DR DAVID BAILEY. GP DEALING WITH ADDICTS

1. Dr Bailey (DD) has approximately 20 drug-related patients on his books - an average workload compared with an average GP in United Kingdom interested in drug addiction. Some are referred by Alcohol and Drugs Service (ADS); some are self-referrals.

2. DD was one of the first GPs on the Island to get a licence to prescribe methadone. He sees about 10 patients at any one time on this programme. He has one patient on a long term subutex programme at present and 2 or 3 people on a detox.

3. DD has a good working relationship with **ADS**. It's easy to contact a key worker quickly. Secure e-mail soon to be rolled out to ADS will further improve communication. ADS deal with referrals much more quickly than in United Kingdom - within a week for a methadone programme for priority cases. In-patient detoxes can be arranged within 2 or 3 months which compares very favourably with United Kingdom. Home detoxes are also done promptly.

4. **Subutex** has distinct advantages over methods of detoxing addicts which are much more labour-intensive requiring higher levels of medical supervision. After initial prescribing and checking the rest of the follow up can be left to ADS. There is a waiting list for subutex programme but DD is not aware of any cases where medical care has been sub-standard as a result as other options have been available. It can be diverted and abused but it is always dispensed on a daily basis.

5. Prescribing **methadone** in a properly controlled manner enables an addict to cease using heroin without experiencing severe withdrawal effects. DD disagrees with the view that methadone is problematic because of its addictive nature. It's an opiate and takes time to come off its use. It has effects like heroin in making people feel woozy and disassociated from reality but is less profound and immediate; its effects are longer-acting compared to heroin. AS with any medication, it is necessary to weigh up the pros and cons but it has advantages compared to the health risks of heroin and the potential to turn to crime.

6. Taking **methadone** under daily supervision in a chemist has disadvantages for people working and also in terms of being identified. However, supervision prevents leakage of supply onto the streets. Allowing people to take home quantities raises problems of security in the home, particularly where there are children. Most people live within a short distance of a chemist. Some may be trusted to take a 'Sunday' dose but this should not be considered a right. It may sound hard but if someone is motivated to come off heroin the methadone programme will be time-limited programme of a few months.

7. **Harm reduction approach** - The objective of a methadone programme is to help someone reduce and finally come off drug usage. They will be started on a maintenance dose for a period of a month or two. If they came to say after the first week on the programme that they are still using heroin because of withdrawal symptoms the dose can be gradually increased (up to allowable limit) until they no longer have withdrawal symptoms. Once they have a period of stability they may be ready for a detox.

8. There will always be some people who continue to use heroin while on a methadone

programme but it's pretty risky. If testing shows continued use of opiates they will be put on a **warning (yellow/red) card system**. Basically they are using methadone to save themselves money. DD would be uncomfortable continuing to prescribe, after giving some benefit of the doubt, in such circumstances, which would be an abuse of the system and illegal.

9. DD does not consider that prescribing injectable forms of an opiate to an addict (eg heroin or methadone) appropriate for Jersey. The cost of heroin means for the most part addicts use small quantities, albeit they tend to inject more often. It would only be practical in a supervised setting as there would be a risk of it being shared by other people.

10. Prescribing is only part of the solution. **Psychological and social support** is also important in rehabilitation of the patient. Addicts often lead very chaotic lives which can be disruptive to other members of the family. ADS can provide some support but a dedicated social worker would free up the time of the key worker to concentrate on drug issues with the individual. GPs also have limited time to deal with health-related issues and are unable to provide all the necessary social assistance an addict may require.

11. There is some evidence of over-prescribing of benzodiazepines to young people.

12. Limited treatment of **Hepatitis** among drug users (see written submission). Dr Muscat prefers to treat people who are not on a methadone programme.

13. DD agrees that there is not enough known about Hepatitis and HIV prevalence in the Island

14. **Voucher scheme** (see written submission) - lack of money is probably one of the main stumbling blocks in recruiting further GPs to the treatment of addicts.

15. Two day symposium for GPs in Jersey held in 2003 - about ten attended of which only one decided to pursue a licence to prescribe methadone. In the United Kingdom there would generally be one third to a half of GPs licensed to prescribe methadone.

16. **Loss of budget for training GPs** - there will be no money next year in ADS budget. DD has benefited from a number of opportunities to attend latest training courses in the United Kingdom. Training is part of professional responsibility. If training is not available DD would have to consider position in continuing treatment of addicts