THE QUIET REVOLUTION

The way drug users are dealt with by GPs has transformed in the last three decades. **Dr Chris Ford**, who retired earlier this year from her post as one of Britain's specialist drug misuse GPs, looks back at how things have changed in primary care.

I have learned that if we don't know where we come from, we won't know where we are going, so without apologies I shall start at the beginning. Like all my contemporaries, I had no training in drug dependency. In fact in my training practice it was reinforced that we could treat the *effects* of drug use – such as abscesses – but needed to leave everything else to the psychiatrists, as it was a complex psychiatric condition.

In 1964 with the publication of the second Brain Report showing that there had been a significant rise in the incidence of addiction to heroin and cocaine and that the main source of supply was a small number of over-prescribing doctors, it recommended the establishment of special treatment centres, especially in the London area, where addicts could be isolated from the community and treated. These became known as Drug Dependency Units and they were psychiatry-dominated specialist services with an emphasis on abstinence-based treatments. In the early '80s, with a dramatic increase in heroin use from imported heroin, this model continued. GPs were not seen as a useful source of help. This may in some way account for my lack of training, which became starkly apparent during my first week as principal GP when a young man came to see me with his mother.

James was just 18. He looked sad and very anxious and I asked him how I could help him. He told me he had recently started injecting heroin after smoking it for the past two years and desperately wanted to stop. He had attended the local specialist drug service, but they had a long waiting list and he really wanted help now. I explained I wasn't sure what to do but asked what he thought I could do to help. He suggested methadone so I looked it up in the British National Formulary guide and wrote my first methadone prescription. James settled well in treatment. He told his friends and others came. Each one of these patients taught me lots and showed amazing change. My GP partners were supportive, as general practice is about cradle to grave and everything in between. Problematic drug and alcohol use was prolific in Kilburn, so why wouldn't we care for these patients like any other?

The second group of patients, including Beryl Poole (now helpline manager for the Alliance), taught me about partnerships, boundaries, instalment prescribing and so much more. It soon became clear that people who used drugs were as varied as any other group of patients, often had a range of problems including general health, mental health and social problems, but all wanted help to stop and/or reduce the harms and most importantly – to be treated like anyone else.

As the numbers grew it became apparent that more help was needed and community drug teams were introduced to support general practice in this work, but most often ended up doing the work directly, largely due to many GPs' reluctance to take it on – which usually was because they had no training, and had been told that they should not get involved.

Luckily I didn't know any of this and I was not only learning from the patients, I was enjoying every minute of this work. By the time I was seeing over 30 patients with drug problems, I felt I perhaps I needed a little training. I tried to find a course but there weren't any, except the 1984 Clinical Guidelines that were completely unhelpful and strongly stated that GPs should not do this work.

My local CDT kept sending me questionnaires about what help they could be to us as GPs and eventually, I scribbled on one – 'stop the questions and provide some help' and faxed it back. Two weeks later the manager of the CDT came along with Brian Whitehead, a drug counsellor, and said I could borrow him for three months. Twenty-one years later we are still working together. We soon realised that we were managing the most complex people in general practice. Many of these patients had not settled in specialist services.

Change began to happen in the specialist services in the late 1980s with the coming of HIV and the real need for more harm reduction. The NHS and Community Care Act 1990 created a market in health and welfare and allowed voluntary organisations to compete in the new mixed economy of care. This was followed by a definite change in government policy in 1995, with the Department of Health's report into drug treatment services, which supported the role of primary care in this work. Shared care schemes were popping up all over the place, and we developed one in Brent.

We knew a few others doing similar work and realised that there might be many colleagues nationally in this situation. A small group of us got together and decided to hold a conference to share experiences and develop a support network. As I was a member of the Royal College of General Practitioners (RCGP) HIV Working Party at that time we arranged it through the College and the first conference entitled *Management of Drug Users in General Practice* was held in 1996 with 100 delegates. The energy at that conference was magical and so much happened.

Delegates felt at home, friendships were formed and learning took place. I had 'persuaded' my patient Beryl Poole to do a keynote speech. She had never spoken in public before and became more and more nervous. But we had thoughtfully included a speaker from the Department of Health, to kick off the conference. He was appalling and full of prejudice, so his talk freed Beryl up to deliver an amazing speech of great quality. This conference is now in its 17th year and we still have a key-note opening speech from a person who uses drugs.

Our original small group of two grew to include Clare Gerada, Berry Beaumont, Judy Bury and Jean-Claude Barjolin and we realized that there was little literature in the drugs field aimed specifically at general practice. We decided to produce a newsletter. The first newsletter sent to the mailing list of 243 was well received and it soon developed into a quarterly newsletter entitled Substance Misuse Management in General Practice (SMMGP). The mailing list rapidly increased, reflecting a real need to build a primary care network for sharing ideas and information regarding the care of people who use substances. So far, so good – and so unfunded!

It was apparent that extra staff were needed and we managed to get funding to firmly establish SMMGP in August 1999. We believed (and still do) that with the right training and support most GPs would take on this work as it fits perfectly into the model of general practice: patient-centred care (caring for the person not the drug; and their family), long-term care throughout the journey, management of all health and well-being; and seeking help when working above competence and confidence.

With the blossoming of shared care schemes and the 1999 Clinical Guidelines it was recognized that standard national training was required for GPs and other primary care workers. Thanks to the vision of Clare Gerada, the RCGP Certificate in the Management of Drug Misuse was born in 2001. They were an immediate success, almost as if people had been waiting for them. They are annually updated and still run to packed houses. This has led to more training by general practice for general practice. We developed the first guidance specific to primary care covering the use of buprenorphine in opioid dependence treatment in primary care. This has been followed by a raft of other guidance documents for primary care.

It wasn't all positive during this period, with much of the new cash from *Tackling Drugs to Build a Better Britain* in 1998 attached to the criminal justice system. For the first time, NHS and voluntary sector providers were competing with each other for this new money: what we had viewed as a health and social problem became more of a criminal one. The increase in funding had some positive impact, with more national protocols, a move away from post-code treatment and getting more people into treatment. It strove to drive up quality, although the increase in data collection rose enormously. During this time the involvement of the voluntary sector grew, as did the number of GPs seeing their own patients; a growing number of GPs moved on to run specialist services, both within the NHS and voluntary sector. Some retained the range of care offered by primary care, but others became more like prescribing services.

SMMGP continued to go from strength to strength. It has a growing membership, which informs and responds to changing policy. The number of practices involved in working with people who have drug problems went from under one per cent in 1994 to over 40 per cent in 2011. Then last year the incoming Coalition government made a strong call for abstinence, saying methadone was not cost effective. Fortunately after much work behind the scenes a more balanced Drug Strategy was published in December 2010. The strategy has recovery at its heart, with much more responsibility placed on individuals, a more holistic approach and a new focus on housing, employment, offending and localism.

But as this re-balancing of treatment occurs, we must not let the pendulum swing too far the other way. Services are to be monitored on their "number of successes" which tends to equal being drug-free and out of treatment, with no understanding that this is not patient-centred or evidence-based – and could in fact be dangerous to people's health.

Primary care is not immune to these changes and is at real risk. UK General Practice, where everyone can register and receive the full range of health care at no cost at the point of access, is like nowhere else in the world. With general health funding likely to end up in some sort of GP commissioning groups, I feel there could be a real risk to primary care based drug treatment.

It seems likely that commissioning for mental health and drugs and alcohol will remain largely in public health. But every area will have a Health and Well-being Board, in which GPs will be involved and have influence. Will GP commissioning be a good thing or not for patients with drug and alcohol problems? I hope so. In our area we are soon holding a re-launch-come-training day for shared care. We haven't been able to get even five minutes on any one of the local three GP commissioning groups as they 'have more pressing problems'.

The challenge to the fundamentals of the NHS is against a backdrop of a worsening economic situation and the social and welfare structure being under attack and dramatically reduced. But I do know from travelling to other countries that we have the best drug policy and treatment in the world and we need to defend it, as well as develop it to ensure that the gains of the last 25 years are not lost.

For an optimist, there are other signs to be hopeful. The recovery agenda has much to celebrate. Many of us working in primary care feel we have been supporting people along their self-defined journey, but I'm excited about the call for us, as healthcare professionals, to do even better. But we must take care to support the most vulnerable and those that aren't able to reach the artificial markers that policy makers have set. Also for primary care to be able to do this, we need the right resources such as access to psychosocial interventions, in-patient detox and rehab services, housing and employment services.

What will be the role of GPs in the drug treatment system in five years time? I hope and feel it will be continued improvement. That is to provide total care to patients who use drugs: general health care, HIV and hepatitis care, mental health care, substitute prescribing and detoxification. Patients need to be supported by a compassionate, multidisciplinary team providing a range of services, as well as robust specialist services to call upon. But ultimately, with the GP remaining the key-worker.

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