Reci'd Scrutiny Office 20/5/04 RJB

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The Shadow Scrutiny Panel
Scrutiny Office
States Building
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Dear Sirs

I have been a full time medical practitioner in Jersey for thirty years and am the Senior Partner at David Place Medical Practice. I am a member of the Drug Dependency Advisory Group and have been since its formation. I have a special interest in treating addictions and received training in Edinburgh to develop my knowledge of the day to day management of drug addicts in the community. I am responsible for the care of about 80% of patients who present to the Alcohol and Drug service with substance abuse problems.

I have run three clinics a week at Gloucester Lodge from the commencement of the Community Opiate Substitution programme and have been involved with the treatment of drug addicts for the last seven years.

I see 40-50 patients a week, and target heroin addiction, Benzodiazepine addiction as a secondary problem and alcohol dependency in the homeless and Shelter accommodated patients who have no GP. This service is offered free at point of contact as far as patients are concerned. Two sessions a week are devoted to opiate addiction management; the third is designed to deal with health issues and vaccination against Hepatitis B and to monitor patients with Benzodiazepine addictions and alcohol dependency.

I would be happy to give evidence to the committee but would prefer to do so verbally.

I attach a list of discussion points.

Yours sincerely,

M.F. Marks
MB.,BS.,DRCOG

Enc.

1. The existing service.
2. Protocols and guidelines that are currently applied: see attached foreword to British Government Guidelines on Clinical Management. (I can supply the whole of the manual to the panel if you do not already have a copy)
3. Health problems.
4. Dual (psychiatric) pathology.
5. HIV and Hepatitis C. I found 50% positivity for Hepatitis C in a study that I carried out two years ago in Jersey.
6. After care; residential and community: the use of Naltrexone and implants.
7. Harm Reduction Policy: the need for long term treatment in selected cases.
8. Rapid access for arrest referral officer and early referral for treatment.
9. Sentencing policy: ineffective and costly.
10. Treatment of drug addiction for prisoners and remand prisoners being maintained on treatment already prescribed.
11. BOTO binding over treatment orders and POTO probation orders and treatment orders and their medical implications.
12. Further training for doctors and other health professional involved in the treatment of addiction disorders.
13. Opting out for doctors and its long term implications on the needs of the service – the need for a centralised community service.
14. The decriminalisation/legalisation issue.

CHAPTER 1
INTRODUCTION

Key chapter recommendations

Drug misusers have the same entitlement as other patients to the services provided by the National Health Service. It is the responsibility of all doctors to provide care for both general health needs and drug-related problems, whether or not the patient is ready to withdraw from drugs. This should include the provision of evidence-based interventions, such as hepatitis B vaccinations, and providing harm minimisation advice. Every doctor must provide medical care to a standard which could reasonably be expected of that practitioner in his or her position. No practitioner should be put under duress by colleagues or patients to provide treatment beyond that standard unless he or she wishes to.

1. The growth of drug misuse
Prevalence

The question of how many people are using illicit drugs is deceptively easy to ask but notoriously difficult to answer. The most recent published data from the Regional Drug Misuse Databases [1] show that the total number of drug misusers presenting to treatment in the six months ending March 1998, was around 30,000 in Great Britain. Over half of those users presenting were in their twenties (54 per cent), and around one in seven (15 per cent) were aged under 20. The ratio of males to females was 3:1. Over half (55 per cent) reported heroin as their main drug of misuse. Methadone was the next most frequently reported main drug of misuse with 13 per cent of users, followed by cannabis and amphetamines, both with 9 per cent. Drug misuse is a substantial and growing problem, with a significant and profound impact on the health and social functioning of many individuals. Self-reported drug use amongst those aged 16–59 years in England and Wales in 1996, showed that approximately one in ten had used illegal drugs in the last year, and that one in twenty (6 per cent) had in the last month.[2]

People who are involved in drugs may have multiple social and medical problems. Doctors everywhere must expect to see drug misusers presenting for care and will need to be vigilant in looking for signs of drug misuse in their patients.

Historically, drug misuse has been thought of as an urban problem but this is no longer the case. As there is no easily discernible pattern of drug misuse nationally, so there is a wide range of drug misusers.

Young people are increasingly using a wide range of drugs and alcohol at a younger age and the age of initiation into drug use appears to have lowered.[3] There is growing use amongst girls, and polydrug use has become more common as a pattern of misuse.The unclear boundary between so-called 'recreational' drug taking, and drug misuse requiring treatment, highlights the complexity and challenge of the task facing clinicians and services. The typical drug misuser does not exist. Each is an individual with his or her own set of problems.

2. Morbidity and mortality

Misusers of some types of drugs are at an increased risk of death compared with their non-drug misusing counterparts. A long-term follow-up of heroin addicts showed they had a mortality risk nearly twelve times greater than the general population.[4] Another study of injecting drug misusers showed that they were twenty-two times more likely to die than their non-injecting peers.[5] Recent research in the UK has shown that from 1985–1995 there was a marked increase in drug-related deaths amongst young people, aged 15–19 years.[6] Mortality from self-poisoning with opiates has increased over ninefold in the past two decades.[7] The high morbidity and mortality rates make it particularly important that drug misusers are in contact with treatment services.

3. Rights and responsibilities

In addition, a doctor must guard against personal prejudice colouring clinical attitude and practice. The General Medical Council has stated:

> *"It is . . . unethical for a doctor to withhold treatment from any patient on the basis of a moral judgement that the patient's activities or lifestyle might have contributed to the condition for which treatment was being sought. Unethical behaviour of this kind may raise the question of serious professional misconduct."*

All individuals are entitled to the same standard and range of treatments, as set out in these Guidelines. Health Authorities, Primary Care Groups and future Primary Care Trusts in England and Wales, Health Boards in Northern Ireland and Scotland, and Local Health Care Cooperatives in Scotland, all have a duty to provide treatment for drug misusers. All GPs treating individuals for drug misuse have a right to support from their Health Authority or relevant primary care organisation.

4. The changing organisation of primary care

At the time of publication of these Guidelines, the organisation of primary care is undergoing considerable change. The basic tenet of an independent practitioner, working alone or in partnerships, from purpose-built or modified premises, is still in operation. However, the introduction of Primary Care Groups and their equivalents, together with joint working within and outside the profession, and the formation of Primary Care Trusts, will undoubtedly affect the delivery and organisation of primary (and secondary) care. New initiatives such as the introduction of salaried options for GPs in England (Primary Care Act pilots), Section 36 funding (Section 37 in Scotland), Local Development Schemes, nurse prescribing, Health Action Zones (there are none in Scotland), and GP commissioning pilots mean that new ways are available to deliver services to patients.

5. The new policy agenda

Two publications provide a framework for current drug treatment policy in England. Separate strategies exist in Scotland and Wales, which adhere to the same basic principles.

a) The Effectiveness Review (1996)[8]

The Task Force to Review Services for Drug Misusers recommended that all drug misusers need to have access to primary care through normal registration with a GP and that GPs are well placed to identify and offer advice to drug misusers who may not be in touch with specialist agencies. The Review identified a dual role for GPs in the treatment of drug misuse: the provision of general medical services and the provision of care and treatment for drug misuse, including the identification

of drug misuse; where appropriate, referral to specialist drug services; promoting harm minimisation; and undertaking shared care with a service specialising in the treatment of drug misuse. The Review recommended that the provision of shared care, with appropriate support for GPs, should be available as widely as possible.

b) Tackling Drugs to Build a Better Britain (1998)[9]

The new Drugs Strategy, 'Tackling Drugs to Build a Better Britain', identifies treatment as one of its four key elements, and recognises that there is growing evidence that treatment works.

The strategy aims to:

> *"enable people with drug problems to overcome them and to live healthy and crime-free lives."*

This means ensuring that:

> *". . . all problem drug misusers - irrespective of age, gender, race and drug of choice - have proper access to support from appropriate services - including primary care . . . "*

Activity which springs from the strategy:

> *". . . will ensure that prescription of substitute medications in particular and the dispensing of clinical services in general are in line with forthcoming Department of Health Clinical Guidelines."*

6. The generalist, specialised generalist and specialist

These Guidelines recognise that the management and treatment of drug misusers present medical practitioners with particular challenges. The range and complexity of treatment and rehabilitation produces the need for a continuum of medical practice, skills and experience, ranging from the contribution that can be made by all doctors to that made by specialised practitioners. The Guidelines also acknowledge the importance placed on treating drug misuse in a primary care setting, which is often seen as less stigmatising than specialised agencies. Involving GPs in the care of drug misuse and expansion of shared care is not seen as an alternative to the current role of the specialist services. Some drug misusers will continue to need specialist support which it would be unreasonable to expect a GP to provide in general practice. GPs should, however, be sufficiently skilled to identify a problem drug misuser, who is consulting them for other, perhaps related problems. This is likely to require a programme of training for GPs.

For the purpose of these Guidelines, and in order to recognise the expansion of specialisation within a generalist setting, three levels of expertise are described: the generalist, the specialised generalist and the specialist. The terms 'specialist' and 'specialised generalist' are intended to be helpful and descriptive, they should not be considered as representing legal entities. It should be noted that these levels are not meant to be prescriptive, although many doctors will recognise their practice within them. They represent a continuum by which the development of shared care arrangements, training, provision of resources and Home Office licensing arrangements can be targeted. Whatever service a doctor is offering within this continuum, he/she must ensure they are trained to a competence commensurate with that activity. The three levels of care can apply to all doctors whether in the NHS or private practice, be they general practitioners, hospital specialists or doctors whose main expertise is in the area of drug misuse.

Level 1: the generalist
Generalists are medical practitioners who may be involved in the treatment of drug misuse, although this is not their main area of work. They should be able to demonstrate relevant competence to underpin their practice and care for a number of drug misusers, usually on a shared care basis. Services to be provided would be expected to include the assessment of drug misusers and, where appropriate, the prescribing of substitute medication.

All these services would normally be carried out with the provision of support from a shared care scheme or following the advice from a more suitably experienced medical practitioner (specialist or specialised generalist). Practitioners would be encouraged to enter into a locally agreed treatment scheme or guideline to ensure consistent standards and integrated care.

Such doctors would undergo regular training and have knowledge of prescribing issues and options, approaches to the development and understanding of dependence, policy issues and the management of drug treatment.

Level 2: the specialised generalist
A specialised generalist is a practitioner whose work is essentially generic or, if a specialist, is not primarily concerned with drug misuse treatment, but who has a special interest in treating drug misusers. Such practitioners would have expertise and competence to provide assessment of most cases with complex needs.

Examples of a specialised generalist would be a general practitioner or a prison medical officer who deals with large numbers of drug misusers in their practice and who, with other professionals and agencies, provides many of the services that are necessary. Their drug misuse practice would possibly involve prescription of specialised drug regimens. Additionally, they can potentially act as an expert resource in shared care arrangements for general practitioners and professional staff operating at Level 1.

Such doctors would be required to undergo appropriate training to enable them to maintain this level of competence.

Level 3: the specialist
A specialist is a practitioner who provides expertise, training and competence in drug misuse treatment as their main clinical activity. Such a practitioner works in a specialist multidisciplinary team, can carry out assessment of any case with complex needs and provide a full range of treatments and access to rehabilitation options.

Most specialists would normally (but not always) be a consultant psychiatrist who holds a Certificate of Completion of Specialist Training (CCST) in psychiatry, and is therefore able to provide expertise, training and competence in drug misuse treatment as their main clinical activity. This data would be held on the specialist register of the General Medical Council. Such doctors would be required to maintain their level of specialist competence by

attending appropriate training events

Their practice would probably involve prescription of injectable and other specialised forms of prescribing, which will require appropriate Home Office licences. They can act as an expert resource in shared care arrangements for other practitioners and professional staff.

Specialists in addiction would hold a higher qualification with a CCST in psychiatry, and would be required to maintain their level of specialist competence by attending appropriate training events.

7. Evidence-based approach to care

In a substantial proportion of patients, drug misuse tends to improve with time and age,[10] particularly when specific treatment and rehabilitation techniques are used. There is also increasing evidence that treatment (medical and social) is effective in maintaining the health of the individual and promoting the process of recovery. Studies of self-recovery by drug users have shown that access to formal welfare supports, together with encouragement from friends, partners, children, parents and other significant individuals, is commonly involved in the pathway out of addiction.[11] Treatment studies do not support the view that a drug user has to reach 'rock-bottom' before being motivated to change. Harm minimisation refers to the reduction of various forms of harm related to drug misuse, including health, social, legal and financial problems, until the drug user is ready and able to come off drugs. A harm minimisation approach improves the public health and social environment by:

a) Reducing the risk of infectious diseases and other medical and social harm

There is good evidence that harm minimisation approaches have had considerable success in reducing the rate of Human Immunodeficiency Virus (HIV) among injectors in the drug misusing population.[12]

b) Reducing drug-related deaths

Drug-related deaths can be reduced by:

i. engaging and retaining dependent drug misusers in treatment;
ii. improving individuals' knowledge of both the risks of overdose, and methods of avoiding overdose.

It is likely that a reduction in diversion of prescribed medicine onto the illegal market would also avoid some drug-related deaths.

c) Reducing criminal activity

Many drug misusers support their drug taking with significant criminal activity, which is both costly and damaging to the individual and wider society. Evidence shows that conventional drug misuse treatment in the UK significantly reduces criminal activity.[13]

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