experimentation in an increasingly complex team structure. Drawing the primary health care team together is a clear goal of the Edwards report, hence community psychiatric nurses, community nurses for mental handicap and midwives are all to be firmly embedded in one or more primary health care teams.

The most radical and important proposal in the report is the creation of new primary health care authorities responsible for both family practitioner services and community health services in all districts. This entirely logical proposal begs the question whether the new authority should be based on an expansion of the present family practitioner committee or of the district health authority community unit. The report sensibly avoids this contentious point but it gives indirect evidence of the committee's favoured view in the recommendations which deal with the interim arrangements before the new primary health care authorities are established. Here Edwards recommends the formation of community units within all existing district health authorities, the establishment of liaison committees and a clearly defined primary health care budget for each health authority. There is no recommendation for concomitant strengthening of the present family practitioner service planning and management budgets, despite the recognition that family practitioner committees have been grossly underfunded for these new activities since legislation changed their role in 1985. We must conclude that a properly resourced community unit of a health authority and an underfunded, hard pushed, cash limited family practitioner committee are not intended to be equal competitors in the race for leadership in the new primary health care authorities.

The United Kingdom Central Council for Nursing and Midwifery may be upset by the recommendation for generalist nurses in primary health care rather than specialist nurses, the proliferation of which we have been witnessing in recent years. A service based on generalists but supported by a smaller number of specialists is the model upon which medicine has operated since the advent of the National Health Service. If nurses adopt the same structure continuity of care will be greatly enhanced and administration will be more flexible.

Our society needs more professional input to chronic and continuing care as well as support for acute crises in young single parent families and the elderly living alone. It is therefore appropriate for the Welsh nursing review to recommend a far greater role for well trained generalist nurses working in primary care teams. However, two issues cause disquiet in this otherwise forward-looking report. First, a major shift towards health promotion in a profession already short of staff must lead to a reduction in some other activity. Is it the nurse's traditional role of caring for the sick that will be discarded? Secondly, the long term goals of this report have implications for family practitioner services which extend to the structure and function of their premises, contractual and legal responsibility for patients, financing of services and inter-professional relationships. It is hoped that these will be properly addressed during the consultation process with representatives of the medical profession. Without such consultation the primary health care team will stagger into the next century in its fragmented form instead of achieving the integrated approach proposed by the review of community nursing in Wales.

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References

1. Review of Community Nursing in Wales. *Nursing in the community — a team approach for Wales.* (N. Edwards Chmn.) Cardiff: Welsh Office, 1987.
2. Department of Health and Social Security. *Neighbourhood nursing: a focus for care. Report of the Community Nursing Review.* London: HMSO, 1986.
3. Secretaries of State for Social Services, Wales, Northern Ireland and Scotland. *Promoting better health. The Government's programme for improving primary health care (Cm 249).* London: HMSO, 1987.

Management of drug misuse in general practice

MOST general practitioners are unsure and apprehensive about their role in the management of drug misuse. Drug misusers, in common with all our patients, are entitled to the full range of primary health care services. It is entirely appropriate that we should concern ourselves with their general medical problems and also with the problems associated with their drug misuse.

The general practitioner is well placed to see addiction in its true perspective. It is not just a condition which affects the primary sufferer alone. There are many equally important secondary sufferers who badly need help — parents, partners, siblings, children and other relatives and friends. These family members often suffer more serious and longer lasting harm than the addicts themselves. General practitioners are frequently approached by concerned family members seeking help for the addict. The family may be misguidedly paying fines incurred by the addict or protecting him in other ways from the legal and social consequences of his criminal activities. Some relatives go to the lengths of procuring drugs for the addict, either by illegal means or by manipulating the general practitioner or consultant psychiatrist to prescribe. This behavioural pattern of shielding a person from the natural consequences of his actions is known as 'enabling' — it enables the addict, the alcoholic and the compulsive gambler to remain addicted. Families which practise enabling do great damage to themselves as well as to the addict.

Other problems arise because mothers and fathers often disagree on how best to 'manage' their addict child. This can lead to irreparable damage within the marital relationship. Brother and sisters resent the amount of time and effort spent on the 'black sheep' and because of the problems within their dysfunctional family they often fail to achieve their potential in life. The distress of the spouse or partner is extreme and readily understandable. The problems and distress of the children of addicts and alcoholics are insidious and long term. Such children have to compete with the drugs for parental attention and approval. They grow up sometimes as high achievers but suffer from great insecurity and loneliness.

It is perplexing that so few professionals recognize the dimension of the family problem. It is best tackled by voluntary self-help groups: there is no need for a professional 'empire' to be set up. Most people will have heard of Alcoholics Anonymous and its associated fellowship for family members, Al-Anon. The fact that Narcotics Anonymous has an associated fellowship for families called Families Anonymous is less well known. Families Anonymous groups are being set up all over the country. Their goal is to assist the family member to find serenity. They do not set out to solve the problems of the addict or to give advice

but do their work by honest sharing of experiences within the group. It is particularly useful for general practitioners to refer families to such groups because this circumvents all the problems relating to confidentiality. Families attending these groups are easily recognized because as they follow the group programme they stop 'enabling' and start to practise 'tough love', which basically means being cruel to be kind or allowing the addict to experience the consequences of his actions. As far as treating addiction is concerned, getting involved with the family is of far greater benefit than counselling the addict or prescribing or indeed any other form of therapy.

Prescribing in general has an undeserved reputation as a panacea for treatment of drug addiction. Short-term reducing courses of a substitute drug for the purpose of detoxification can sometimes be helpful. However, long-term open-ended or maintenance prescribing is actually counterproductive to recovery. It suggests that an addict is totally powerless and that the prescribing doctor has to take over the responsibility for the patient's continuing existence. Arguments that such prescribing helps the addict to get better by enabling him to avoid legal and financial problems are entirely specious. External problem solving has no effect on addiction in the long-term; the impetus for recovery comes from internal changes.

Short-term detoxification is well within the remit of the general practitioner and some doctors may wish to provide this service for their addicted patients. By means of an unhurried assessment interview it can be established whether or not the patient takes drugs in a dependent way. During this assessment interview it is also very important for the doctor to educate the patient about the dangers of needle and syringe sharing.

For patients addicted to drugs of the opiate class methadone is at present considered to be the drug of choice for detoxification. It is long acting, relatively boring and the Drug Tariff formulation is non-injectable. Short acting drugs such as dextromoramide (Palfium, MCP) make addiction much worse because the addict craves his next 'hit' about two hours after his previous one. In general it can be assumed that most tablets will be crushed up and injected intravenously by addicts rather than taken daily as intended by the prescriber. Help in determining the right initial dose for detoxification can be found in the *Guidelines for good clinical practice in the treatment of drug misuse.* However, for all practical purposes the usual starting dose is 30 mg methadone mixture (Drug Tariff Formula) daily. A dose below 20 mg per day is inappropriate and a dose above 40 mg should rarely be given in general practice. Most addicts will overstate the amount of drug they take in order to persuade the doctor to prescribe a large dose of methadone. Prescribing on a daily basis prevents the addict from using up his supply too soon, but means that a general practitioner has to write six prescriptions each week. This problem will soon be overcome as the DHSS plans to issue special prescribing forms to general practitioners for the treatment of addiction. These forms will allow the pharmacist to claim special fees for daily dispensing and the forms will be valid for up to 14 days.

Insomnia is always a problem for recovering addicts. They need to be advised that it will last for at least six months and that they will have to employ strategies other than drugs to combat it. All drugs with an addictive potential need to be avoided by recovering addicts. This includes the full range of benzodiazepines. There is an additional problem with temazepam capsules. The liquid drug is often squeezed into the barrel of a syringe and injected intravenously. There is a flourishing black market for this preparation and because of this many general practitioners now choose to prescribe only the non-injectable temazepam syrup for all patients.

In managing the drug misuser a general practitioner can enlist the help of other professionals, such as community nurses, social workers or members of specialist drug teams. If a general practitioner has confidence in the services available locally, he or she may wish to delegate some of the task of assessment and counselling to these professionals. However, the responsibility for prescribing is solely the general practitioner's. Decisions about the issue of prescribing and also procedures regarding notification of addicts to the Home Office need to be undertaken with great care.

Detoxification will at best produce a drug-free addict. It needs to be understood that the person will almost certainly relapse. Sometimes counselling and family support can help in preventing relapse. A detoxified addict has to find non-drug ways of getting high. He has to find ways of filling the day which previously was entirely devoted to the search for drugs and he also has to learn to cope with situations of risk and say 'No' when someone offers him drugs.

The most effective way for addicts to avoid relapsing is to attend Narcotics Anonymous meetings, where they come in contact with others in recovery who are happy and who have usually made a success of their lives. This band of ex-junkies who voluntarily help each other needs to be more widely recognized and understood. Thousands of people in this country and around the world are in recovery thanks to Narcotics Anonymous. Yet because advertising is forbidden by the fellowship, most of us remain happily ignorant or regrettably sometimes in knowing denial about its effectiveness. The ultimate and unfailing remedy for addiction is 'Don't take drugs; go to meetings'.

The more I deal with addicts the more I am coming to understand that recovery comes from within. It is not just a matter of becoming drug free, of getting a job or of making external changes in life. For most addicts that internal change has to do with learning how to love themselves. The fact that their families and friends love them to distraction is of no use if they do not love themselves. For so many years drugs have hidden the addict from the world and the world for him. Even more important is the fact that drugs hide the addict from himself so that he loses touch with his own feelings and his own spiritual values. Once an addict has come to understand this he begins to contemplate change.

I think of myself as a signpost rather than a counsellor. I am happy to point my addicted patients toward the real experts, especially those in the voluntary fellowships who can help them far more than I can. However, I am also a sower of seeds. Some germinate immediately, many fall by the wayside on barren ground but many of these germinate unexpectedly at a later date. I am sure that most contacts between addicts and general practitioners are of value to the addict. They are also of value to the doctor as they teach us to like these seemingly unlovable people, to see some good in most of them and, above all, not to sit in judgement.

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Useful publications

Banks A, Waller T. *Drug misuse. A practical handbook for the GP.* Oxford: Blackwell Scientific (for Institute for the Study of Drug Dependence), 1988.

Chang JM. *Coping with drug misuse in general practice.* Queenborough, Kent: Abbott. (Obtainable from Abbott Laboratories Ltd, Queenborough, Kent ME11 5EL.)

Department of Health and Social Security. *Guidelines for good clinical practice in the treatment of drug misuse.* London: DHSS, 1984. (Obtainable from DHSS Store, Canons Park, Government Buildings, Honepot Lane, Stanmore, Middlesex HA7 1AY.)

Dixon A. *Dealing with drugs.* London: BBC Publications, 1987.

Lefever R. *The Promis handbook on alcoholism, addictions and recovery.* London: Promis Books, 1988. (Obtainable from Promis Books, 1 St Quintin Avenue, London W10 6NX.)

Useful addresses

Narcotics Anonymous, PO Box 246, Milman Street, London SW10. Telephone: 01-351 6794 (24 hour answerphone), 01-351 6066 (14.00–20.00 hours weekdays).

Families Anonymous, 5–7 Parsons Green, London SW6. Telephone. 01-731 8060.

Institute for the Study of Drug Dependence, 1–4 Hatton Place, London EC1 8ND.