Newsletter - *December 2016*

Revolution and counter-revolution: the state of substance misuse treatment in the UK

Aldous Huxley - that fine author and "drug misuser" - once said: *"That men do not learn very much from the lessons of history is the most important of all the lessons from history."* And so in addressing what I think the future of drug treatment might look like, I will start with some brief reflections on where we came from, because there-in lie lessons that it seems we have yet to learn.

Throughout my five years of undergraduate training four decades ago, I never received a single lecture on chemical dependency – sadly that seems to be still true for many medical schools to this day. Addiction treatment in the 1970s was in the hands of a handful of psychiatrists scattered over the UK, who had enormous waiting lists as a consequence. If someone seeking addiction treatment was lucky enough to survive the wait to see one, "treatment" was almost universally time limited and abstinence focused – and if you relapsed, well, it was your fault, you had had your chance after all.

The 1980s saw the emergence of the HIV (and HCV) epidemics and by the end of that decade the National Treatment Outcome Research Study (NTORS) had produced its earth shattering statement that if you "spend £1 on treatment, that saves £3 elsewhere"... and the treatment they evaluated was predominantly opioid substitution treatment (OST) maintenance prescribing. All of a sudden politicians became concerned with harm reduction treatment provision, and come 2001, the National Treatment Agency for Substance Misuse (NTA) was created to oversee the creation and quality monitoring of treatment services, and to harmonise what was at the time a "postcode lottery". The services created were initially delivered through NHS community psychiatric services as GPs were still actively discouraged from involving themselves in addiction treatment. But by the mid-1990s the annual RCGP conference on managing drug and alcohol problems in primary care had already started, and was subsequently followed by the creation of the RCGP Certificate in the Management of Drug Misuse and a tidal wave of primary care involvement followed after that.

What followed over the ensuing decade can only be described as a revolution – 200,000 heroin users in treatment annually, 11,000 GPs completing the RCGP Certificate and getting involved in community treatment, and access to treatment becoming almost immediate at most points in the country. Premature deaths were being averted, disease transmission reduced, crimes and imprisonments fell and families stayed together. However the vast gains of so much treatment came at considerable cost, and by the middle of the "Noughties" competitive tendering by commissioners led to more efficient Third Sector companies being handed a greater and greater proportion of community treatment, hitherto delivered by the NHS.

The 2010 Coalition government saw a seismic shift in political bias toward abstinence-oriented treatment, the Health and Social Care Act of 2012 saw the disbanding of the NTA, and the funding of drug treatment delegated to local authorities. And soon after that followed austerity, savage cuts in local authority budgets, and most recently "Brexit".

So, in getting to where we are today, drug treatment over the past few decades in the UK went from a tiny number of time-limited abstinence-oriented specialist services of varying quality and quantity, through a boom of effective service delivery across the majority of the UK; with addiction medicine legitimised, mainstreamed into primary care, and treatment demonstrated to be both effective and cost effective.

But almost as quickly as this revolution happened, a ***counter-revolution*** is already well under way:

- **Erosion of specialism**: Addiction as a specialism is being extinguished; the failure of education mechanisms to adapt to the new landscape of treatment provision has indirectly led to less than half the number of Specialist Registrars training in addiction medicine today than there were just a few years ago – where will tomorrow's research and experts come from? Where will the Mental Health Trusts get expertise from for all their general psychiatry patients with co-morbid addictive problems?

- The politically arbitrary prejudice that favours **abstinence**: We need to be honest here – whilst we were complacently congratulating ourselves for all of the harm that maintenance prescribing was undoubtedly reducing, it did come at the cost of ambition for the patient to regain his or her independence. There is no doubt that the misnamed "recovery agenda" has encouraged more well-resourced and resilient people to leave treatment and gain independence sooner than they would have done without the leverage. But idealistic zeal needs to be tempered because there is a spectrum of "recovery capital" and the recovery trajectory of many will be slow, and fragile.

- **Funding cuts**: Despite the overwhelming evidence of addiction treatment cost-effectiveness from numerous Returns on Social Investment studies which confirm that at the very least it pays for itself, there is a Russian Roulette of commissioning out there. Every commissioning cycle is an empirical experiment in cost cutting – how cheap can we go before the sky falls in? No one knows – but the bear pit of competitive tendering compels all involved to put hope before expectation. And with competing calls on County Halls' diminishing budgets from children that need safeguarding, frail elderly who need care and even holes in the road that need to be filled, drug addiction treatment is a soft target for the cuts.

- And the **recommissioning cycles** cause widespread disillusionment and chaos – it is utterly extraordinary that the complex care of hundreds - or sometimes thousands of vulnerable people - can be just torn up overnight as offices and phone numbers change, staff melt away, thousands of potentially life-threatening CD prescriptions taken from one computer system and put on another, and, vitally, the critical therapeutic relationships between patient and worker disrupted on a grand scale – and all this is possible because of some arcane European regulation which was designed to obtain best value for County Halls' stationery supplies, or waste collections – but not for complex medical services. That major disasters have thus far been averted does credit to all involved, but that doesn't make it right.

Now, with drug related deaths at an all-time high, alcohol consumption at an all-time high, and child safeguarding and sexual abuse awareness also at an all-time high, it might be assumed that addiction services would be *further* invested in – but no, they could not be under more threat; indeed all the lessons that we have learned and all of the treatment gains over recent decades could be reversed – the country (well, England and Wales anyway) seems hell-bent on returning to a landscape of almost no specialists and time limited abstinence-oriented services according to local whim.

So is this cyclical, and are we are at the bottom of a cycle? Or is this more linear and headed we know not where? Will an upswing of investment depend on another catastrophe like AIDS – some new BBV, or contagion from drug injectors to the wider population to create panic and proper funding? Or a new drug epidemic, as we might be beginning to see of Fentanyl? Or a novel psychoactive substance that catches fire and leads to social disorder and crime?

Or are we simply going to bottom out at a level of funding that reflects the wider population's disinterest and prejudice about the worth of treating "drug addicts"? What must happen in my view is:

- Reverse some of the harms of the Health and Social Care Act. There must be **joint commissioning** of addiction services between Clinical Commissioning Groups and Local Authorities - or put them back into the NHS – it is bonkers to dislocate cause from effect: CCGs pick up all of the costs of addiction in A&E departments, liver units etc.– so they should have an investment in treating the cause of the problem.

- Argue for **minimum standards and funding** in treatment services – the postcode lottery is unacceptable anyway, but when left to the whims of local authorities and subject to far more prejudice than any other branch of medicine, it must be protected. We wouldn't tolerate such arbitrary funding of cancer services, so why should it be acceptable in addiction services?

- It is not too late (but it nearly is) to compel RCPsych and Health Education England to overcome their inertia and work with the Third Sector to safeguard the **training** of the future specialist... we must argue for mandatory funding of training in all commissions to continue the training of doctors, nurses and psychologists in addiction medicine, as well as the competencies of generic staff in quasi-medical roles.

- Stop the nonsense of **pointless recommissioning** – of course taxpayers' money should be spent well and funders should have the right to get rid of bad and/or inefficient services …but recommissioning has become a habit; even high performing services are being dismantled and good services being disrupted. Recommissioning needs to justify its very considerable costs. Because it:
    - demoralises staff – the best ones leave
    - guarantees far worse performance for 18 months
    - costs a lot of money
    - rips up therapeutic relationships

Services need evolution not revolution... and if this really is a European piece of legislation, maybe Brexit might help!

There is one thing that has happened over the past 40 years which I do not believe will be reversed, which is the invaluable involvement of general practice: GPs are the experts in chronic relapsing conditions; addiction ravages families, they are the experts in family medicine. And as addiction stems from damage to mental, social and physical health, so GPs are trained to address these same three dimensions of health. It is exactly right that general practice should take a major part in community treatment and every year our annual conference renews my faith that despite all of the pressures on primary care, there remain a lot of very good people at the heart of addiction treatment.

People who use drugs fascinate us because they pose unique challenges: Where most of our patients need our advice and medical skills, drug users need less advice and more listening, less medical knowledge and more caring. Where most of our patients have problems that we fix with drugs, for them, the drugs *are* the problem. When most of our patients come to us for our expertise, with drug using patients, *they* are the experts: they use a language we don't understand, doses of drugs that terrify us, and come from lives that most of us will have little comprehension of. And when most of our patients are terrified of dying, most drug users seem terrified of living.

Written by Gordon R Morse for SMMGP. *The views expressed by the author of this article are his personal ones and do not necessarily represent those of any other individual or organisation.*

SMMGP Clinical Update

The highlights of this month's Clinical Update are:

- Respiratory health screening for opiate misusers in a specialist community clinic: a mixed-methods pilot study.
- A screening study to determine the prevalence of airway disease in heroin smokers.
- Severe and fatal pharmaceutical poisoning in young children in the UK.
- ''You can never work with addictions in isolation'': Addressing intimate partner violence perpetration by men in substance misuse treatment.
- Medical professionals' perspectives on prescribed and over-the-counter medicines containing codeine: a cross-sectional study.

Euan Lawson – who has been writing our popular Clinical Updates for a long time - is standing down with this December 2016 update. We wish to express our sincere thanks to Euan for sharing his passion and expertise with us over the years, and we wish him well in his future endeavours. Do you think you could write the SMMGP Clinical Update? If so, see the job advert on our website:

http://www.smmgp.org.uk/html/jobads/job187.php

Respiratory health screening for opiate misusers in a specialist community clinic: a mixed-methods pilot study, with integrated staff and service user feedback. *Mitchell CA, Pitt A, Hulin J, et al. BMJ Open 2016;6:e012823*

This paper was based in a single community substance misuse clinic in England. They recruited 36 participants and documented the respiratory health of participants using spirometry, a health-related quality of life questionnaire, the asthma control test, and other asthma and chronic obstructive airways disease (COPD) questionnaires.

Out of 36 participants, 34 reported that they had smoked heroin. They had eight participants who were diagnosed with asthma and scored 13 on the asthma control test (suggesting poorly controlled asthma). There were a further 28 participants who did not have any respiratory diagnosis and out of these 79% scored under 18 on the Lung Function Questionnaire which suggests symptoms associated with the development of COPD. Spirometry showed that 14% of the participants had FEV1/FVC ratios that were consistent with obstructive airways disease. There was positive feedback from service users and staff about the respiratory health screening programme.

A screening study to determine the prevalence of airway disease in heroin smokers. *Lewis-Burke N, Vlies B, Wooding O, L Davies & Walker PP. COPD: Journal of Chronic Obstructive Pulmonary Disease 2016;13:3, 333-338*

This was a UK-based study where they aimed to determine the COPD prevalence in two local community drug services. They recruited 129 subjects and 107 were heroin smokers. They collected basic demographic details, smoking history information, and details of symptoms including MRC dyspnoea scores. They also completed a COPD assessment tool and performed spirometry.

The result showed that 30 heroin smokers were identified as having COPD - giving an overall prevalence in this sample of 28%. Breathlessness and wheeze were more common in subjects with COPD but symptoms were common in all heroin smokers. They also noted that MRC dyspnoea scores were higher in those with COPD and health status was lower. Only four of the subjects (11%) had previously been diagnosed with COPD and only 16 (53%) had received any inhaled medication. The asthma prevalence was very high at 33% and, like the people with COPD, they were similarly and significantly undertreated.

Commentary: It is crucial to remember that if somebody has any symptoms at all then further evaluation and management is *normal clinical practice* and doesn't need to be justified in the same way as a screening process. Just because their care has been appalling doesn't now make it screening. That's important because there is a risk that one might look at these studies and be uncertain about whether to do such measures as spirometry and assessment of respiratory health. They absolutely should be going on.

And note the finding in the Lewis-Burke study that symptoms were common in heroin smokers. We can have a debate about whether we should screen those who are asymptomatic but, for those in current clinical practice, don't delay. Get a handheld spirometer, ask the questions and start finding these people and having these conversations to manage their health.

Severe and fatal pharmaceutical poisoning in young children in the UK. *Anderson M, Hawkins L, Eddleston M, Thompson JP, Vale JA, Thomas SH. Arch Dis Child 2016, May 16.*

This study was an analysis of national data sets that contained information relating to severe and fatal poisoning in children in the UK. They found that between 2001 and 2013 there were 28 children aged under four years who died due to accidental poisoning as a result of a pharmaceutical product in England and Wales. Methadone was the responsible drug in 16 (57%) cases. They also found that a further 201 children aged four years and under were admitted to the paediatric intensive care unit with pharmaceutical poisoning between 2002 and 2012. In these cases the

responsible drug was found in just 115 children and the most common drugs were benzodiazepines (22/115, 19%) and methadone (20/115, 17%).

Commentary: This paper in the Archives of Disease in Childhood is not specifically related to substance misuse but it is the findings that are so pertinent. Like any research paper the language tends to be neutral but referring to registered deaths as 'cases' can't gloss over the highly uncomfortable finding in this paper that 16 children died as a consequence of methadone poisoning. And that methadone will almost certainly (though the paper doesn't have this level of detail) have been prescribed for people as part of opioid substitution therapy. Each of these deaths is an appalling tragedy.

We provide safe boxes in our services and all the services that I've worked in always have provided these boxes. This is the absolute minimum we should be doing but I also think it is important that we don't simply pay lip service to this, that we make it an active part of our consultations with people who are prescribed OST and have these drugs at home. We need to take every opportunity to warn people and to highlight, again and again, the devastating consequences to children of any ingestion at all of substances such as methadone. Resolve now to do more in each and every consultation.

''You can never work with addictions in isolation'': Addressing intimate partner violence perpetration by men in substance misuse treatment. *Radcliffe P, Gilchrist G. Int J Drug Policy 2016 Oct;36:130-140*

This paper reported on a discourse analysis of drugs and alcohol policy documents over the period 1998-2015 that examined how English drug and alcohol policy has addressed intimate partner violence (IPV) among substance misusers. They also completed interviews with 20 stakeholders and analysed these interviews thematically.

Their results showed that the way in which policy "frames" IPV perpetration among drug and alcohol misuse has implications for how that service provision will then occur. They noted that in recent years IPV has been given a raised profile due to its implications in child safeguarding. The authors draw attention to how the ACMD produced the Hidden Harm report in 2003 which drew attention to the estimated 250,000-350,000 children of drug misusing parents and the risks to which they were exposed. The concern then was about the risk of children witnessing intimate partner violence and this seemed to mark one of the first occasions when substance misuse, child abuse and neglect were drawn together.

The in-depth telephone interviews involved five national policymakers and 15 practitioners in the substance misuse sectors in London and south-east England. The overall results suggested that practitioners were not particularly knowledgeable about IPV perpetration amongst substance misusers. Overall, the identification of IPV perpetration was generally reported to be opportunistic. Even in areas where there is a MARAC (multi agency risk assessment conference) there were often occasions when victims were slow to be referred.

More obviously, it was clear there were very few examples of perpetrator programs that the treatment providers could use to get help for perpetrators and that practitioners only had a very vague understanding of the possibility of finding routes to help perpetrators.

Commentary: This is a detailed paper and the conclusions are not always straightforward. Most importantly for me, it challenged my views on those who perpetrate the violence. For example, the report offers views on Responsible Disinhibition Theory – one that it is often used as a post hoc justification or 'excuse' that covers up individual responsibility for violence that, arguably, would take place anyway. It is clear that male power and control is a central driver for IPV perpetration. I'm inclined to think back to all the men with whom I've had consultations who were guilty of intimate partner violence. And, yet, I've barely raised it, hardly talked about it. We tend to reserve our consultations for those who are victims, not the aggressors. I'm not alone in this and the paper was clear that there simply do not seem to be services for perpetrators.

Clearly IPV perpetration has a complex set of factors when we deal with populations who are vulnerable, socially disadvantaged and who may well themselves have been abused in the past or are still abused now. There was an inherent paradox uncovered in the paper with some staff who perceived they did not always have the skills necessary to ask questions about IPV perpetration but, on the other hand, the treatment aspirations of people who enter services often include the desire to improve their relationships.

One practitioner put it thus: "you can never work with addictions in isolation". If you don't feel confident in managing perpetrators of IPV then perhaps this is an area, as suggested by NICE in their 2014 guidelines for domestic abuse, that you should be seeking to develop for yourself and your organisation.

Medical professionals' perspectives on prescribed and over-the-counter medicines containing codeine: a cross-sectional study. *Foley M, Carney T, Rich E, et al. BMJ Open 2016:6:e011725*

This study was a cross-sectional design using a questionnaire to ask 300 prescribing professionals working in primary care settings about their perspective on prescribed codeine use, their ability to identify dependence, and the options for treatment in the UK.

The participants indicated that they regularly reviewed patients who were prescribed codeine, understood the risk of dependence and recognised the potential for codeine to be used recreationally. However, over half of the participants felt that the patients were unaware of the potential adverse health consequences of using high doses of combination codeine medications. They also noted that a quarter of the participants had found patients resented being asked about medicines containing codeine.

There were 40% of participants who thought it was difficult to identify problematic use of codeine unless they were informed by the patient and they did not feel confident in identifying codeine dependence. And, less than 45% of the participants agreed that codeine dependency could be managed effectively in general practice. The most popular method of managing was a slow gradual withdrawal of the codeine-based products with a strong emphasis on education and counselling options.

Commentary: This was the first study which has examined medical professionals' perceptions of medicines containing codeine across UK. One of the things I noted from the demographic details was that just under 30% of the professionals interviewed had had specialist training in substance misuse. That's woeful. Overall, most of the people interviewed were general practitioners (79%) but they did also interview some independent prescribers and specialists in family medicine. No pain specialists responded to the invitation to participate in the research. The lack of specialist training in substance misuse indicates there is still a significant gap between education and practitioners.

Managing opioid misuse and dependence is a huge challenge. I'd argue that despite the views of many people that it can't be managed in general practice, the problem is that it can't be managed *anywhere* just yet. No one has the resources and there is little in the way of existing systems.

Services need to be developed that will address the wider medical concerns in those with dependence to prescribed opioids. General practice is well placed to manage the holistic needs of this group but, as ever, it will need resources and those involved will need to develop their skills. That's quite a challenge when so many other problems are competing for time and money.

SMMGP is part of the Opioid Painkiller Dependence Alliance, for more information about the aims of the Alliance, see www.opda.org.uk