Creating a new drug service in Edinburgh

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Abstract

After one year Edinburgh's Community Drug Problem Service has shown that if psychiatric services offer consultation and regular support for drug users many general practitioners will share the care of such patients and prescribe for them, under contract conditions, whether the key worker is a community psychiatric nurse or a drug worker from a voluntary agency. This seems to apply whether the prescribing is part of a "harm reduction" strategy over a long period or whether it is a short period of methadone substitution treatment.

Given the 50% prevalence of HIV infection among drug users in the Edinburgh area and the fact that only half of them have been tested for seropositivity, the health and care of this demanding group of young people with a chaotic lifestyle are better shared among primary care, community based drug workers, and specialist community drugs team than treated exclusively by a centralised hospital drug dependency unit. As the progression to AIDS is predictable in a larger proportion of drug users who are positive for HIV, there is an even greater need for coordinated care between specialists and community agencies in the near future.

Introduction

Edinburgh, with a population of nearly half a million, has the highest known rate of HIV infection in Britain among its intravenous drug users, of whom half are thought to be infected.[1] An estimated 3000 drug users are known to services in Edinburgh and the surrounding areas.[2] Until 1986 centrally funded voluntary drug agencies offered a range of support services, counselling, and drop in centres for drug users. In addition, J R Robertson and his partners, practising in the Muirhouse district of Edinburgh, managed a disproportionately large number of drug users on their list of patients,[3] and other Edinburgh practitioners shouldered more than their fair share of patients with drug problems.

The mental health unit at this hospital had no specialist drug clinics but offered outpatient and inpatient treatment to drug users through the general psychiatric services. In the five years before 1988, 538 drug users had been seen at the hospital, and double that number had been referred to a psychiatrist from the self poisoning unit, prison, and other agencies.

By 1986 at the infectious diseases unit at Edinburgh's City Hospital a screening and outpatient clinic had been started for those who were infected with HIV, three fifths of whom were or had been intravenous drug users. Methadone prescribing was one of the strategies used to manage drug users with HIV infection. Then many drug users who were negative for HIV began demanding drug treatment from the City Hospital, too. The chief medical officer of the Lothian Health Board recommended that only drug users infected with HIV should be prescribed methadone. The Advisory Committee on the Misuse of Drugs commented unfavourably on this.[4]

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Leading up to a psychiatric drug service

About 1986 the government encouraged setting up 15 experimental needle exchange schemes, and Edinburgh was chosen as one of the centres. At the time I was a consultant in community psychiatry in north Edinburgh, known to the voluntary drug agencies, and I offered to provide medical cover for the needle exchange clinic set up at Leith Hospital in 1987 and staffed by a community psychiatric nurse and local drug workers. A two hour clinic was held once a week which offered counselling, needles, syringes, condoms, and advice about sterilising equipment. By the end of the first year it was clear that this was an inadequate service. Most of the drug users were young (mean age 24·5 years), had little or no contact with their general practitioners, had a chaotic lifestyle using several drugs intravenously, and showed other high risk behaviours, including regular needle sharing and unprotected sex.[5] Half of the 120 needle exchange clients were tested for HIV and half of those were seropositive and lived in or around Leith, many in deprived social circumstances.

In 1988 my part time post was converted to that of a full time drug consultant, funded by money earmarked for AIDS. A medical secretary and 1·25 G grade community psychiatric nurses were appointed (three fourths of the second nurse's time was allocated to the Muirhouse surgery), and a further four nurses were appointed later as demand increased. A social worker offered a trial attachment, and this enhanced links with the area teams. No beds were allocated to the new post, but this hospital agreed to continue admitting one drug user at a time to each of four acute sector wards when inpatient detoxification was required.

The new service

The new service, the Community Drug Problem Service, was designed to complement existing services offered by general practitioners, voluntary agencies, the City Hospital, and the continuing needle exchange scheme.[6] Briefly, this was a specialist referral service for all drug users regardless of their HIV state, offering a "harm reduction" approach for continuing drug users to prevent HIV negative users from becoming seropositive and HIV positive users from infecting others and offering treatment to those who wished to come off drugs altogether.

The objectives were to make contact with the maximum number of intravenous drug users; reduce needle sharing, unsafe sexual behaviour, and injecting drug use; stabilise oral drug use and lifestyle; reduce criminal behaviour and drug intake; and ultimately to stop drug use altogether. In addition to needle exchange, counselling, and health education the

service offered the opportunity for methadone substitution treatment as maintenance treatment or as part of a gradual reduction programme. According to a recent review of methadone treatment in the United States, methadone is one of the most helpful means of reducing the risk of spreading HIV among drug users.[7]

A letter was sent to all general practitioners and drug agencies saying that, in common with policies in other psychiatric clinics, the general practitioner would be expected to prescribe the recommended medication weekly and local pharmacists would dispense daily. The staff team (psychiatrist, community psychiatric nurse, or voluntary drug worker, or all) would establish a provisional contract with the drug user, subject to the general practitioner's agreement, recommending a starting dose of methadone and the expected reduction schedule. The contract also listed the following conditions: the drug user must not demand extra drugs from the doctor over the negotiated amounts; sell the prescribed drug; continue to use a chaotic mixture of drugs, only the prescribed drug; fail to see the key worker weekly. In most cases regular urine analysis was included and a specimen was to be given during the interview.

A case conference would be called at the general practitioner's surgery when relevant—for example, if the patient was a mother with small children—before the contract terms were discussed. No contract was valid until the doctor had given consent. Doctors were encouraged to telephone the Community Drug Problem Service should they wish to query the recommendations, which they received by post with a detailed letter about the patient. Most general practitioners welcomed the weekly support, supervision, and monitoring of the patient's drug taking behaviour that the team offered in exchange for the burden of weekly prescribing, and they recognised the value of shared care.

Although referrals were made direct to the hospital, the key worker would see the patients in the community either at a local health clinic or in the local social work department. Most commonly, patients were followed up at home, which involved the extended family in counselling. The observations of the drug user's partner were often valuable: they sometimes needed support themselves and their joint relationship often benefited from the contract.

The table gives some details of the first year of the Community Drug Problem Service. A statistical analysis is being prepared.

Discussion

There were 221 referrals to the service in the first 12 months and 152 in the following six months, which suggests that general practitioners approved of the service. There were proportionately fewer referrals from Muirhouse because Dr J R Robertson and partners, helped by the community psychiatric nurse, managed their own patients who were drug users. Many drug users were referred from Leith, often after having attended the needle exchange scheme, but referrals came from all over Edinburgh. In general referral letters were comprehensive, expressed concern about the patient's welfare, and sought help with management strategies. Few doctors or drug users requested residential detoxification at the initial referral.

When referrals were made from voluntary drug projects the worker concerned was invited to attend the initial appointment and share in the management decisions. The male to female ratio of referrals was 4:1, unlike the projected prevalence ratios of 2:1 in the community.[3] This suggested that women drug users were less prepared to attend a statutory agency. Half the referrals in the first year were under age 25, and less than a tenth under 20. Most were polydrug users of 2-10 years' duration, injecting heroin in the past, buprenorphine, cyclizine, and temazepam currently, and supplementing these with dihydrocodeine and benzodiazepines. About half of the 221 referrals in the first year had been tested for HIV antibody state, a similar proportion to those attending the needle exchange scheme. The consistency of this finding suggests that there is serious undertesting in this high risk group. The statistics need to be examined to determine the distribution and characteristics of those who chose to be tested, usually before referral.

Testing was not a standard requirement for treatment by the Community Drug Problem Service. Among the 221 referrals, 146 (66%) patients attended for the first appointment, which was usually in the community. This attendance rate was no lower than for other psychiatric services and higher than expected for drug users. In the first half of the second year this improved: of 152 referrals, 111 (73%) attended.

Details of patients referred in first year to Community Drug Problem Service

	First year No (%)	Second year (first six months only) No (%)
No referred	221	152
Information from referral letter:		
Average age 25 years		
No tested for HIV 104: 72 men, 32 women		
No HIV positive 38: 27 men, 11 women		
No HIV negative 76: 55 men, 21 women		
No attended	146 (66)	111 (73)
Treatment offered (n=146):		
Methadone reduction programme	68 (47)	
Methadone maintenance	38 (26)	
Residential detoxification/rehabilitation	6 (4)	
Counselling and support	34 (23)	
No longer attending (n=53):		
Discharged back to general practitioner	6 (4) (three on maintenance treatment)	
Discharged to City Hospital	6 (4) (all HIV positive)	
Lost contact	32 (21) (25 counselling only)	
In prison	9 (6) (eight in methadone programme)	

Treatment offered

In the first year 106 (73%) patients were offered outpatient treatment with methadone on contract terms, with weekly support from the key worker and regular prescribing by the general practitioner. A tenth of the referring doctors refused to prescribe methadone, which left the drug user to choose inpatient detoxification, gradual withdrawal from street drugs with support from the drugs team, or transfer to another doctor who would prescribe methadone. The drug team took no part in such transfers but contacted the new general practitioner once the patient had transferred.

A recent survey of all Lothian general practitioners about drugs and AIDS (response rate 75%) showed that half have prescribed or would prescribe substitute drugs to drug users and just under half would not (G Bath, personal communication). This suggests that referrals to the Community Drug Problem Service were largely from the first group. An evaluation of general practitioner referral patterns and attitudes to prescribing in collaboration with the Community Drug Problem Service will be carried out.

Reduction programme

Of the 146 patients seen in the first year, 68 (47%) were prescribed methadone in a reduction programme (usually reducing by 2·5-5 mg a fortnight). The starting dose was loosely calculated from the Department of Health and Social Security guidelines of methadone equivalent to alleged street drug intake,[8] reduced slightly to take into account the predictability and purity of prescribed drugs, the 24 hour duration of

methadone, the exaggeration of an anxious drug user, and the Community Drug Problem Service's general but flexible policy of a maximum dose of 60 mg methadone. In practice most people started at about 30-40 mg.

Maintenance

The length of drug use, the frequency of high risk behaviour and the lack of motivation for a life free of drugs, or a series of failed attempts at withdrawal determined whether a maintenance period was offered. Past prescribing by psychiatric services and seropositivity for HIV also influenced the decision in favour of maintenance. Probably the most important factor, however, was the age of the drug user: those over 30 were more likely to be offered maintenance than those in their early 20s, for whom reduction seemed a better objective. No one under 18 was offered methadone. Only six people were persuaded to undergo residential detoxification or rehabilitation programmes, though this partly reflects the absence of specialist drug beds at this hospital, the unpopularity of admission to an acute psychiatrist ward, and ambivalence about rapid changes in behaviour by Edinburgh's young drug users.

Counselling and support only were offered to 34 (23%) because this was considered to be the best option, because the drug user was too unstable for contract conditions, or because the patient's general practitioner refused to prescribe substitute drugs.

No longer attending

Of the 53 patients no longer attending, six were discharged back to their general practitioner (three on long term maintenance treatment with methadone), and six, all of whom were positive for HIV, to the City Hospital for medical follow up. Nine patients were sent to prison during drug treatment, usually for offences committed before attending the service. Eight of these had been on maintenance treatment with methadone, which was not continued in prison. There was concern about their exposure to illicit drugs and shared needles in prison. Drug users who were released from prison consistently described continuing their drug intake in prison and had injection sites to confirm this. The remaining 32 failed to reattend or could not be traced at their home address. Notably, 25 of these had been offered counselling only, suggesting that methadone treatment increases the likelihood of continued contact with the Community Drug Problem Service. Time will tell whether such contact can produce long term benefits in harm reduction and drug use.

The future

Preliminary evidence from a pilot evaluation of substitution treatment with methadone in Edinburgh (J Chalmers, personal communication) indicates that the patients taking methadone for six months stabilised their drug intake and appreciably reduced high risk behaviour, injected less and reduced needle sharing, and had fewer drug related offences. Little change, however, seems to have occurred in the use of condoms, and the potential spread of the HIV virus to heterosexuals from this young, chaotic, and sexually active group of drug users continues to cause concern.

Further evaluation of behavioural change will be carried out when the new psychologist is in post. A semistructured interview on all patients referred to date has provided some data which are being processed, but in depth research is necessary. A walk in clinic will be opened at the Community Drug Problem Service. Selected drug users whose drug use and lifestyle are too chaotic for prescribed drugs will be given methadone on site. This will allow staff to monitor dosage more effectively by observing patients for at least the first three days of treatment.

Conclusions

In a city where the prevalence of HIV among drug users is alarmingly high it is difficult to justify the rigid non-prescribing policy adopted by some medical practitioners who await incontrovertible evidence that medical intervention can appreciably alter patterns of drug use and high risk behaviours. Embarking instead on an unproved but commonsense reduction approach of controlled substitution treatment with methadone and providing equipment and condoms would indicate a responsible attempt to maintain contact with drug users, try to alter their behaviour, and hopefully curb the spread of the potentially fatal HIV virus. It is debatable whether the Community Drug Problem Service should offer a centralised hospital prescribing policy for drug users whose general practitioners are not prepared to prescribe, while encouraging other general practitioners to continue shouldering their burden of drug users through shared care with the Community Drug Problem Service.

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ANY QUESTIONS

Are midtrimester miscarriages increasing?

Since women experiencing miscarriages, whether first or second trimester, are not always admitted to hospital and since gestational age at miscarriage is not included in routine data collection in any part of the United Kingdom, this question cannot be answered at national level. Aberdeen Maternity and Neonatal Data Bank,[1] however, contains detailed information on all pregnancy outcomes in a complete population over several decades and a special analysis shows no increase in the rate of midtrimester miscarriage.—MARION HALL, *consultant obstetrician and gynaecologist, Aberdeen*

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