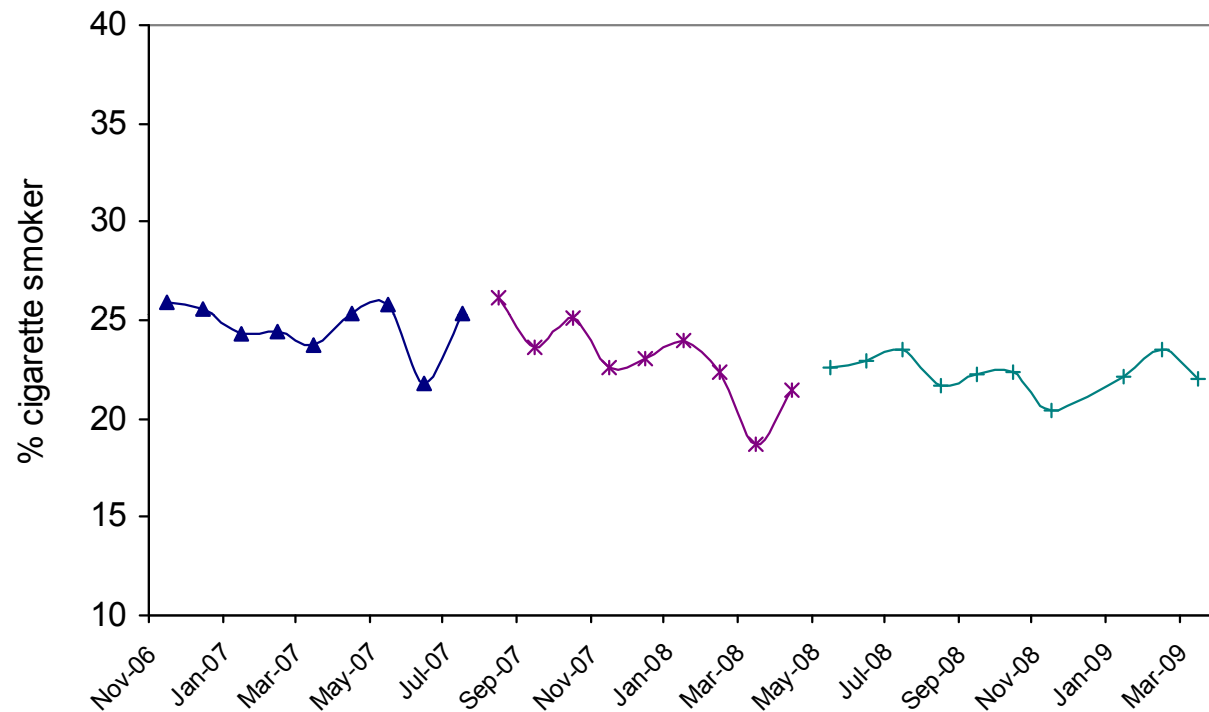
Figure 2: Drug use outcomes - community



We know that treatment works

# If we go only for public health measures...

West,  
smokinginen  
gland.info,  
STS010,  
slide 16



- Smoking levels in the UK decreased following introduction of the smoking ban
- But heavy smokers are less likely to want to give up ([statistics.gov.uk/pdfdir/nsd0309.pdf](http://statistics.gov.uk/pdfdir/nsd0309.pdf))

# Summary

- Evidence shows that the addictions have a clear biological basis, in the area of mental functioning
- Addiction psychiatrists have a wider, deeper and more extensive knowledge of basic science, clinical presentations and treatments options and opportunities than other staff working in the addiction field, and are therefore 'specialists' in the field of addiction
- Other staff groups with more limited training have more generic roles to play in the provision of addiction treatment in the UK
- For patients with addictive disorders to have the best opportunity to obtain up-to-date, competent and effective treatment, the services they access must contain specialists, i.e. Consultant Addiction Psychiatrists