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Section of Drug Misuse and Dependence - Guidelines on Clinical Management quoted by Deputy M. Dubras-

> '*In a substantial proportion of patients,* ***drug misuse tends to improve with time and age,*** *particularly when specific treatment and rehabilitation techniques are used. There is also increasing evidence that that treatment (medical and social) is effective in maintaining the health of the individual and promoting the process of recovery. Studies of self-recovery by drug users have shown that access to formal welfare supports, together with encouragement from friends, partners, children, parents and other significant individuals, is commonly involved in the pathway out of addiction.'*

1 **Is addiction an illness inherent in the individual or is addiction due to the nature of opiates?**

(a) Addiction should be considered as a disease not a crime. For some people, a minority, there is a predisposition to substance misuse.

(b) Addicts will tend to work through addiction, assuming they survive, over a period of 10 - 15 years, unless there is some form of major intervention.

(c) Average life expectancy for an addict is 35 years of age. (Disputed)

(d) Addiction is a revolving door disease - people come for treatment, leave relapse and return for treatment.

(e) Family lines of alcohol addiction can clearly be traced in numerous cases. Studies have not been undertaken in respect of opiates. However, opiates are much more addictive and withdrawal is more severe.

(f) 'Pink List' (a confidential document listing drug addicts treated by GPs - which must by law be reported to Medical Officer of Health within 7 days).

- In 1998 there were 149 names; 9 have died; 14 are still in treatment.
- In 2004 there are currently 231 names, of which 102 have significant known criminal records - 30 are currently in prison with sentences amounting to a total of 100 years.

2. Harm Reduction in Prison

(a) Medication currently withdrawn from addicts on reception including those on remand, not convicted - allowed to go into withdrawal, given dihydrocodeine (which Dr Marks is not allowed to use) treatment programme cut off - **there is no medical justification for that happening**.

(b) Dr Marks has raised this issue with Medical Officers at the Prison. The practice is justified by the Prison for various administrative reasons - but **a questionable practice in terms of Human Rights**.

(c) **Harm Reduction measures in Prison** - '*We need to stop talking about a programme which is designed to get people off drugs. Harm reduction should be the policy at all levels, in and*

out of prison. It isn't currently the case. My obligation is to get everyone I'm looking after off drugs preferably sooner rather than later. There are budgetary constraints, protocols, designed to take people in off the street onto substitution medication, reduce the dose and off. There is harm reduction in place in the community, needle exchange, free condoms and so on.'

(d) It makes common sense to have harm reduction measures in place in the Prison. Since there is a number of addicts in the Prison (and there is evidently a ready supply of drugs getting in and needle sharing happening) they should have access to similar harm reduction measures available to those on the outside, to minimise the impact of them being there, otherwise there is a risk of spreading infection within prison and to the community.

(e) Cost of keeping a prisoner at La Moye = £42,000 pa. The cost of keeping the 30 sick people (mentioned above) in prison amounts to **£4.2 million.**

(f) 70 % of prisoners are addicts or mentally ill - often both. (United Kingdom f igures)

3. HIV and Hepatitis C

(a) In seeking out HIV in the drug using community Dr Marks has yet to find a single new case. (NOTE: subsequently discovered one case)

(b) Hep B vaccinations are available free at weekly addiction clinic.

(c) Hep C is common among drug using population - but nowhere near as prevalent as in United Kingdom. 50% negativity in drug using should be seen as an opportunity to stop that group spreading the disease.

(d) Cost of treating Hep C very expensive - we are only beginning to see the impact in the community. It takes a long time to feed through into the community - it's a monster of great proportions which hopefully will be addressed by immunisation in the future.

4. Methadone Subutex and alternatives

(a) Pleased to be using subutex - by choice, would only use methadone in limited specific circumstances.

(b) Unable to prescribe subutex to those using valium or benzodiazepines due to licence restrictions (these are ignored in Australia)

(c) Subutex much safer because it's a blocker not just a replacement; easier to withdraw from; no need for community nurse visits

(d) Cinderella service - lack adequate aftercare to keep addicts off drugs - staff facilities resources almost non existent by comparison with facilities and expenditure on prisons.

(e) Another way of going beyond methadone - In Australia, naltrexone (opiate blocker) used effectively as implants - allows time with aftercare to look upon life in a different way - regarded with serious disquiet in public sector in United Kingdom.

5. Heroin

(a) Heroin confiscated by enforcement agencies cannot be recycled for legal use due to levels of purity.

(b) Low price drug at source eg in Afghanistan.

(c) Cost of heroin in Jersey is very high (highest in world) - £20,000 pa to feed drug habit. Drug use seldom shows in crime statistics.

(d) Young people mainly who come into contact with the Law and are then pushed into prison rather than treatment.

(e) Wrong impression that we have a lot of hard core users in Jersey. Many come into contact with drugs at early age - under 16. We could have a major impact on this group - we should go at **with every possible option** - they are not yet died-in-the-wool addicts - we should be trying to save them from a disease with results in short life expectancy, marginalisation, debilitation. Young are a very vulnerable group targeted by pushers.

(f) Easy to distinguish professional dealers from addicts -

'*The conviction of a confirmed addict for possession with intent to supply should be struck from the book*'.

6. 'Window of opportunity' - Why does there appear to be a lack of immediate response to people in crisis?

(a) Limited number of key workers at ADS with a very heavy caseload. There is a duty counsellor on call at ADS between 9am and 5pm who can respond to people who call at Gloucester Lodge.

(b) There are various protocols in place, designed to identify the nature of the problem, confirm the addiction, assess how they can be helped most effectively. It does take time - but it should not be more than a few days.

(c) There are safety issues involved - eg clients can't be started on a methadone programme over the weekend when there are no staff available to monitor.

'*If I start a patient on methadone on Thursday and he dies on Saturday, then I go to prison'.*

(d) There aren't usually waiting lists for methadone or subutex programme - at present, however, there is a waiting list because Dr Marks has been away in Tanzania, so there have been no clinics.

(e) There are two other GPs who provide services for addicts in their surgeries up to a point, within the constraints applied by their practices.

(f) Dr Marks works on a voluntary basis for ADS, not on a contract basis. He is paid a fee by the States but the service to the client at his addiction clinic is free. The clinic operates out of hours - at lunch time or in the evening.

7. Use of voluntary agencies - is there sufficient importance attached to them?

(a) Favours 12 step approach as the basis of life-long abstinence - nothing to beat it.

(b) Tremendous success rate for places like the Priory in United Kingdom but very expensive (£4,000 a week) and based on self-selection so the success rate is very high.

(c) There is a serious problem persuading people between ages 16 and 25 to adopt this approach. There is a place for residential facilities based on an alternative approach but it is probably better for young people to be off the island - it is too easy to walk out after some weeks and renew former drug contacts.

(d) No intention of running down local residential facilities - this is part of a wider debate on after care and psychological support and merits longer discussion.

(e) He believes that the Island is working towards increasing referrals to voluntary agencies as there is now a budget, £70,000, for this purpose, but only recently.

8 Opting out of treating addicts.

(a) New United Kingdom contracts for GPs, likely to be adopted as a model here in Jersey, allows GPs to opt out of treating addicts. This already happens at a high level here in Jersey - very few GPs treat addicts.

(b) He sometimes reminds colleagues of this statement by the General Medical Council -

It is unethical for a doctor to withhold treatment for any patient on the basis of a moral judgement that the patient's activities or lifestyle might have contributed to the condition for which treatment was being sought. Unethical behaviour of this kind may raise the question of serious professional misconduct.

9. Centralised Community Service - how would it work?

(a) Dr Marks explained that he enjoyed what he was doing - an interesting area of medicine because you achieve good outcomes (like an obstetrician!). You change people's lives with relatively small interventions - but he won't be around for ever.

(b) He would love to see a good general practice based community service, with young group of professionals doing the job he is currently doing but in a recognised contractual way. He would give priority to this over building a new wing for the prison.

(c) An example is Spittal Street centre in Edinburgh, one of most famous in the world, where all addicts referred by GPs. The opposite of divide and rule.

(d) The more you allow addicts to be treated in the community, with 100 GPs each doing what they like, the less control you have over what is going on.

(e) The Island could do a great deal more to provide community detox and aftercare through a centralised service - we are dealing with the future of young people, the future of our society.

(f) Addiction is a problem for the community to deal with. There is no problem with operating

a subutex programme in the community.

(g) Residential detox should not be part of the psychiatric service. It is used currently because an adequate community service doesn't exist. In general psychiatric wards are not designed or equipped for detox.

(h) There is an argument for 'shooting galleries', ie safe environment, where addicts can use safely in a supervised environment. It would be better for everyone - eg reduce the risk of finding needles on beaches.

(i) 'Gold standard prescribers' should be allowed to prescribe diamorphine to addicts but in very rare circumstances

10 Dealing with addiction - should we deal with the whole person, the root personality causes or just focus on physical effects of using opiates?

(a) If psychological issues are not dealt with, clients will come back requiring further treatment.

(b) A high proportion of addicts have **dual pathology**. Dr Marks is always on the look out for psychiatric problems - As much practising psychiatry as conducting an opiate substitution programme.

(c) He has very good support from the **psychiatric service** - he can access a consultant on the phone and get a consultation within a week. This means he is able to see a number of quite seriously ill people within the community dealing with drug and psychiatric problems.

(d) He comes into conflict with psychiatrists over issue of **depression.** He tends to react early in treating depression otherwise it will lead to failure with other programmes. There are particular medications - such as mirtazipine - which are effective in reducing the side effects of opiate withdrawal. Up to half his patients are on this medication. Most instances of depression in the community are seen by GPs rather than psychiatrists who treat only the most severe cases.

(e) It is vital to **follow up** opiate substitution programmes but this proves to be very difficult. Patients, who have received free treatment in his clinic for addiction, are then expected to pay for follow up treatment.

11. Other issues

(a) Reference was made to other issues outside the remit of the Panel, including decriminalisation of drugs and cannabis-induced pyschosis.