

The Royal College of Psychiatrists

Memorandum of evidence to Home Affairs Committee Inquiry into Drugs

This submission has been prepared by Dr Owen Bowden-Jones, Chair of the Faculty of Addictions, Royal College of Psychiatrists.

1. Summary

1.1 The Royal College of Psychiatrists (RCPsych) is the leading medical authority on mental health in the United Kingdom and is the professional and educational organisation for doctors specialising in psychiatry.

1.2 The RCPsych Faculty of Addictions comprises medical doctors who have completed extensive training in psychiatry and addiction, and service users with lived experience of addiction and addiction services. It thus has expertise in all aspects of addiction, including individual brain mechanisms, behaviour, and its overall effect on the family, society and the economy. It has unique expertise in the management of addiction problems in complex cases, particularly co-morbid mental health problems.

1.3 The Faculty supports a holistic approach that considers how biological, psychological and social factors impact on a person's life and recovery journey.

1.4 We welcome the opportunity to submit evidence to this important Inquiry. Our evidence identifies 13 key points for consideration:

- i. Drug policy should be based on evidence of clinical effectiveness and value for money. Cost alone is an inadequate measure: cost-effectiveness requires study of effectiveness divided by cost.
- ii. There is strong national and international evidence for a range of cost-effective substance misuse treatments.
- iii. There remain significant gaps in the evidence base, particularly with respect to recovery interventions. These gaps need to be explored using rigorous research methods.
- iv. The Drug Strategy 2010 themes of reducing demand, restricting supply and building recovery should be broadened to include improving the public health and well-being of the individual, their family and their community. The role of Public Health England and

Health and Wellbeing Boards in its implementation needs to be fully considered.

- v. Patterns of drug use in the UK appear to be changing. Close attention should be paid to the increasing prevalence of new psychoactive substances and their potential harms.
- vi. High quality drug treatment requires an appropriately trained and qualified workforce. There are currently serious concerns about the loss of psychiatric addiction expertise from the treatment system and an urgent review is recommended of re-tendering processes to ensure commissioned services continue to meet the needs of all service users.
- vii. Drug policy needs strong leadership, particularly at a time of great change. This leadership, with particular expertise in substance misuse, should be embedded in Public Health England and in local Health and Wellbeing Boards.
- viii. It is important to protect drug treatment monies from being diverted into other services. There is currently no clear mechanism for preventing such disinvestment.
- ix. Drug and alcohol payment by results models are operating quite separately, with the potential for much confusion. It is also possible that in their current form they might fail the most vulnerable users.
- x. A change in individual treatment for a stable patient to a more challenging aspirational approach can be constructive but must be properly supported. There must also be safeguards to protect against unintended destabilisation.
- xi. Similarly, a change in policy to a more challenging aspirational approach can be constructive but must be properly supported. Good intentions alone are not enough: actual measurable benefits must be identified and tracked.
- xii. Gains from treatment are various and differ between individuals and over time. Movement to abstinence from the problem drug(s) is a typical early objective. This will often involve consideration of the individual relevance of alcohol and prescription drugs.
- xiii. Health gains and other benefits may sometimes be supported by medications. When this is constructive, they should be available and utilised, but their continuation over time should be regularly reviewed.

2. Evidence-based policy

2.1 We welcome the 2010 Drug Strategy, particularly its focus on building recovery.

2.2 Building recovery in communities is an opportunity for the treatment field to refocus on the personal aspirations of people with substance misuse problems.

2.3 Treatment and rehabilitation should be seen as a balance of reducing harm and accruing positives for individuals and their communities.

2.4 The Drug Strategy commitment to “using the evidence to drive the very best outcomes” rightly underpins the document.

2.5 Drug policy should be focused on interventions with strongest the evidence of clinical and cost effectiveness.

2.6 The College supports the Drug Strategy’s ambition to identify where the evidence is “too sparse or weak” and to tackle any “evidence gaps”.

2.7 There is now a very strong body of UK and international evidence supporting a range of drug treatments (including pharmacological and psychological treatments), and public health interventions. Authoritative NICE Technology Appraisals and Guidelines are available for several areas of substance misuse treatment.¹⁻⁶

2.8 Effective treatment has been shown to deliver a range of benefits for patients, families and communities including reduced illicit use, increased health and social functioning, reduced overdose, reduced transmission of blood-borne viruses, and reduced crime.

2.9 Additionally, there are widely available, well-accepted good practice guidelines for clinicians.⁷⁻⁹

2.10 NICE-approved Quality Standards are available for alcohol treatment and are being developed for drug treatment. These provide a very valuable benchmark.

2.11 Even treatments strongly supported by science will only be effective if delivered by a workforce skilled to provide them. There is considerable concern nationally about the loss of psychiatric addictions expertise from the drug field and the effect this will have on the quality of care. In some cases, cost savings are resulting in the commissioning of services with insufficient expertise to meet the needs of this often complex group of patients.

2.12 Of particular concern is the lack of robust evidence supporting the

recovery interventions described in the Drug Strategy when compared to the international research.¹⁰ In this context, the work of the Recovery Orientated Drug Treatment (RODT) working group, exploring the integration of current evidence-based treatments with recovery systems, is welcome.¹¹

2.13 Given the financial climate, there is concern about investment in treatments that have not yet been shown to be efficacious or cost-effective.

2.14 There is a significant risk that parts of the Drug Strategy are moving ahead, before the evidence has caught up. With this comes the danger of investment in interventions which may later be discovered to be ineffective, or worse, have unintended negative consequences for particularly vulnerable groups of people, for example those with more severe dependence on single/multiple drugs and those with co-existing psychiatric or physical health problems.

2.15 We recommend that in this context a clear framework is devised for developing the evidence base and that new interventions should be trial led, with clear outcomes and on a small scale, before they are rolled out more widely.

Criteria used by the Government to measure the efficacy of its drug policies

2.16 The current National Drug Treatment Monitoring System (NDTMS) is well established, with high levels of compliance from services.

We recommend that the NDTMS should continue and be further developed to better capture co-morbid mental illness and newer drugs.

2.17 Payment by results pilots have been established for alcohol and drugs recovery. This is an ambitious and complex initiative with little existing national or international evidence guiding this approach. Drug and alcohol payment by results models are operating quite separately, with the potential for much confusion.

2.18 We are also concerned that the proposed drug payments systems do not mirror the well established 'clustering' payment by results model used in mental health. The clustering payment by results system now has a developing evidence base in contrast to the drug recovery pilots.

2.19 While we support the Drug Policy's definition of recovery as "an individual, person-centred journey", we have concerns that the payment by results systems in their current form will fail to take account of the most vulnerable individuals, with the most severe and complex addictions, for whom the recovery journey will be most difficult. In particular, it would be counter-productive for patients to be encouraged prematurely to attempt

excessively challenging change pathways without proper prior consideration and planning of safety measures in the event of destabilisation.

2.20 We recommend that appropriate safeguards are built into the proposed payment by results systems to protect those with the most severe and complex problems.

3. Independence and Quality of Advice to Government

3.1 The main statutory source of independent advice to Government is the Advisory Council on the Misuse of Drugs. The College strongly supports the role of this body on scientific matters.

3.2 We also support the continued use of working groups to tackle complex clinical/ service delivery issues. A recent example is the Recovery Orientated Drug Treatment working group, exploring the integration of evidence-based prescribing treatments with recovery principles.

3.3 The Royal Medical Colleges and other professional bodies provide another source of independent and quality expert advice to Government.

3.4 Recently a 'quartet' of such organisations - the Royal College of Psychiatrists, the Royal College of General Practitioners, the Royal College of Nursing and the British Psychological Society - has come together to provide expertise on substance misuse issues to Government.

Such support to Government, which should include the perspective of service users, is to be encouraged.

4. Public Health

4.1 Public health is defined as "preventing disease, prolonging life and promoting health". This definition fits well with the ambition of drug policy.

4.2 There has been considerable success in the UK with respect to public health initiatives relating to substance misuse problems.

4.3 In particular, the use of needle exchange programmes to combat the spread of HIV/AIDS as well as other blood-borne viruses has resulted in some of the lowest transmission rates for HIV in Western Europe.

4.4 People with substance-misuse problems are particularly vulnerable to a range of health problems, including smoking.

4.5 The Royal College of Psychiatrists and the Royal College of Physicians will be producing a report in 2012 addressing 'Substance misuse and public

health'. This document will highlight the importance of public health in drugs policy.

4.6 We recommend that, in addition to the Drug Strategy's three broad themes of 'reducing demand, restricting supply and building recovery', a further specific theme should be included: 'improving public health and well-being of the individual, their family and the community.' We hope that this would encourage a more holistic and integrated approach to drug misuse and its impact, not only on users themselves but on their families and wider community. We know, for example, that substance misuse is a significant factor in many child protection cases.

The impact of the transfer of functions of the National Treatment Agency for Substance Misuse to Public Health England and how this will affect the provision of treatment

4.7 It has yet to be announced which functions of the National Treatment Agency are to be transferred to Public Health England.

4.8 It is essential that the drugs field continues to have strong political leadership with a national oversight of quality.

4.9 The current reorganisation of local and national structures poses a very real threat that the focus on drug policy will be lost.

4.10 We have a number of concerns about the transfer of local drug treatment budgets to the Public Health leads within Local Authorities.

4.11 There is a need to brief Public Health leads on the broader health needs and priorities of this population. This is particularly important, as Local Authorities will be assuming control for the budgets previously held by the Primary Care Trusts.

4.12 People with drug problems are a vulnerable and often disenfranchised group who suffer significant stigma. They are often less able to advocate for their needs when compared with other health groups.

4.13 In this context, it is particularly important to protect drug treatment monies from being diverted into other services. There is currently no clear mechanism for preventing disinvestment.

4.14 Having drug services only within the wider health managed by Local Authorities and not by clinical commissioning groups could be detrimental, as alcohol and drugs are so prevalent and overlap with some many other health issues. Health and Wellbeing Boards should ensure that drug and alcohol issues are a major focus of Joint Strategic Needs Assessments.

4.15 There is also concern that Local Authorities may insist on all drug and alcohol services being put forward for tender within their procurement policies. There is a major risk that this will significantly destabilise the entire system.

4.16 It is equally important that drugs services should not only consider opiates but also over-the-counter drugs, abuse of prescribed medications and all internet-sourced drugs. Many of those with drug problems also misuse or are dependent on alcohol, hence there must be clear co-ordination with all health commissioners and providers.

4.17 We recommend an urgent review of re-tendering processes to ensure that commissioned services are able to meet the needs of all service users, including those with complex use and co-morbidities such as mental health problems.

5. Novel Psychoactive substances

5.1 Discussion of this area is complicated by terminology. 'Legal highs' are by definition legally available, however some of the most frequently used (Mephedrone) and harmful (*Gamma*-Hydroxybutyric acid [GHB]/*Gamma*-Butyrolactone [GBL]) drugs in the UK, were once 'legal highs' but are now illegal.

5.2 One approach would be to adopt the term 'novel psychoactive substance' (NPS) used by the ACMD in its recent report.¹² NPSs remain easily available in the UK, typically via the Internet.

5.3 Their level of use and the degree to which they cause harm remains unclear due to the current reliance on self-reporting.^{13, 14} There are however reports from clinical services of significant harms associated with GHB/GBL, Ketamine and Mephedrone.

5.4 New NPSs are appearing on the European illicit market at an alarming rate, with little opportunity for assessment of risk.

5.5 The ACMD has proposed a temporary banning order, which could be applied to chemical classes. There is contradictory evidence on the effect of banning legal highs on subsequent levels of consumption. Further research is urgently needed.

5.6 Understanding the prevalence of the use of NPSs is essential but there must now also be a focus on their potential harms and how to treat those who use them.

5.7 There is significant evidence of changing drug use both in the UK and internationally. Of particular concern is the apparent rise in the use of club

drugs, over-the-counter medications, abuse of prescription medications and internet sourcing.

5.8 We recommend there is robust surveillance of these changes as well as the development and evaluation of psychosocial and prescribing treatments.

6. Poly-substance use

The relationship between drug and alcohol abuse

6.1 Poly-substance misuse is the norm for many. Some people who give up illicit drugs subsequently develop dependence on alcohol.

6.2 In this context it is important to have a highly skilled workforce able to comprehensively assess all potential substances of misuse, understand the complexities of managing polysubstance misuse and be alert to the risks of cross-addiction between different substances.

6.3 Poly-substance misuse presents a particular challenge for payment by results for drugs and alcohol recovery in that the identified outcomes are less likely to be achieved by the most complex cases and thus the most vulnerable individuals.

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References

1. NICE (2007) *Drug misuse: Methadone and Buprenorphine*. NICE technology appraisal 114. London: National Institute for Health and Clinical Excellence.
2. NICE (2007) *Naltrexone for the Management of Opioid Dependence*. NICE technology appraisal guidance 115. London: National Institute for Health and Clinical Excellence.
3. NICE (2007) *Drug Misuse: Psychosocial Interventions*. NICE clinical guideline 51. London: National Institute for Health and Clinical Excellence.
4. NICE (2007) *Drug misuse: Opioid detoxification*. NICE clinical guideline 52. London: National Institute for Health and Clinical Excellence.

5. NICE(2011) *Psychosis with coexisting substance misuse*. NICE clinical guideline 120. London: National Institute for Health and Clinical Excellence.
6. NICE (2009) *Needle and syringe programmes*. NICE Public Health guideline 18. London: National Institute for Health and Clinical Excellence.
7. Department of Health (England) and the devolved administrations (2007) *Drug Misuse and Dependence: UK Guidelines on Clinical Management*. London: Department of Health.
8. Royal College of Psychiatrists. *Substance misuse detainees in police custody. Guidelines for clinical management* (Fourth Edition). College Report 169 November 2011.
9. Evidence-based guidelines for the pharmacological management of substance misuse, addiction and comorbidity: recommendations from the *British Association for Psychopharmacology*. *Journal of Psychopharmacology* 18 (3), 2004; 293-335.
10. Strang et al. *Drug policy and the public good: evidence for effective interventions*. *Lancet* 2012; 379: 71-83.
11. Recovery Orientated Drug Treatment. Interim report of the expert working group. National Treatment Agency 2011.
12. Advisory Council on the Misuse of Drugs. *Consideration of the novel psychoactive substances*. Home Office, London, 2011.
13. Winstock et al. Mephedrone, new kid for the chop. *Addiction*. Jan; 106 (1): 154-61.
14. Drug Misuse declared: Findings from the 2010/11 British Crime Survey. Home Office, London, 2011.