

# SMMGP

Substance Misuse Management in General Practice

***Second National Conference on Managing Drug Users in General Practice***  
***'Embracing the Diversity' Friday 25 April 1997***

Don't forget, come and join the debate, make your voice heard and help to influence national policy. Details from Claire Manning, Conferences, RCGP, 14 Princes Gate, London SW7 1PU  
**0171.581.3232.**

**Report: 8th International Conference on the Reduction of Drug Related Harm:**

This year it returned to Europe and took place in Paris. It is the annual conference of 'The International Harm Reduction Association' which is concerned with the development of drug policies to reduce the harmful consequences of drug use. It promotes research and honest education about drugs, encourages drug policies based on harm reduction principles and is a voice for humane, pragmatic and effective policies in the global debate on drugs.

This year several of us working in and with general practice in Britain and many other countries presented papers at the above conference. We joined the great and the good and the invited speakers included the best in psychology and sociology, epidemiology, criminology, public health and research. The plenary sessions included harm reduction, harm minimisation, drug education, strategies for families and communities and the hidden health burden in different global areas. Many lessons could be learnt about all illicit drugs, women's specific problems, every variety of prescribing and most viral illnesses that can affect the drug user. Waking up in a cold sweat with the phrase 'shifting paradigms' became the norm. From theories to practicalities, from young people to long term users, from outreach to syringes exchanges, prisons to residential units, stimulants to benzodiazepines, the A to Z of drug use was covered in symposia, lectures and discussion. It would be foolish to attempt to summarise all the sessions, with over 1200 delegates world wide that had converged on the beauty of Paris and a full social programme including a wonderful Cuban salsa band!

It was great and important to see representatives from users groups from many countries. They presented, questioned and relaunched an international users group. Always seen as a diverse, non-representative group of people, their diversity was certainly no more than the diversity of GPs, both nationally and internationally! Their presentations were certainly never out of touch with the problems and many had an honesty that very few of the professionals could ever hope to achieve.

In many countries, it seems that there are moves to make general practice the backbone, main stay and chief provider of all that is good for drug use problems. There was vocal support and a strong sway for primary care as opposed to secondary psychiatric care as the only reasonable response to most global needs.

We, in the UK, may sometimes feel that we have so much to achieve in drug use problems. Compared to what is going on in North or South America, Australasia or the rest of Europe, I can guarantee that we should be counting ourselves lucky by way of resources and what we are able to achieve. If there is a gold standard for drug treatment problems, the UK certainly is the epicentre. Personally, I left with the feeling that if I had a drug problem myself, I would probably move to the Wirral in England!

**Stefan Janikiewicz, general practitioner and Wirral Drug Services**

(Details of next years conference in Brazil from HIT conferences, 8 Mathew Street, Liverpool L2 6RE.)

**HARM REDUCTION:** Sometimes we can forget that harm reduction policies came before HIV infection. There have been interventions aimed at reducing the harm associated with drug use, which have always existed alongside other more abstinence-orientated approaches in drug treatments. We only need to remember the beginning of the 'British System' in 1920s which was perhaps one of the first examples of methadone maintenance as an acceptable alternative to the sometimes, difficult aim of abstinence. Some GPs find maintenance difficult. Are we obstructing change? Aren't we meant 'to cure'? Are we supplying the illicit market? Others of us see it as the intervention most appropriate to general practice. With maintenance and other harm reduction strategies, such as needle exchanges and by promoting other methods of drug use such as chasing or smoking we can enable our patients to continue to use but more safely, until they feel ready and able to stop themselves.

**Injectables: Newsletter No:4:** We asked for comments here are extracts from two replies:

**1. Dr Petre Jones, GP East Ham, London:** Dr Martin presents a reasoned and logical argument for the provision of an injectable service in general practice. The principles which underpin his argument are exactly the same as for maintenance methadone, namely harm reduction and realism, and allowing patients to make choices and take responsibility. Interestingly the success rate Dr Martin quotes is similar to my own using oral methadone for those who will accept it. I have never prescribed injectables because of lack of experience, but I agree that this is a area that we may have to engage in. However, I can see 2 major hurdles to the progression of the debate. Firstly cost, injectable methadone is roughly twice the price of methadone mixture. For many purchasers funding existing services is becoming increasingly difficult and drug users tend to be given a low priority in health service provision. The second hurdle is the problem of private prescribers, (admittedly mainly a London problem). In the last year I have admitted 2 people on separate occasions to ITU with septicaemia following injecting large amounts of IV methadone and crushed dexamphetamine tablets. The spectre of this dangerous private prescribing will cast a shadow over the provision of responsible injectables services and make the moral argument harder to win. To overcome such misunderstandings we must make the distinctions between caring and ethical services, and those who have allowed money to blur the boundary between empowering the patient to deal with their problems and simply supplying potentially dangerous and addictive drugs for personal gain.

Unless these issues are debated we are unlikely to see injectable services develop.

**2. Clive Barrett, Drug specialist, Consultancy Liaison Addiction Service, London SE11:**...So are we returning to the 60's when GPs had less limits on what they could prescribe? Will we see the loosening of the legislation to allow GPs to prescribe Diamorphine and cocaine to drug users? I don't think so, but what should be considered the limit of good practice? There are many different views; the majority opinion at this moment of time is for GPs to keep to prescribing only oral formulations of methadone and leave the specialist services to manage the more complex cases. This is not dogma, just present accepted practice which can change over time, preferably in the light of research outcomes rather than prejudicial opinion.....From your own argument it would be pointless to prescribe methadone, in whatever formulation, if the patient prefers a different opiate, such as heroin. As you rightly say 'it is highly likely that they will sell the second substance prescribed by the doctor and buy the substance he or she wants', and many users would prefer ampoules for its higher street value.....My conclusion to your final point would be that prescribing is inappropriate until the patient is prepared to change their behaviour. Other interventions can be offered by the GP until that time, e.g. hep B testing and vaccination, general medical care, advice and information, even motivational interviewing!

If you have any contributions, suggestions or would like to join the mailing list for this newsletter, then contact us: Brian Whitehead and Chris Ford, SMMGP Newsletter, Brent & Harrow Health Authority, Grace House, Harrovia Business Village, Bessborough Road, Harrow HA1 3EX