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The College

New models of services for drug misusers

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This joint conference was held in the salubrious surroundings of the Royal Institute of British Architects in Portland Place. The front of the building has a pair of sculpted figures depicting the spirit of man and woman as the creative forces of architecture. On this day they might have depicted the creative but unlikely double act of the Royal College of Psychiatrists and the Department of Health who organised the conference as an overview to the development of district level drug services to make a comprehensive health care service available to drug users. The services are at present patchily distributed. In the past few years there has been a rapid expansion in drug services although there has been a dearth of psychiatrists actively involved with them. The advent of HIV and AIDS has added a note of urgency to the need for a co-ordinated effective response to this major public health problem.

The hall was packed with over 200 psychiatrists when the conference was opened by Sir Donald Acheson, Chief Medical Officer, Department of Health, who commended the College for their recognition that psychiatrists have a major and necessary role to play in the response to drug problems in the HIV era, in drawing up requirements for specialist training in this field, and in providing guidance on the development of a district service for drug misusers. The number of HIV positive drug users in the UK continues to increase and the great majority of these people will develop AIDS. The Government has given high priority to funding an expansion in the drug services after the 1982 Advisory Council on the Misuse of Drugs (ACMD) report on Treatment and Rehabilitation. The ACMD reports on AIDS and Drug Misuse (1986 & 1989) drew attention to the need for services to expand and diversify. Services now need to bring people into contact with help and to provide education, prevention and treatment. The infected drug-using population is the largest source of potential transmission to the general heterosexual population and are the major source for vertical transmission to the children of infected mothers.

There are now 100 needle exchange schemes in operation in the UK in an attempt to reduce the spread of HIV infection through needle sharing. There is a pressing need for greater liaison with genitourinary clinics, antenatal clinics and other parts of the voluntary and statutory services that come into contact with people who are HIV positive.

Two general psychiatrists then described how they actually provided local services for drug users as part of their general psychiatric services.

Dr Jeffrey Marks, a general psychiatrist from Cheltenham, told how his general psychiatric training had left him totally unprepared to deal with the small unexpected number of drug users in his district. He dealt with this problem as part of his general psychiatric load for many years until 1984 when he took advantage of the Central Funding Initiative to start the Gloucestershire Drug Project and subsequently expanded this in 1986. He argued that the most important thing in setting up his service was that having already attempted to respond to his local problem he was ready to apply for funding when it became available.

Dr Philip Thomas outlined the services for a disadvantaged inner city community in the Moss Side of Manchester. He focused on the role of the general psychiatrist in the Community Drug and Alcohol Team (CDAT). In his view, one of the key roles for the general psychiatrist was to support general practitioners in their work with problem drug users. This could be done through a combination of informal clinical contacts and more formalised teaching sessions. In this way only a minority of problem drug users needed to be referred to the specialist regional drug services. This service works with limited inpatient facilities. The psychiatrist spends one session per week with the CDAT, supplemented by sessions from a senior registrar and sees the more difficult patients and those requiring special psychiatric assessment.

Michael Smith, Community Psychiatric Nurse and Co-ordinator of the Trafford Community Drug

Team (CDT) described the operation of a CDT. They had started with the aim of providing short term out-patient detoxification with oral methadone but had shifted in the past two years to longer term prescribing. Their main aim was to reduce the risk of HIV infection and transmission. Their consultant psychiatrist input was two sessions per week during which time he would see ten people and prescribes for 100. In view of their prescribing policy they have had difficulty involving local GPs and have employed a clinical assistant to try to involve more of them. Nobody in the audience questioned the role of the psychiatrist in this team but there was a gasp at the mention of his weekly prescribing rate.

The role of the GP as a non-specialist managing drug misuse was then discussed by Roy Robertson, a GP who has been practising in Edinburgh for ten years. He described how the patients in his practice had been flooded with heroin in the early 1980s. This unfortunately occurred along with the spread of Hepatitis B and then the spread of HIV. In his view, a key role for the GP is to provide primary health care with general preventive health education giving advice on harm reduction to prevent the spread of HIV. The GP can also play a vital role in giving family planning advice and can involve the whole family by providing support to tackle a difficult problem over a long period of time. His average annual consultation rate for IV drug users was 45 visits in HIV negative people and 59 visits or more in HIV positive individuals. This compares with an average patient consultation rate of three to four per year before they initiated drug use.

There was a rapid increase in HIV infection rates in 1983 and many of his patients are now becoming symptomatic with ARC or AIDS. Half of the drug users are married or cohabiting and 52% have children (total 201 children). Up to 30% of them have been abstinent for more than two years. The main aim for ongoing injectors has been to reduce the risk of contracting HIV. There has been a reduction in needle sharing practices with 40% never sharing but 26% continue to share on an occasional basis. Heterosexual transmission has increased and he was able to identify two patients where transmission had occurred from an intravenous drug user to a heterosexual non drug user and from that patient to another heterosexual non drug user. This was a graphic clinical example of the predicted future heterosexual spread of HIV.

In contrast to Dr Robertson's practice, Dr Martin, a GP from Bedfordshire, spoke from the floor describing his practice which has 40 intravenous drug users, none of whom are HIV positive. He prescribes injectable methadone to some of them. He stated that his main aim in this liberal prescribing policy was to prevent them from contracting HIV. Recently three of his patients had stopped drugs completely. Dr Martin Mitcheson from Bristol questioned the resource implications of ethically distributing drugs and supporting the staff in this field. He wondered what would have happened if every district had been as prepared as Cheltenham and Manchester to apply for money from the Central Funding Initiative.

In summing up the morning's discussion, Dr Jim Birley, President, The Royal College of Psychiatrists, was struck by how different the problems appeared to be in different areas suggesting that careful ecological investigations should be performed in order to tailor the service to the specific problems of each district.

The afternoon session covered the issue of regional services and national training in substance misuse. Dr Philip Fleming, Director, Wessex Regional Drug Dependency Service, described how his service is designed as a tertiary referral service but provides direct service to some districts that have no local service. In his view, other regional roles were the planning and development of district services and the organising of regional conferences to provide liaison and information exchange and training. Another key role for regional services was to bring together the statutory and non-statutory service and to advocate for the continuing development of services on every level. A speaker from the floor then questioned whether districts were taking money allocated for drug services and putting them into other parts of their service and asked what role the region should have in monitoring this. Dr Dorothy Black, Senior Medical Officer, Department of Health, said it was the role of the Regional Drug Advisory Committee to audit the allocation of funding.

Dr John Strang, Consultant Psychiatrist at the Drug Dependency Unit, The Bethlem Royal and Maudsley Hospital, considered the training issues. In the last few years there has been a large expansion of drug services with funding for services in every district. But the expansion in training for psychiatrists has not kept pace with the service expansion. Despite the large demand it is still very difficult to obtain psychiatric input to drug services due to the lack of trained staff. This was hardly the picture of a nation and profession reacting appropriately to a major drug and HIV problem. There is a need for 100 to 200 general psychiatric posts with a special responsibility for local drug services as well as substantially full-time posts for 30 to 40 specialists or regional drug addiction units. Every single higher psychiatric training scheme should provide adequate training in drug and alcohol problems and there should be active promotion of drug training options. Many people who work in the drug field had drifted into it quite like drug addicts in that they started dabbling and before they knew it they were hooked. The system should be geared to hook the half motivated. Short term urgent action is required in the face of the HIV crisis, to

pump prime the system over the next two to three years to maximise existing training potential. This training initiative should be time limited and should aim to achieve excellent training in a minimum period of time. This has been done in old age and forensic psychiatry. There is also a need for a training course for consultant psychiatrists who are now being asked to deal with problem drug users. In his view the present training is threadbare. In ten years time the question will be asked did the psychiatric profession provide the input and leadership that was required of it. The answer so far would be no!

Dr Gerry Stimson, a sociologist from Goldsmith's College, provided an overview of a service moving through a key period of crisis. The drug services he said had been forced by the HIV and AIDS problem to reassess their aims and objectives. They were looking for new ways to work with clients. He stated that prevention and penal deterrence have had a dismal impact on the prevalence of drug use. It is unrealistic to expect fewer people to start or more people to stop drug use. In the longitudinal studies we could expect 40% to be abstinent at ten years but in the AIDS era we cannot wait this long. Adopting a public health model there are up to 75,000 intravenous drug users at risk from HIV infection in the UK. Each one that becomes infected will cost approximately £30,000 to treat from infection to death. The assumption of the new model was that injectors were able, willing and motivated to change their injecting practices. A flexible user friendly service was needed to mobilise this change.

In the UK, 97% of people attending a needle exchange scheme knew that HIV could be transmitted by sharing. Of those attending, two-thirds were not receiving any other form of help at that time and one-third had never had help. Studies had shown a slight but significant reduction in needle sharing among attenders. But the key issue remains how to draw in the high risk intravenous drug users who continue to share and are particularly likely to contract and transmit HIV.

A contributor from the floor expressed dismay that psychiatrists were now being asked to respond to drug misuse and not drug prevention and that the psychiatric profession was giving away the moral high ground in a panic over AIDS. He felt that the provision of needles would result in more general use and more harm. He said that treatment was being replaced by doctrine and dogma and that psychiatrists should not give their moral blessing to such procedures. Dr Stimson said that syringe exchange schemes could have a potential negative effect and that assessment must be done on what is likely to happen in each local situation. The best indicator probably was the prevalence of injecting drug use. Studies in Amsterdam had not demonstrated an increased prevalence of intravenous drug use despite the liberal supplies of injecting equipment. Dr Stimson emphasised that the urgency and magnitude of response demanded by the advent of AIDS was such that we needed to think about ways to institute massive cultural change and encourage the growth of self-help organisations. Change could not be doctor driven but needed every sector of society to be involved.

The conference was wound up by Professor Grahame-Smith, Chairman, Advisory Council on the Misuse of Drugs. He endorsed the view that both specialist and generic services must seek to promote behaviour change away from risk-laden activities but expressed disappointment with the degree of change in Dr Stimson's studies.

Although some disparate views were expressed about approaches to drug users there was broad agreement that the psychiatric profession currently faces a challenge if it is to mobilise in response to the greatest public health problem of the latter part of this century. Dr Robertson's presentation on the Edinburgh epidemic demonstrates the need for a comprehensive range of services. Psychiatrists must not be the hiatus in the response to the HIV/AIDS epidemic.