Written evidence from Royal College of Psychiatrists

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Introduction
The Royal College of Psychiatrists (RCPsych) is the professional medical body responsible for supporting psychiatrists throughout their careers, from training through to retirement, and in setting and raising standards of psychiatry in the United Kingdom.

Summary and recommendations
1. The system of local authority commissioning is not working. The Government must review the costly and protracted commissioning of addiction services. The NHS must have a bigger role in the commissioning of addiction services and investment must be protected.

The 2017 ACMD report: ‘Commissioning impact on drug treatment’ found the re-procurement of addiction services creates unnecessary ‘churn’, resulting in poorer recovery outcomes. Furthermore, NICE have found a mixed pattern of commissioning arrangements which will inevitably produce a mixed pattern of recovery outcomes. Any review of addiction services should consider how we can ensure that the NHS, local authorities and the third sector can better work together to provide effective, accessible addiction services. The proposed changes to primary legislation which governs how health and care services are structured and delivered are an opportunity to implement the legal changes needed to make this happen.

2. Cuts to public health budgets have starved addiction services of the funding they need to treat people and reduce harms resulting from drug use.

New analysis of Ministry of Housing, Communities and Local Government data by the Royal College of Psychiatrists has found that since 2013/14 local authorities have cut funding on drug services by 26.1%, with the largest cuts in the South West (36.4%), London (34.6%) and Yorkshire and Humber (33.6%). The cuts have starved addiction services of the funding needed to treat people and prevent harms resulting from drug misuse. The cuts are a false economy as additional costs are incurred through increased pressure on the NHS, such as the doubling of drug-related hospital admissions since 2006/07. The ACMD’s report also found that addiction services face disproportionate decreases in resources which are likely to reduce treatment penetration and the quality of treatment.

3. The College’s workforce census has found a 24% fall in the amount of NHS consultant posts from 2011-2017. The Government must recruit and train the specialised workforce to treat people with cooccurring conditions.

As funding for addiction services has been cut the proportion of addiction specialists (psychiatrists, nurses and psychologists) working in these services has fallen. This reduces the ability of services to meet the complex needs of the people in need of treatment. NICE recommended, evidence based psychological and pharmacological treatments are increasingly not available. The lack of clinical expertise in some services also reduces the advocacy for patient’s needs, that is a key part of the role of an addiction psychiatrist.

4. With the cost of the drug Buprenorphine rising by 700%, the Government needs to make sure failures in the pharmaceutical market do not lead to an increase in deaths.

With clinicians no longer able to access generic versions of Buprenorphine most clinics can no longer afford to offer NICE recommended treatment for addicts. This would never be accepted for cancer patients and shouldn’t be accepted for this drug.
5. As part of a review of addiction service provision, the Government should review the legislative framework for implementing Safe Consumption Rooms (SCRs) where local need dictates their introduction would benefit the local community. Supervised injecting facilities have been shown to be effective in encouraging people with high risk, injecting behaviour to engage with treatment services and reduce the harm they experience. Research has found that injecting rooms can reduce drug-related deaths as part of an integrated pathway into care. SCRs increase the number of people accessing primary health care and drug treatment, especially among the hard to reach homeless populations. They have also been shown to reduce the impact of drug use on communities by reducing street disorder and encounters with the police.

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

1.1 There has been a concerning increase in the amount of drug related deaths, drug related hospital admissions and drug poisonings in the last 10 years. These increases coincide with a move from harm reduction to abstinence-based recovery and with the damaging cuts to the public health budget which local authorities use to fund addiction services.

1.2 The Statistics on Drug Misuse, England (2018) found drug related deaths have risen markedly in the last ten years. In 2017 there were 2,503 deaths, a 28% increase on 2013 (1957) and a 53% rise since 2006/07 (1,637). 61% of the deaths in 2017 were people aged between 30 and 49.

1.3 It also found that in 2016/17 there were 7,545 hospital admissions with a primary diagnosis of drug-related mental health and behavioural disorders, 12% higher than 2006/07. Admissions increase to 82,135 where drugs are the primary or secondary reason for admission, which is over double the level of 2006/07.

1.4 The 14,053 admissions for drug poisoning are 40% higher than 2006/07. The number of admissions was highest for 25-34-year olds. A Public Health England report found that in 2017 there were 140 people newly diagnosed with HIV who inject drugs. The report also found that the overall utility score for health-related quality of live for the general English population is 0.86, whereas injecting drug users living with HIV scored 0.31, the lowest group living with HIV.

Societal harms

1.5 Harms resulting from drug use do not only impact the individual ‘user’, there are indirect harms on their families and the communities in which the user lives.

2. What are the reasons for both the initial and the continued sustained use of drugs?

2.1 The reasons for the initiation of drug use and why an individual continues are different and complex. Initiation is related to peer pressure and availability of the substance. Continuation and the progression to addiction is associated with social and emotional deprivation, adverse childhood events (such as abuse and neglect), genetic vulnerabilities and a lack of opportunities for education and employment.

2.2 Many patients with mental health problems also use drugs. When drug and alcohol services are inadequately resourced, they are unable to provide the specialist partnership interventions this group needs. These patients are not given the support they need.
3. How effective and evidence-based are strategies for prevention and early intervention in managing and countering the drivers of use?

3.1 Prevention and early intervention can work and there is evidence for brief interventions being effective in alcohol users\textsuperscript{x}.

3.2 There is also evidence that some targeted interventions can prevent drug use among vulnerable young people. However, these interventions are not available universally due to cost and will become less available as funding reduces even further.

4. How effective and evidence-based is treatment provision?

4.1 It is well accepted that treatment for drug misusers works. This is particularly true for opiate substitution (OST) for opiate users (largely heroin in the UK). There is a large body of evidence for the effectiveness of OST when it is provided in conjunction with adequate support for individuals to deal with the range of complex problems they face. This usually includes health problems, psychological difficulties including mental illness, as well as wider support for housing, employment support.\textsuperscript{xi}

5. Is policy sufficiently geared towards treatment?

5.1 In its report\textsuperscript{xii} ‘Commissioning impact on drug treatment’ the ACMD concluded that drug and alcohol treatment appear to be facing disproportionate decrease in resources, likely to reduce treatment penetration and the quality of treatment in England.

5.2 It comes as no surprise that the rise in drug-related deaths, drug poisonings and drug-related hospital admissions have occurred while addiction services have been starved of funding.

5.3 New analysis of Ministry of Housing, Communities and Local Government data by the Royal College of Psychiatrists has found that since 2013/14 local authorities have cut funding on addiction services by 17%. Spending on drug services has been cut by 26.1%, with the largest cuts in the South West (36.4%), London (34.6%) and Yorkshire and Humber (33.6%). These cuts have made it more difficult for people to receive the help and treatment they need for their drug misuse disorders.

Drug related deaths

5.4 These have increased in England by 58% over the last 10 years\textsuperscript{xiii}. This rise has happened at the same time as funding cuts to services. There are other possible explanations for the increase - such as increased morbidity in ageing opiate user population and the use of the more dangerous drug fentanyl - but it is also credible that a less flexible and poorly funded treatment system is less good at retaining complex and risky patients who are at risk of overdose.

5.5 We do know that the risk of death among heroin users in treatment is substantially lower than users out of treatment, and that retention in methadone treatment is protective against deaths overall\textsuperscript{xiv}. Thus, the increase in deaths maybe a consequence of services retaining patients less well.

Loss of specialist harm reduction services

5.6 Harm reduction has historically been the foundation of drug treatment services. Needle exchanges ensured that we did not suffer a catastrophic HIV epidemic in drug users in the 1990s\textsuperscript{xv}. Research\textsuperscript{xvi} has also found that attenders of needle exchanges are more likely to be homeless, to inject more frequently, and to be a more chaotic and destitute population than non-attenders. As services have shrunk, many have had to consolidate into a one stop shop service, with needle exchanges now most commonly provided in pharmacies, as it is no longer prioritised in commissioning. This means that the people
with high risk injecting behaviour will now not access a treatment service as they obtain their new needles from the pharmacy.

5.7 This is particularly worrying in the context of NHSE’s ambition for England to be the first country in the world to eliminate Hepatitis C\textsuperscript{vii}. This ambition will not be reached unless effective harm reduction prevents reinfection.

**Inability to implement evidence based pharmacological treatments**

5.8 The cost of buprenorphine has increased by over 700\textsuperscript{xviii}. This means that a NICE evidenced treatment which is highly effective for opiate misusers is increasingly unavailable, as services cannot afford the increase in price on top of already stretched budgets. Services face cutting other support services to provide medication.

5.9 There are other wasted opportunities. Naloxone, when given to service users can save lives following overdose. A new preparation of naloxone which can be given intranasally is now available and is more expensive that the injectable form. It is particularly likely to be acceptable to families of services uses who may find injecting unpalatable. In the current funding environment services cannot afford the intranasal naloxone.

**Reduction in alcohol treatment numbers and reduced treatment quality**

5.10 There has been a 16% decrease in the numbers of people presenting for alcohol treatment, from 155,381 in 2013/14 to 131,008 in 2017/18\textsuperscript{xx}. Co-located alcohol and drug services are less attractive for alcohol uses who are often a more stable and socially integrated group. Services that are not being funded to provide a specialist service for alcohol users that is good enough are also unlikely to be providing one that is tailored to the needs of drug users.

5.11 There is evidence that inpatient detoxification services are reducing in quality as well as number. A 2017 CQC report\textsuperscript{xx}, which was a summary of a series of inspections on residential alcohol detoxification services, found that quality was generally poor. Many of these services also see drug users. The number of inpatient detoxification places has reduced dramatically over the last 5 years with very few facilities in the NHS. In many areas this means there is nowhere for complex drug and alcohol users to be safely treated, apart from through emergency hospital admissions.

**Reduction in skilled staff numbers**

5.12 Reductions in budgets means there are fewer consultant addiction psychiatrists. The Royal College of Psychiatrists workforce census shows a dramatic decline in the number of NHS addiction consultants. In 2013\textsuperscript{xxi} there were 95 consultants compared with 72 in 2017\textsuperscript{xxii}, a fall of 24%. Services used to have their own consultant lead, but these are now often shared across wide geographical areas to reduce costs. When a service is transferred to the voluntary sector provider, the doctor taking over may not be at consultant level. There are many examples of services not having a specialist. Therefore, not only has there been a reduction in the workforce the skill base of the workforce is declining which will impact treatment and recovery outcomes.

5.13 New addiction psychiatrists are not being trained. Despite workforce being a priority in the drug strategy, HEE, PHE and the NHS have not been able to find a way to halt the decline in training numbers. Psychiatry is a shortage speciality and in the current environment addiction psychiatry is not prioritised with regard to other psychiatric subspecialties.
5.14 Addiction psychiatrists can manage complex patients, work with other health services, treat dual diagnosis, innovate with new treatments and carry out research into new treatments.

5.15 Other professions – particularly addictions psychology – are also declining dramatically. GPs who used to have an interest in treating substance users are less likely to want to do so.

**Safe consumption rooms**

5.16 Supervised injecting facilities have been shown to be effective in attracting people with high risk, injecting behaviour to services and reducing the harm they experience. Research has found that injecting rooms may contribute to reducing drug-related deaths. They also increase the number of people accessing primary health care and drug treatment, especially among the hard to reach homeless populations. They have also been shown to reduce the impact of drug use on communities by reducing street disorder and encounters with the police.

5.17 Glasgow has come a considerable way in demonstrating the need for a facility, but the current legislative framework has not allowed this to progress. The Royal College of Psychiatrists believe this needs to change to enable local areas to set up these services where local need has been demonstrated.

**Reduced links with criminal justice**

5.18 Prisons have high levels of drug problems and it is a priority to reduce these. Treatment, particularly OST, reduces criminal behaviour. Individual prisoners are at a high risk of overdose when they leave prison. OST in prison can reduce these deaths but if community services are not resourced adequately to outreach to prisons then these prisoners will not be retained in treatment after discharge and are more likely to reoffend.

**Ageing drug users**

5.19 We know the UK drug using population is ageing and suffers from multiple physical health problems. The lack of integration between health and public health funded addiction services makes services less able to meet these multiple needs. Individuals are ending up in hospital rather than having preventative care. Drug services help bridge that gap for complex marginalised individuals.

**Research**

5.20 Without adequate resources and skilled addiction psychiatrists the amount of research being done in the UK will fall. This will reduce our capacity to cope with new problems and find innovative solutions for old ones.

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

6.1 A stable treatment system which is well integrated into local health systems and can respond to local need.

6.2 A workforce plan which is robust and can deal with the needs the treatment system will have in the future. The is particularly the addiction psychiatry workforce but also applies to other professional groups.

6.3 A system which can manage the diverse patient groups who use substances and respond to their differing needs.
6.4 For innovative practice, which has been proven to be effective in promoting recovery and saving lives, is resourced where it is needed.

6.5 That service users with addiction problems are given treatment which is high quality and equitable with other treatment populations. And that they are not subject to stigma.

7. What responses to drugs internationally stand out as particularly innovative and/or relevant, and what evidence is there of impact in these cases?

7.1 There is good evidence from many sites across Europe and North America that prescribing injectable heroin to treatment resistant opiate users can improve outcomes. An English multicentre trial\textsuperscript{xxvii} was able to demonstrate that the approach is both effective and cost effective. These findings are also supported by Byford et al’s paper.\textsuperscript{xxviii} To date, lack of resources have meant that this evidence-based approach has not been funded. Even in areas where the model was running successfully, they have not been commissioned and the prescribing has stopped.

7.2 The Government’s own report by PHE in 2017\textsuperscript{xxix}, shows the UK used to have best practice in the world, but we are slowly losing it. Our level of treatment penetration has historically been one of the highest in Europe. The reducing number of heroin users is a credit to this. However, if this system continues to be starved of money this will not be continued. We will have a “one size fits all” inflexible system which cannot manage complexity and will not be fit to cope with any emergent substance misuse issues.

\textsuperscript{iv}https://www.gov.uk/government/collections/local-authority-revenue-expenditure-and-financing
\textsuperscript{v}https://www.rcpsych.ac.uk/improving-care/workforce/our-workforce-census
\textsuperscript{vii}http://www.emcdda.europa.eu/topics/pods/drug-consumption-rooms_en
\textsuperscript{x}https://academic.oup.com/alcalc/article/49/1/66/145551
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