

Chapter 11 – The role of healthcare professionals

11.1 Introduction

There are three levels at which doctors are involved in responding to illicit drugs. All doctors in clinical practice will encounter patients whose health is affected by use of psychoactive drugs. The basic competence required of all practitioners is the ability to recognise when drug use is contributing to health risks. This is achieved by history taking and examination, provision of appropriate advice, diagnosis of drug-related harm, and prescribing safely in a way that minimises the contribution of prescribed drugs to drug-related harm.

Some doctors, particularly GPs and psychiatrists, will have greater involvement, requiring additional competence in treating drug dependence, in managing withdrawal and relapse prevention and in maintenance prescribing. The specific competencies required are discussed in more detail in a recent report from the Royal College of Psychiatrists and Royal College of General Practitioners, *Delivering quality care for drug and alcohol users: the roles and competencies of doctors. A guide for commissioners, providers and clinicians*.¹

Many doctors involved in public health, and in specialist management, will also have a further role in advocating policies to minimise drug-related harm in the community. Medical practitioners' knowledge and experience of the biological, psychological and social factors predisposing to illicit drug use, and of the direct and secondary health harms of illicit drug use, have an important contribution to the development of prevention and treatment programmes.¹

This chapter reviews the current situation in the UK and the competencies required of doctors to fulfil the responsibilities associated with these levels of involvement in responding to illicit drug use.

11.2 Current trends in the UK

As noted in **Chapter 2**, current use of illicit drugs has been declining in the UK since the 1990s, but this is not reflected in a long-term decline in problem drug use, drug-related deaths, recorded drug law offences or the number of people in/expenditure on drug treatment. These trends should inform medical professionals' response to illicit drug use in the UK.

The following list summarises the data related to drug use, offences and treatment presented in various parts of this report.

- It has been estimated that in 2009-2010, 35.9 per cent of 16 to 59 year olds in the UK had used drugs in their lifetime (ever), while 8.7 per cent had used drugs in the last year (recent use), and 5.0 per cent had used drugs in the last month (current use) (see **Section 2.1**).
- Current drug use in adults aged 16 to 59 years in England and Wales was reported to be 6.7 per cent in 1996, and fell to 5.2 per cent in 2011-2012 (see **Section 2.2**).
- This has largely been driven by a decrease in cannabis use. Over this time period, opiate and ecstasy use has remained relatively stable, amphetamine and hallucinogen use has declined slowly, and use of any cocaine has increased slightly (see **Section 2.2**).
- A survey of nearly 1,500 new UK prisoners in 2005-2006 found lifetime use of heroin, crack cocaine, cocaine powder, amphetamines or cannabis was reported by 79 per cent of prisoners, with approximately one-third having used heroin or crack cocaine during the year before custody (see **Section 10.2**).
- Rates of first initiation of use of drugs in prison are also high. In a 1997 survey, over a quarter of the men who had used heroin reported first initiating use in prison (see **Section 10.2**).
- The number of problem drug users aged 15 to 64 years in the UK has increased from 357,160 (9.26 per 1,000 population) in 2006 to a peak of 404,884 (10.10 per 1,000 population) in 2009, an increase of 9.07 per cent. This has since declined to 379,262 people (9.31 per 1,000 population), and represents approximately 10 per cent of all UK drug users (see **Section 2.2**).
- There were 1,930 (3.1 per 100,000 population) drug-related deaths in the UK in 2010, an increase of 67.5 per cent from 1996, although there are year-on-year fluctuations (see **Section 3.3**).
- The rate of drug-related deaths in 2010 was highest in the 35-39 years age group and 79.4 per cent of the deaths were men and most continue to be related to use of opioid drugs (see **Section 3.3**).
- The data from 2010 show a reduction in drug-related deaths for all age groups except the oldest (60 plus years), suggesting there is an ageing cohort effect (see **Section 3.3**).

- From 2005-2006 to 2010-2011, recorded drug law offences in the UK increased by 19.7 per cent from 255,670 in 2005-2006 to 270,045 in 2010-2011. Of the offences in 2009, 15.7 per cent were for trafficking and 83.8 per cent for possession (see **Section 3.4**).
- In 1994, around 67,000 people were counted as being in treatment, rising by 26.9 per cent to 85,000 in 1998-1999 and a further 129.9 per cent to 195,400 by 2006-2007, giving an overall rise from 1994 to 2006-2007 of 191.6 per cent (see **Section 5.10**).
- There is a positive correlation between the prevalence of problematic drug users aged 15 to 64 years and deprivation. Hospital admission rates for drug-specific conditions for both male and female individuals have shown a strong positive association with deprivation (see **Section 4.4**).
- The most recent data available indicate that there are around 5,800 NHS hospital admissions for drug-related mental health and behavioural disorders each year in England, and over 11,500 admissions for drug poisoning (see **Section 3.5**).
- The budget for drug treatment interventions in the criminal justice system in England and Wales was over £330 million in 2006-2007 and spending on drug treatment in prisons increased from £7 million in 1997-1998 to £80 million in 2007-2008 (see **Section 5.10**).
- Expenditure on the UK's drug strategy is around £1.2 billion per annum, of which £300-400 million is on enforcement, with most of the rest spent on treatment. It is estimated that at least as much again is spent each year dealing with drug-related offences in the criminal justice system and prisons, while the wider social and economic costs of drug-related crime are estimated at around £16 billion a year in England and Wales (see **Section 6.4**).
- The economic and social costs of Class A drug use (cocaine, crack cocaine, ecstasy, heroin, methadone, LSD and psilocybin (magic mushrooms)) in 2003-2004 in England and Wales were estimated to be £15.4 billion, equating to £44,231 per year per problematic drug user (see **Section 3.5**). The costs of drug-related deaths were estimated to be £923 million.

11.3 Issues arising from these trends

In the general population in the UK, around 10 per cent of adults have ever used drugs and a little over half this number are current users. Of these, only around 10 per cent are problematic drug users (see **Glossary**). The level of use of opioid drugs has remained relatively unchanged over the last 15 years and most problematic drug use and drug-related deaths are associated with opiate use. Use of opioid drugs is an important area to target.

These population figures do not reflect the findings in socially deprived groups and those who are in prison, where rates of problematic drug use and treatment are many times higher. The problem of illicit drug use in the UK requires a multifaceted approach that tackles social deprivation and inequality, alongside dealing with the health consequences of drug use.

11.4 Basic medical competence

Doctors have a responsibility to treat all their patients. Many patients who use illicit drugs come from the most marginalised sectors of society, and present with distinct and complex medical and social issues. By the time they present for treatment, they are likely to be socially marginalised or in prison. Their presenting complaints can be either directly or indirectly related to their drug use, but often mean that each patient requires a high level of care and attention. These patients are likely to be difficult to treat, as a result of feeling they have little to lose. It is essential that they are offered treatment in a non-judgemental way that includes aspects to support their social reintegration. As set out by the GMC in *Good Medical Practice*:²

'You must not refuse or delay treatment because you believe that a patient's actions have contributed to their condition. You must treat your patients with respect whatever their life choices and beliefs. You must not unfairly discriminate against them by allowing your personal views [including your views about a patient's lifestyle] to adversely affect your professional relationship with them or the treatment you provide or arrange.'

11.4.1 Maintain an awareness of the non-medical facets of drug use

Drug problems (and even more so, alcohol problems) are common, and although they often bring individuals into contact with the health system, they are frequently overlooked or ignored (see **Section 9.1**).³⁻⁶ Failure to address underlying factors contributing to ill health is suboptimal care. Maintaining an awareness of the non-medical facets of drug use, taking a drug use history, and providing personalised health advice regarding drug use, are the three basic responsibilities of medical practitioners.

Patients are often defensive, and are not always open or truthful about drug use (see **Section 8.2.1**). History taking is more effective if undertaken in a neutral, non-judgemental manner, framing drug use as a medical rather than an ethical issue.

11.4.2 Undertake opportunistic brief interventions

Brief interventions are intended to prevent or reduce drug use, through getting patients to think differently about drug use and possible treatment. These interventions aim to increase the motivation of drug users to change their behaviour. The spectrum of advice ranges from stopping drug use to using drugs in ways that are less risky (see **Section 9.2**). Interventions that attend to the immediate priorities of people who inject drugs, such as advice on vein care for injecting drug users, have the potential to engage individuals and set them on a path towards treatment and social reintegration.

11.4.3 Prescribe safely

Doctors have the power to exert an immediate and powerful influence on drug use through their prescribing practices. Prescription regimes are the control structures that enable psychoactive substances to be consumed for approved medical purposes while preventing their use for non-approved purposes.⁷ As indicated in **Section 9.3**, the non-medical use of, and dependence on, prescribed drugs is a rapidly growing public health concern. Prescribing safely in a way that minimises the contribution of prescribed drugs to drug-related harm is thus crucial. It also raises many issues for health professionals. Prescribing doctors accept absolute clinical and legal responsibility for their prescribing decisions,⁸ and must exercise particular caution when prescribing to patients with a history of, or predisposition to, illicit drug use and dependence. Medications used for the relief of pain, including opioid drugs and certain sedatives, have the potential to trigger a relapse in recovering addicts, reactivating the original addiction or precipitating an addiction to a previously unknown substance.⁹ Avoiding stimulating or exacerbating existing addictive disorders requires a rigorous assessment of the patient. The GMC's *Good practice in prescribing medicines* states that doctors must:

*'Be in possession of, or take, an adequate history from the patient, including: any previous adverse reactions to medicines; current medical conditions; and concurrent or recent use of medicines, including non-prescription medicines.'*¹⁰

This can be particularly challenging to those in primary care, who operate under immense time constraints. It is important to refer to the *British National Formulary* as appropriate, to inform prescribing behaviour. When prescribing for a patient, doctors should also consider whether ongoing monitoring and supervision are required, such as:

*'...further consultations; blood tests or other investigations; processes for adjusting the dosage of medicines, changing medicines and issuing repeat prescriptions.'*¹⁰

Supervision is particularly important when OST is prescribed. This tends to be provided by the dispensing pharmacist. Good communication between the prescriber and the pharmacist is essential: the DH recommends that prescribers liaise with the pharmacist when first prescribing controlled drugs for a patient, to ensure that the pharmacist is:

- introduced to the new patient
- part of a suitable local scheme and can provide supervised consumption of the prescribed medicine if requested by the prescriber
- able to confirm that the prescriber and prescription are genuine.¹¹

Ongoing communication can also help to alert the prescriber to any concerns the pharmacist may have about the patient's health and wellbeing, as well as their treatment compliance.¹¹ Sharing information in this way should be conducted in line with locally determined confidentiality agreements.

Other interventions aimed at minimising the contribution of prescribed drugs to drug-related harm focus on preventing the diversion of psychoactive substances from the medical system into the illicit marketplace. Control strategies adopted in the UK include restricting the type and quantity of medicines that can be sold over the counter, enforcing prescription guidelines (including requirements for detailed record keeping), restricting the settings in which the drug in question can be administered (eg hospitals, specialist clinics) and withdrawing a drug from the legal market.⁷ There are also limitations placed on the number of doctors who have the authority to prescribe particular drugs. Under the Misuse of Drugs (Supply to Addicts) Regulations 1997, doctors must hold a general licence that is issued by their relevant health department in order to prescribe, administer or supply diamorphine, dipipanone or cocaine in the treatment of drug addiction.¹²

The control strategies outlined above do not eliminate non-medical use of psychoactive drugs, since they can be sourced through other channels, including theft, prescription forgery/alteration, and via the internet.^{13,14} In addition, doctors are increasingly advised to be vigilant for '*doctor shoppers*' – individuals visiting numerous physicians to obtain multiple prescriptions, often for the same drug.¹⁴

11.4.4 Lobbying medical schools for improved training on drugs of dependence in the medical curriculum

Those who use drugs will inevitably be seen by doctors. For this reason, it is vital that, as a part of the undergraduate medical curriculum, medical students have the core skills and knowledge to identify and understand the complexities of drug use.

Medical students receive very limited training in issues of drug use and dependence at an undergraduate level. Surveys of medical schools' curricula from the mid-1980s onwards have all indicated that the education of medical students about drug use is typically patchy and uncoordinated.¹⁵⁻¹⁹ Although medical schools currently include some teaching and learning about drug use, this topic is often taught within psychiatry or public health,¹⁹ with the result that drug use is often seen by students as a specialised, or peripheral subject, rather than the common pervasive problem that it is in reality.¹⁹ It is essential that medical schools and medical students are encouraged to place a greater emphasis on the care of those who use drugs.

11.5 Managing patients with drug-related health problems

There is wide variation in the extent to which primary care physicians become engaged in managing illicit drug users.²⁰ As identified in **Chapter 9**, this may be because of a sense of pessimism about being able to effectively treat drug-using patients, avoidance of antagonising patients and, possibly, reluctance to work with stigmatised patients.

A 2005 joint report from the Royal College of Psychiatrists and Royal College of General Practitioners estimated there were around 130 consultants in addiction psychiatry in the UK.²¹ In 2005, a random sample of GPs in England and Wales, found that over half of those surveyed provided treatment to users of opioid drugs.²⁰ The findings published suggest that during the time of the survey, between 41,000 and 62,000 users of opioid drugs were receiving GP treatment.²⁰ The previous survey of opioid treatment in general practice settings, which took place in the mid-1980s, found only 19 per cent of GPs were treating patients who used opioid drugs.^{22,23} Over two-thirds (61%) of these patients were approaching their GP for help with withdrawal, rehabilitation, or both, indicating a demand by users of opioid drugs for help with initiating abstinence from drugs.²² The findings suggest that not all drug users are receiving treatment in general practice settings, especially given recent estimates of there being over 260,000 users of opioid drugs in the UK.²⁴

Both GPs and addiction psychiatrists provide services such as drug-related information and advice, screening, brief psychosocial interventions and harm-reduction interventions.^{1,21,25} Community-based drug assessment, coordinated care planned treatment and drug specialist liaison can be conducted or arranged by GPs, but more complex patients are best managed by practitioners with specialist

experience and knowledge.^{1,21,25} Inpatient specialised drug-treatment settings are usually headed by consultant psychiatrists, although this is often with the support of supervised junior medical staff.^{1,21,25}

In 2007, NICE, in association with the National Treatment Association for Substance Misuse and the four UK health departments, published *Drug misuse and dependence: UK guidelines on clinical management*.¹¹ These guidelines, commonly known as 'The orange guidelines', provide guidance to all clinicians on the treatment of drug use and dependence, at all levels of interaction with drug users.

While 'The orange guidelines' have no specific statutory status, the standards and quality of care set out in the guidelines are taken into account in any formal assessment of clinical performance in this area. There are also separate defined legal obligations in relation to the prescribing of controlled drugs published in both 'The orange guidelines'¹¹ and the *British National Formulary*.^{26,27} Clinicians should act in accordance with these. They include ensuring that prescribers act within Home Office licensing arrangements for the prescription of restricted medications such as diamorphine for the management of illicit drug use.

Chapter 8 discusses in detail the logistics of managing opioid-dependent patients using OST. **Chapter 9** details how patients may present to either primary or secondary care in states of acute withdrawal. In these instances, healthcare professionals have a responsibility to manage the clinical emergency, stabilise the individual, and slow the rate of change so that their physiology can adapt and the distressing and uncomfortable symptoms of withdrawal are reduced.

Doctors are also responsible for addressing the individual healthcare needs of patients who use drugs. As noted in **Chapters 8-10**, blood-borne viruses, such as hepatitis B and C as well as HIV, are common among drug users, especially those who use drugs intravenously. In addition to harm-reduction measures, an essential part of managing this aspect of drug use should include offering immunisation against hepatitis to patients who want it.

Harm reduction focuses on the safe use of drugs, and includes provision of clean injecting equipment and education on how to use drugs safely. There have been arguments over the ethics of harm reduction,²⁸ and there is a perception among some healthcare professionals that harm-reduction techniques may lead to an increase in drug use by individuals who would otherwise be deterred. Those who support harm reduction assert that, rather than encouraging drug use, it offers a realistic way to help keep drug users safe, as well as respecting their choice and individual freedoms.²⁸ **Chapters 5 and 6** also highlight some of the public health benefits for society at large that arise from harm-reduction and prevention methods.

The most serious potential harms associated with illicit drug use are overdose and death. **Chapter 8** details how this is particularly true for use of opioid drugs. Maintaining patients in high-quality treatment is the most effective preventative measure for these risks. Clinicians can also prevent the risk of drug overdose by providing education to drug users on the risks of overdose, the dangers of combining drugs, and how to respond effectively if overdose takes place. In the event of an overdose at a healthcare facility, all services working with drug users should have an emergency protocol in place that covers the management of drug overdoses (see **Section 8.6.1**).¹¹

Chapter 4 explores the high comorbidity between drug use and mental health problems; this comorbidity is associated with complex factors that often impact negatively on treatment.¹¹ To ensure the needs of the individual patient are met, medical professionals should undertake a comprehensive assessment, produce an individual care plan and ensure appropriate care pathways are in place.

11.6 Promoting public health policies and practices to reduce drug-related harm

Doctors can play an essential role in refocusing debate and influencing global drug policy, so that it is based on public health principles, and results in better health outcomes for all illicit drug users.

The drug debate, both nationally and internationally, has been influenced by emotions and ideologies, when, in reality, a subject as important as the use of drugs should be based on rationality and scientific evidence. What is needed is a solid and pragmatic approach to drug use, which is informed by the best available evidence and puts health at the centre of any decisions.

As highlighted in **Chapter 6**, there are strong views in this debate. There is a widely held view within the drugs field that the prohibition of production and supply of certain drugs has not only failed to deliver its intended goals, but has been counterproductive.²⁹ This is especially so with regard to health.³⁰ Stringent user-level enforcement does not necessarily reduce levels of drug use,^{31,32} as many other factors are also involved (see **Chapter 6**). It may be that a new approach is required. Before this can occur, rational debate is needed to inform an understanding of what is, and what may not be, working with the current approach to drug use, and options for change. As emphasised by the 2012 UKDPC report, *A fresh approach to drugs*,³³ such deliberations must be independent, evidence based, and centred on the health and wellbeing of all. An essential component of this will be ensuring that all relevant parties, including health professionals, and the organisations that represent them, are consulted, so that a clear, unbiased and effective approach is achieved.

These conclusions are echoed by the 2012 Home Affairs Select Committee report, *Drugs: breaking the cycle*, which is based on a year-long inquiry into national and international aspects of drug use.³⁴ It focuses on the need to 'break the cycle' of drug addiction and concludes that '*...there is now, more than ever, a case for a fundamental review of all UK drugs policy in an increasingly globalised world*'. The report recommends establishment of a Royal Commission – to be set up immediately and report in 2015 – to '*consider the best ways of reducing the harm caused by drugs*' and '*instigate a public debate on all of the alternatives to the current drug policy*'. It presents strong arguments for focusing on problem drug users, with interventions that are 'tailored to the individual', and calls for the setting of measurable targets that are based on evidence of what works. Recognising the lack of reliable data in some areas, it further recommends allocation of ring-fenced funding to drugs policy research.

11.7 Conclusion

Medical practitioners responding to drug dependence need a frame of reference that helps them to respond empathically and effectively to challenging patients. Dependent drug users have the same rights to medical treatment as any other individuals with a chronic disorder, and effective medical management is likely to include harm reduction, maintenance treatment and support to eventually abstain from drug use.

An effective drug policy must take account of the complex biological, psychological and social factors involved in illicit drug use and aim to distinguish the harms associated with drug use from the unintended adverse consequences of attempts to minimise drug use.

An effective policy that significantly reduces the harms associated with illicit drug use would have enormous benefit for individuals and generate large savings to society in terms of the cost of medical treatment and the financial and social costs of associated crime.

There is a widely held view within the drugs field that the current legal framework has failed to deliver its intended goals of reducing illicit drug use. There are strong views on both sides of this debate, but it should be informed by the best evidence. While it must be accepted that international consensus dictates that supply and possession of illicit drugs must remain a criminal offence, this framework deserves to be re-examined in a way that takes account of all the evidence available.

Doctors are ideally placed to play a key role in refocusing debate and influencing global drug policy, so that it is based on public health principles, and founded on rigorous scientific evidence.

Summary

- Medical training should provide graduates with basic knowledge about the social and personal factors increasing the risks of illicit drug use, the adverse health consequences of the illicit use of drugs, and the role of doctors in identifying drug-related harm and initiating intervention.
- Doctors should maintain an awareness of the non-medical facets of drug use, and exercise caution in prescribing drugs with the potential for non-medical use.
- Doctors should take a drug use history when indicated, undertake brief opportunistic interventions to reduce drug-related harm, and refer to specialist services as appropriate.
- Guidance on clinical management of drug use and dependence is provided by 'The orange guidelines', available to all clinicians.
- Doctors can play an essential role in refocusing debate and influencing global drug policy, so that it is based on public health principles, and results in better health outcomes for all illicit drug users.
- Doctors with knowledge and experience of helping patients affected by illicit drug use are ideally placed to engage in debate to promote a rational approach to drug policy that is evidence based and health oriented.

