Written evidence from NHS Substance Misuse Provider Alliance (NHS SMPA)

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Executive summary

The reported rise in drug related deaths has been of particular concern to the NHS Substance Misuse Provider Alliance (NHS SMPA). We therefore welcome the opportunity to respond to the Health and Social Care Committee Inquiry into Drugs Policy, and the focus on health.

This paper surveys the range of health harms associated with drug use and the failure of drug and wider services to work collaboratively to address the complex needs of frequent and long term drug users. The problematic use of alcohol is often associated with drug use and as a key element in service provision. Whilst the scope of this Inquiry does not specifically reference alcohol, this is a significant dependency that merits consideration in conjunction with this review.

We endorse a ‘whole system’ approach to prevention, early intervention and drug treatment, with drug agencies working creatively and cooperatively with physical, mental health, social care and criminal justice services to address health inequalities and premature deaths, and secure better health, well-being and inclusion by people using drugs. The paper offers a number of examples of effective, integrated care from our services and internationally.

Whilst maintaining the ambition to help people become free from drug dependence, we continue to value the role of high quality, personally tailored opioid substitution therapy (OST) in mitigating harm for long term heroin users.

We are also concerned that the committee addresses the ‘Quality Gap’ between evidence based and routine practice in services for people using drugs, with safeguarding of specialist, clinical expertise, increasing research capacity to learn from what we do, and quality standards in commissioning and review of drug services.

Based on our observations, we have set out five key recommendations for the committee to consider.

1. Introduction

1.1 About the NHS SMPA. Founded in 2016, we are an alliance of NHS drug and alcohol treatment providers. In collaboration with service users, carers and other organisations, we are committed to contributing positively to the development of quality and innovation in substance misuse services.
1.2 In developing this response, we have drawn on the observations, expertise and understanding of our members and people with ‘lived experience’ of using drugs, supported and working in our services.

2. Health and harms:

What is the extent of health harms resulting from drug use?

2.1 Drug use can affect the individual, those around them, and wider society. The health harms, side effects and adverse reactions are well documented for traditional drug use such as heroin, cannabis, amphetamines, cocaine and crack, and reflect the nature and purity of the drug, how it is used, the frequency and duration of use, and life circumstances. Health harms are starkly represented by the reported increased incidence of premature death amongst drug users. They encompass poor vein health, overdose and drug poisoning, blood borne viruses and bacterial infections especially among injectors, liver damage from undiagnosed or hepatitis C, lung damage from drugs and tobacco, cardiovascular disease, sexual risk taking and associated sexually transmitted infections, drug driving accidents, depression, anxiety, psychosis, troubled interpersonal relationships, self-harm and suicide. Drug users also have more tooth decay and periodontal disease than the general population, with further consequences for quality of life and general health.¹

2.3 Services are less well versed in the health harms associated with newer drugs, such as new psychoactive substances (NPS), chemsex, image and performance enhancing drugs and opioid based painkillers.

2.4 Many people using our services have co-occurring conditions and a health profile that is severely compromised through poly-drug use, smoking and drinking, mental health issues, multiple risk behaviours, and adverse personal and socio-economic circumstances. They are often unable to access the care they need from physical and mental health services, including dentistry.

2.5 The rise in drug related deaths has multiple and complex causes, but has been attributed significantly to an ageing cohort of increasingly ill and vulnerable heroin users and the failure of services to work cooperatively to address the multi-faceted health needs of people using drugs.²

3. Prevention and early intervention

What are the reasons for both the initial and the continued, sustained use of drugs? This refers to the wide spectrum of use, from high risk use to the normalisation of recreational use.

² Advisory Council on the Misuse of Drugs (ACMD) (2016) Reducing Opioid-Related Deaths in the UK
3.1 The people supported through our services cite different reasons for starting to take drugs: experimentation; ‘fitting in’ with particular groups; enhancing body image or performance; looking for a ‘buzz’ or intensifying feelings of pleasure; managing pain, stress, depression or anxiety, or the ‘empty space inside’. They recognise the impact of easy availability of drugs and decreasing costs, and belonging to a particular culture where drug taking is an accepted feature.

3.2 We are familiar with the developmental disadvantage and vulnerabilities conferred on some children and young people that can translate to later harmful use of drugs, alcohol and mental health problems. These include adverse childhood experiences, such as problem parental alcohol or drug use, family conflict, sexual, physical and emotional abuse, chaotic lifestyle, neglect or loss; looked-after status; co-existing behavioural disorders, emotional and attachment difficulties; failing school performance; social marginalisation, for instance, through school exclusion and becoming a young offender; and early sexual activity, smoking, drinking and drug use.

3.3 Personal circumstances that feature severe and multiple disadvantages for adults, experienced by people who are homeless, long term unemployed, involved with the criminal justice system, or faced with domestic violence and abuse, are likely to accompany continued drug and alcohol use and relapse from abstinence.

*How effective and evidence based are strategies for prevention and early intervention in managing and countering the drivers of use? This includes whether a whole-system approach is taken.*

3.4 Whilst the evidence base for drug prevention and early intervention is not well developed, there are some promising approaches that consider all aspects of users’ lives and are designed to avert progression from initial use to more harmful patterns of drug taking and dependency.

3.5 Strategies include:

- Increasing investment in the mental health of children and young people, and ensuring effective transition planning and pathways between child and adolescent mental health services and addiction services, for young people experiencing problems with mental health and drug use.

- Support to local schools to extend the educational curriculum to include risk taking, relationships, building resilience, decision making, experimentation and use of drugs and alcohol.³

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Public Health England’s initiative to develop targeted interventions to support parent’s recovery from problem alcohol drug use and the risk exposed to children.⁴

3.6 We think there are lessons to be learnt from Iceland in developing a ‘whole community’ approach to tackling drug use in 16-20 year olds.⁵ Further, that there is much more room for specialist addiction agencies to work creatively across health, social care and criminal justice services, to raise awareness of drug and alcohol use, recognise interdependencies between substance use and mental health, and help other practitioners to develop skills in Identification and Brief Advice Interventions and referral pathways.

3.7 The NEPTUNE I project illustrates how this can be done, with professionals and service users developing clinical guidance for screening, assessment and treatment of harm resulting from club drugs, and implementing these in settings where health complications are more likely to be presented in A&E, drug treatment services, GP practices and sexual health clinics.⁶

4. Treatment and harm reduction

*How effective and evidence based is treatment provision? This refers to both healthcare services and wider agencies, and the extent to which joined up care pathways operate*

4.1 As NHS services, we are able to provide high quality, patient focussed, evidence based, integrated treatment and care for people with complex needs associated with drug use, that is delivered by trained staff and clinicians with specialist expertise. In addition, we learn and innovate from what we do, within a clear framework of quality governance, assurance and accountability.

4.2 There is a strong evidence base for Opioid Substitution Treatment (OST) using methadone or buprenorphine to treat heroin dependence. The strength of OST has been in reducing the harm associated with heroin addiction, specifically in reducing overdose deaths, acquisitive crime and the risk of bacterial borne viruses, particularly in conjunction with availability of clean needles and syringes. Licensed prescription of injectable diamorphine (pharmaceutical heroin) to previously unresponsive chronic heroin addicts significantly lowers their use of street heroin.⁷

⁴ Public Health England Problem parental alcohol and drug use: A toolkit for local authorities
4.3 Use of Naloxene demonstrably saves lives. It inhibits the effects of an overdose long enough for the patient to be taken to hospital where they can be treated and observed until there is certainty that the opiates are out of the users system.

4.4 Psychosocial interventions that draw on sound explanatory models for addictive behaviour are effective when implemented through competency assessed training and outcomes focussed supervision for staff. Drug users with additional mental health needs also benefit from more intensive psychological therapies such as Cognitive Behaviour Therapy, EMDR, Dialectical Behaviour Therapy, and Mentalisation Based Therapy to address trauma, complex PTSD, and difficulties in emotional regulation and interpersonal relationships. In practice, drug users have limited access to these.

4.5 Specialist treatment agencies cannot tackle the health inequalities associated with drug use in isolation. However, real challenges exist in developing and maintaining care pathways across the wider system for physical, mental health and social care and criminal justice, including differing service priorities and restrictive access criteria.

*Is policy sufficiently geared towards treatment? This includes the extent to which health is prioritised, in the context of the Government’s criminal justice-led approach.*

4.6 There is ample scope to expand our understanding and definition of treatment goals and recovery for drug users and the breadth of physical and mental health outcomes intended.

4.7 Whilst maintaining the ambition to help people become free from drug dependence, it is important to be pragmatic about the prospects of long term heroin users completing drug treatment, and continue to invest in high quality opioid substitution therapy of optimal dosage and duration, and ensure that naloxone medication to reverse the effects of opioid overdose is available routinely.

4.8 A concerted, national drive is required to establish collaborative and joined up provision between specialist drug services, and wider physical, mental health and social care systems, to address health inequalities and premature death amongst people using drugs.

4.9 We believe that better outcomes for people with complex needs could be afforded though greater use of integrated and joint commissioning across local authorities, clinical commissioning groups and the criminal justice system, and the opportunities presented by the Long Term NHS Plan (2019), with closer alignment of substance misuse and mental health services, attention to alcohol, smoking and physical health care, sustainable transformation partnerships and integrated care trusts.

4.10 In addition, drug policy needs to address the emerging ‘Quality Gap’ between the interventions we know to be effective and routine practice in drug treatment services.
4.11 We attribute this partly to budget cuts in drug and alcohol services, mirrored by a significantly reduced investment in the social fabric supporting recovery.

4.12 Competitive tendering has created additional upheaval and ‘hidden harm’ where compromising quality for quantity and the loss of integrated, cooperative services have outweighed any short term financial benefit.

4.13 Many parts of the country have seen a shift towards basic drug treatment provision, a workforce under increasing strain, and a loss of expertise and opportunities for training and recruitment of specialist professionals skilled in delivering safe, evidence based interventions, with diminishing returns for better health by people using drugs.

4.14 One solution towards addressing the quality gap would be to develop quality standards that identify the structural components, processes, outputs and outcomes expected from high quality, evidence based drug services, and are reinforced through quality assurance, inspection and review systems applicable to other health services.

5. **Best practice**

*What would a high quality, evidence based response to drugs look like?*

5.1 A high quality, evidence based response would feature:

- A clear set of values supporting inclusion and equal access to universal health care.
- Services that are safe, effective, caring, and responsive to people’s needs for specific drug treatments and wider physical and mental health and social inclusion, and well led.
- Clinical leadership, training and supervision to support the implementation of evidence based practice.
- Research capacity and ability to provide evidence to inform future activities.
- User involvement in the design, delivery and review of drug services.
- Clear pathways (‘no wrong door’) into better physical and emotional health and wellbeing, employment, housing, and social inclusion.
- A coherent, systematic approach to reducing health risks and harms and drug related deaths.
- Compliance with quality standards and performance indicators that go beyond successful completion of drug treatment and abstinence and support long term maintenance with opioid substitution treatment (OST), and improvements in health and wellbeing.

5.2 Some of the best practice examples for integrated care cited by our members and within a report by NHS SMPA and Collective Voice\(^8\) include:

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Physical health: A physical health risk alert system (‘Red Flag’) with enhanced nursing interventions for drug users (Derbyshire Healthcare NHS Foundation Trust).

Liver Health: NHS services working together in London to provide a bespoke outreach fibroscan and testing service for the assessment of hepatitis C and liver disease, and a seamless pathway into treatment for people who are homeless and/or using drugs and alcohol (Imperial College Healthcare NHS Trust, Central and North West London NHS Foundation Trust).

Ante-natal care A ‘one stop shop’ approach in Thurrock for women who are using drugs and pregnant to help them with appointments and streamline medication and specialist midwife input. (Inclusion – Midlands Partnership NHS Foundation Trust).

Mental Health:

- Clinical Psychology leadership in setting up quality assured training and supervision for the delivery of psychosocial interventions by NHS and 3rd sector addiction agencies, with more intensive psychological therapies accessible by people using drugs, including social behaviour and network therapy which enlists significant others in the recovery process (Leeds and York Partnership NHS Foundation Trust).

- Availability of integrated pharmacological and phased psychological approaches to address complex trauma and substance misuse (South London and Maudsley NHS Foundation Trust).

- Use of ‘structured clinical management’ for individuals with borderline personality disorder and drug use, involving liaison with other services and teams, such as GPs, midwives, probation officers, to help formulate an understanding of a person’s pattern of behaviour and develop a consistent therapeutic approach across services (South London and Maudsley NHS Foundation Trust).

5.3 We think there is scope to reduce drug related deaths and other harms in areas with a high concentration of injecting drug use through the introduction of medically supervised drug consumption clinics, as seen in some other parts of Europe.9

5.4 We welcome the Home Office licensing of drug testing facilities Weston-super-Mare, Somerset.10 Originally developed in countries such as USA and the

9 The Guardian. Wed 21 Nov 2018. How ‘fixing rooms’ are saving the lives of addicts. Across Europe, facilities that offer medical supervision for addicts are dramatically reducing drug related deaths.

Netherlands, and operated by Loop (drug safety charity) in music festivals in the UK, these offer people information on what they are taking and individually tailored advice on harm reduction. We consider that these could be extended to other locations where drug use is prevalent.

6. **Key Recommendations for action**

6.1 In response to the Inquiry on Drug Policy and Health, the NHS SMPA makes the following recommendations:

1) Continue to invest in abstinence based approaches for people using drugs and maintenance and harm reduction programmes for a significant cohort of drug users with more complex needs.

2) Develop a coherent, systematic approach to addressing health inequalities and premature deaths by people using drugs, supported by integrated and collaborative care between drug services and primary, community, emergency and hospital based physical and mental health care.

3) Safeguard specialist clinical expertise (Psychiatrists, Nurses, Clinical Psychologists) and suitable trained and supported staff working in drug services.

4) Invest in research to expand the evidence base in drug services, for instance to identify health harms related to newer drugs and support the uptake of effective interventions and innovations in routine practice.

5) Develop quality standards and inspection to assure quality, adequate resourcing and support for the commissioning of drug services.

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