Psychiatric Bulletin (1989) **13**, 316–332

The College

HIV disease and psychiatric practice*

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I. Introduction

The psychiatric implications of HIV infection make it likely that in the years ahead increasing numbers of individuals suffering from HIV disease will come into contact with the mental health services. The extent of the problem now and its likely future spread suggest that the need for psychiatric involvement will not be restricted to the main metropolitan areas, and so a wider discussion of possible problems is desirable now, so as to anticipate and tackle potential difficulties.

Knowledge about the psychiatric implications of HIV disease is accumulating but it is clear that many questions remain unanswered, and that shifts in emphasis should be expected in the future. Similarly, the ethical and legal consequences of HIV disease are still the subject of debate, and while a measure of agreement is now being reached, there are areas of debate which remain unresolved. It is hoped that these guidelines will assist psychiatrists in the process of discussion and clarification of issues relevant to their clinical practice.

These guidelines refer to adult patients. While many of the issues covered here would also apply to children and adolescents, their particular clinical and practical problems would require separate consideration.

The guidelines contain first an overview of psychosocial and neuropsychiatric problems related to HIV disease; second, they consider practical questions concerned with ensuring optimum care of patients; thirdly, they refer to infection control issues in psychiatric settings; and finally, they make further specific recommendations.

*Paper prepared at the request of Dr J. L. T. Birley, President of The Royal College of Psychiatrists.

II. Overview of psychosocial and neuropsychiatric problems in HIV disease

Both psychological reactions (such as affective disorders, adjustment reactions, or neurotic disorders) and organic brain syndromes (acute and chronic) can occur in HIV patients. The prevalence and type of psychiatric disorder will vary with the stage of infection and the degree of physical problems, personality characteristics and individual vulnerability, as well as the extent of social supports.

(a) Psychosocial problems

Many individuals suffer adjustment reactions on learning of a positive HIV antibody test result, but these disorders are usually of limited duration and persistent disorders, such as major depression, are less common. However, there are reports of suicide following notification of the test result, and it is therefore important to ensure that the test is carried out with the person's informed consent (see below) and that disclosure of the results is done with sensitivity and care. Individuals presenting with persistent fear of HIV infection in spite of a negative HIV antibody test result may be referred to psychiatrists. As in the case of other disorders characterised by morbid fears of illness, careful assessment will be necessary to identify disorders requiring specific treatment, such as major depression, hypochondriasis, or schizophrenic illness.

Psychosocial problems are more common in symptomatic HIV antibody positive individuals, such as those developing persistent generalised lymphadenopathy (PGL) or AIDS-related complex (ARC), some studies suggesting that these patients suffer greater psychiatric morbidity than AIDS patients. Mania and schizophrenia-like disorders in

patients without signs of organicity have been described, the aetiology remaining unclear.

The psychosocial reactions to the diagnosis of AIDS are similar to those seen in other potentially fatal conditions, but here they are magnified by the stigma attached to it and by fears of social rejection. The prevalence of psychiatric disturbance is greatest shortly after the diagnosis is made, and in the later stages of the disease, and so it is likely that these patients will be referred to liaison psychiatrists working in general hospitals. Major depression and adjustment reactions are the main disorders. The risk of suicide, even while in the general hospital, is significantly increased at this stage, one report indicating a prevalence greater than 30 times that of a comparable population. Mania and schizophrenia-like disorders have been described in AIDS patients, often as part of an organic brain disorder (see below).

(b) Neuropsychiatric problems

HIV infection can be associated with a variety of neuropsychiatric and neurological symptoms resulting from the direct effect of the virus on the nervous system, or secondary to opportunistic infections (e.g. cerebral toxoplasmosis and cryptococcal meningitis) or tumours related to immunodeficiency (e.g. lymphoma and Kaposi's sarcoma). Nervous system manifestations can develop early in the infection, at the time of seroconversion, taking the form of a transient acute aseptic meningitis. However, chronic neuro-psychiatric syndromes are more likely as the infection progresses and as other signs of immunodeficiency become apparent.

Research evidence to date suggests that asymptomatic HIV antibody positive individuals do not differ in a clinically significant degree from negative controls in their performance on neuropsychological tests, although there is still some debate about this matter, and further research will be needed before a definitive conclusion can be reached. Symptomatic HIV individuals (PGL, ARC) show a greater prevalence of neuropsychological impairment than asymptomatic HIV patients and negative controls, although the exact prevalence of such abnormalities, their significance and prognosis remain the subject of debate, and further research will be needed before reaching definitive conclusions.

A syndrome of subacute encephalitis attributed to HIV has been described in a majority of AIDS patients, and the term "AIDS-dementia complex" has been introduced to refer to a chronic syndrome characterised in the early stages by cognitive and behavioural changes including apathy, psychomotor retardation, impaired memory and concentration and motor abnormalities, which can lead rapidly to global intellectual impairment and severe neurological signs. There is no agreement yet about the prevalence of dementia, unselected samples suggesting between 8% and 16% of AIDS patients, while clinical and pathological studies of patients referred to neurologists suggest a figure in excess of 60%. It is of particular relevance to psychiatrists that symptoms and signs of cognitive impairment could be the first indicator of severe immunodeficiency.

(c) Service implications

It should not be assumed that a psychiatric condition occurring in an HIV positive patient is necessarily due to AIDS. A full psychiatric history must always be carried out. The complex interplay of biomedical and psychosocial factors must be clarified. The history of risk factors can often be better obtained in the setting of a psychiatric history sensitively conducted, than in a medical clinic. For example, a history of IV drug use in a homosexual man may not be obtained until asked for. A most important point is not to assign the diagnosis of AIDS dementia to a cognitively impaired patient before considering and excluding treatable causes of impairment such as depression or other cerebral infections/tumours; latrogenic causes of psychopathology should also be considered. These range from the depressant side-effects of drugs sometimes unfamiliar to psychiatrists, such as interferon, to the more general negative effects of a poor doctor-patient relationship.

The range of problems outlined above will have implications for the psychiatric services, both in hospital and in the community. Much will depend on the extent of the spread of the infection and on geographic and demographic factors, and the development of effective therapies, but in any case, it is likely that in the future, mental health teams will be asked to provide help for HIV patients and their relatives in a variety of settings, including the following:

(a) *In-patient psychiatric care:* both short-term care (for patients with major depression, adjustment reactions, or those at risk of suicide) and longer term, as in the case of patients with chronic brain disorders unable to cope in the community or in general hospital.

(b) *Psychiatric liaison referrals* of patients in the general hospital needing assessment and treatment of functional and organic disorder.

(c) *Out-patient and community care:* most HIV patients are likely to live outside hospital for most of the time, and so their involvement with psychiatric services will be in out-patients departments or with community teams.

(d) *Neuropsychological assessment:* an increase in requests for neuropsychological testing is likely in these patients.

(e) *HIV infection and drug abuse:* Injecting drug users represent the second biggest group of people infected by HIV in the Western World after gay

https://doi.org/10.1192/pb.13.6.316 Published online by Cambridge University Press

and bisexual men. In addition they account for most cases of heterosexual transmission.

Drug users are likely to suffer other infections and problems which may compromise further their immune state. Psychiatrists may have more frequent contacts with drug users than other health care professionals, either for causes directly related to their drug use (detoxification, maintenance, or treatment) or for psychopathology and abnormal behaviours secondary to the misuse of drugs (suicidal behaviour, depression, or drug-induced psychotic states). Psychiatrists are therefore well placed to try to maximise the usefulness of any such contacts, by building into their interventions strategies aimed at teaching drug users to reduce their risky behaviours and attempt to engage them in a programme of change towards safer behaviours both in terms of their injecting and sexual habits.

It is not the scope of these guidelines to enter the debate about which are the most appropriate measures to adopt in the treatment of drug users to stop the spread of HIV. It is, however, clear that services will need to become more flexible in their approach and that workers may have to develop a more graded approach to the problem, where the achievement of intermediate goals, such as change to lower risk behaviour, become acceptable if not ultimate aims of treatment.

(f) *Staff support:* General medical and nursing staff dealing regularly with HIV patients often experience signs of stress and psychological difficulties similar to those described in terminal care and oncology units. There is room for the development of staff support facilities with the involvement of psychiatrists.

Mental health staff are not necessarily free from the irrational reactions to HIV infection shown by the general public or by other professional groups, and it is therefore important that mental health care workers are aware of the potential obstacles for the provision of adequate care to HIV patients, or to those thought to be at risk of carrying the infection. At the same time, it is essential that those caring for HIV patients are aware of how to minimise or avoid the risk of infection to themselves or to other patients. Both these issues will be considered below.

III. Provision of optimum psychiatric care to HIV patients

(a) General considerations

(1) The provision of optimum psychiatric care to HIV patients or to those thought to be infected can be put in jeopardy by the presence of irrational fears of infection (which are usually the result of inadequate knowledge of the risks involved in social activities and medical procedures), or by the existence of negative attitudes towards HIV patients, possibly related to disapproval of their lifestyle, especially in the case of drug users and gay and bisexual patients.

(2) It follows that staff education, with emphasis both on (a) factual information about clinical syndromes and infection control, and (b) opportunity for discussion of attitudes and fears, needs to be an integral part of the training of staff dealing with HIV patients.

(3) All patients should have access to appropriate care for their psychiatric disorder, regardless of HIV status, and such care must include the right to reasonable standards of confidentiality about their condition, and the right to be consulted and asked for consent before medical procedures, including testing for HIV infection, are carried out. An essential component of the care of HIV patients is the provision of counselling and advice about the implications of the infection, and about behaviours with low and high risk of transmission of infection to others.

(4) All patients, regardless of HIV status, should be regarded as potentially at risk of transmitting and acquiring HIV infection, so that individuals are not singled out or dealt with in a special way. This will not only ensure that the confidentiality of an individual patient's status is maintained, but will also lead to a reduction in the risk of transmission of HIV and other pathogens, provided high standards of hygiene and adequate measures of infection control are used in all cases (see below).

(b) Testing for HIV infection (antibody or antigen)

(1) It is important to establish a distinction between SCREENING, or systemic application of HIV testing to determine the prevalence of infection in a particular population or target group; and TESTING, a serological procedure to determine the presence of HIV infection for an individual patient, either at the request of the individual or for diagnostic purposes and at the recommendation of a medical practitioner.

(2) There is no place for routine screening for HIV infection in every day psychiatric practice. Screening for HIV infection should only be carried out as part of a specific programme of research, with clear objectives and procedures, and after careful consideration has been given to practical, ethical and legal issues.

(3) Testing for HIV infection, like other procedures in medical and psychiatric practice, should only be carried out with the patient's informed and explicit consent, except in very rare situations (see below). When testing is patient-initiated, it is important to clarify with the patient the reasons for such a request, discussion of what might be gained by knowing the

https://doi.org/10.1192/pb.13.6.316 Published online by Cambridge University Press

test result, and examination of the possible adverse consequences of a positive test result. Post-test counselling should also be made available to the patient.

Testing for HIV may be considered for diagnostic purposes, when the patient's clinical symptoms or past history raise the possibility of HIV infection. As stated above, when such a situation arises, the doctor should seek to obtain from the patient informed and explicit consent for the procedure, explaining the reasons why HIV testing is being considered, and the implications of the result. While concern about the risk of causing distress to patients found to be HIV negative is sometimes adduced as a reason for not seeking to obtain consent prior to the test, it is important to consider the problems likely to arise when an unprepared patient, unaware of the procedure being carried out, has to be informed of a positive HIV test result.

The process of counselling patients before and after an HIV antibody test should not be confused with other forms of counselling although there are clearly features in common. The major part of HIV counselling requires a detailed knowledge on the part of the counsellor of the illnesses associated with HIV, the test itself, its financial, legal and health implications. Thus, HIV counselling should preferably be carried out only by properly trained HIV counsellors. The opposite is also true and HIV counsellors will require supervision from a psychiatrist to deal with more serious psychopathology.

(4) Testing for HIV infection without explicit consent is permissible only in exceptional circumstances. The General Medical Council 1988 has stated that this should only occur "where a test is imperative in order to secure the safety of persons other than the patient and where it is not possible for the prior consent of the patient to be obtained".

In psychiatric practice, there are other situations where the possibility of HIV testing without the patient's consent may arise, as when the patient is unable or unwilling to give consent for reasons of psychiatric disorder. For example, as in the case of a patient suffering from a severe affective disorder, sever mental handicap or an organic brain syndrome where it is not possible to obtain informed consent. In some such cases, the above guidelines given by the General Medical Council would be applicable. In others, the circumstances may be less clear cut and in the absence of specific advice from the Mental Health Act Commission and other bodies, only general guidelines can be given:

(a) *What would be gained by an HIV test?*

In general, testing without consent in these circumstances should only be carried out when knowing the result would be of diagnostic value and likely to be of benefit to the patient. In many cases, psychiatric treatment may not be affected in short term by knowledge of HIV status, and so it may be possible to wait until the patient has improved and is able to give consent. A likely diagnosis of HIV disease can often be made on clinical grounds, and the appropriate treatment instituted, and so collaboration with medical colleagues would be essential.

The need to know the HIV status for the protection of staff or other patients would only apply to patients showing aggressive or uninhibited behaviour, and such instances would be covered by the advice given by the GMC. Staff anxiety about the possible risks of infection through ordinary procedures would not be a sufficient reason for testing without the patient's consent.

(b) *What procedures should be followed to ensure the correctness of HIV testing in these circumstances?*

The reasons for deciding to carry out HIV testing should be carefully stated in the notes by the responsible medical officer. The decision to test should be the result of discussion within the team and should whenever possible involve a second opinion by a psychiatrist and/or physician. Notification of the local health authority's solicitor and/or the doctor's legal adviser or defence association has been suggested and would appear to be a wise precaution. In general, the doctor carrying out HIV testing in these circumstances should do so with the awareness that the decision may have to be defended in court.

(c) *Does the patient need to be detained on a section of the Mental Health Act?*

It does not necessarily follow under current legislation that a patient who was unable to give consent would have to be legally detained before testing, nor would Section 3 allow a test to be carried out without consent, unless the psychiatric condition were thought to be a direct result of HIV infection and HIV testing formed part of the management of the psychiatric disorder.

It should be emphasised that such cases are extremely rare and that a genuine clinical need to test without consent may be even rarer. However it is not at present possible to state unequivocally that in such circumstances an HIV test should *never* be carried out. In the end it is up to the psychiatrist, after taking advice from colleagues in the same and other disciplines and being sure that he understands the issues involved, to make the decision in the best interests of his patient. It is not a good enough reason that other patients may be at risk if the HIV status is not known since, under these circumstances, it should be assumed that the patient is HIV antibody positive and appropriate precautions taken.

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(c) Confidentiality in relation to HIV antibody status

(1) HIV patients, like other patients, have the right to expect reasonable standards of confidentiality regarding their status. There are, however, limits to the principle of confidentiality, and patients should be aware of such limits from the outset.

(2) Patients are usually treated by a clinical team, rather than by one single individual, and the question of disclosure to team members arises. In general, only those team members who *need to know* should know the patient's status. The need to know would arise because of the patient's needs (e.g. to give psychological support to a depressed patient), or out of the need to reduce the risk of infection to staff or patients (e.g. patient with severe diarrhoea). In some health districts, local guidelines request that the Infection Control Officer and Infection Control Nurse should be informed of any admissions of HIV patients. In all these cases, it is important for the doctor to discuss fully with the patient the reasons for disclosure to other team members before doing so. Within the multidisciplinary teams the dissemination of information will therefore be partially determined by the style of work.

(3) When it is desirable to inform other health care professionals, such as the general practitioner, it is essential to discuss the matter with the patient, and obtain consent before contacting them. In most cases, the patient will agree to disclosure to other health care staff likely to be involved in their future care.

(4) If, in spite of discussion, a patient still refuses to allow disclosure to other health care staff, the GMC advises "the doctor has two sets of obligations to consider: obligations to the patient to maintain confidence, and obligation to other carers whose own health may be put unnecessarily at risk. In such circumstances, the patient should be counselled about the difficulties which his or her condition is likely to pose for the team responsible for providing continuing care in the future. If, having considered the matter carefully in the light of such counselling, the patient still refuses to allow the general practitioner to be informed, then the patient's request for privacy should be respected. The only exception to that general principle arises where the doctor judges that the failure to disclose would put the health of any of the health care team at serious risk. The Council believes that, in such situations, it would not be improper to disclose such information as the person needs to know. The need for such a decision is, in present circumstances, likely to arise only rarely, but if it is made the doctor must be able to justify his or her action."

(5) The GMC is also clear in its advice about informing the patient's spouse or sexual partner: "The Council has reached the view that there are grounds for such a disclosure only where there is a serious and identifiable risk to a specific individual who, if not so informed, would be exposed to infection. Therefore, when a person is found to be infected in this way, the doctor must discuss with the patient the question of informing a spouse or other sexual partner. The Council believes that most such patients will agree to disclosure in these circumstances, but where such consent is withheld the doctor may consider it a duty to seek to ensure that any sexual partner is informed, in order to safeguard such persons from possibly fatal infection."

(d) Other ethical and legal issues

(1) In line with the GMC advice, psychiatrists and other staff will be expected to give HIV patients the same standard of care they would offer to any other patient. Doctors who have a conscientious objection to a particular course of treatment, or who lack the necessary knowledge or skills to provide adequate management, would act properly if they were to refer the patient to another doctor. However, it is unethical for a doctor to refuse medical care for which there are facilities, on the grounds that the patient suffers from a condition which could expose the doctor to personal risk. It is also unethical for a doctor to withhold treatment from a patient on the basis of a moral judgement that the patient's behaviour or lifestyle might have contributed to the condition for which treatment is being sought.

(2) As in other clinical situations, the issue of whether to continue to treat a particular patient and prolong life when its quality is severely reduced may need to be discussed. In the context of psychiatry, this problem may arise in relation to individuals who have survived a serious suicide attempt, or those expressing suicidal ideas. There are no easy answers to some of these dilemmas, but as in other such cases not involving HIV infection, careful assessment of the patient's mental state, support to deal with the situation and introduction of palliative care measures to minimise physical discomfort, would be necessary. Discussion with colleagues and with staff working in terminal care units would be highly recommended.

IV. Avoiding HIV infection in psychiatric practice

(1) The risk of HIV infection to patients or staff in psychiatric settings is minimal, and limited to a few specific situations. It is therefore essential for all staff to be well informed about the circumstances where risk of infection may or may not be present.

(2) From the infection control point of view, the most effective way of reducing the risk of infection with HIV and other pathogens is to deal with all

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patients as potentially at risk of transmitting and receiving HIV infection.
(3) Infection is only likely to occur as a result of parenteral inoculation with infected blood or body fluids, as in the case of accidents involving needlestick injuries or other sharps, or by means of contamination of lacerated skin or mucous membranes.
(4) It follows from the above that there is no risk of infection to other patients or staff in ordinary social situations such as sharing a room, shaking hands, touching or social kissing, sharing of crockery and cutlery, cleaning, serving food or bedmaking.
(5) HIV patients do not require nursing in a single room because of their HIV status, except in cases where there is bleeding, blood-stained fluids or secretions, or when the patient is immunocompromised and likely to acquire infections from other patients, or the patient is an infection risk from organisms other than HIV. With these exceptions, the decision as to whether to nurse in a single room will depend on the patient's psychiatric needs and right to privacy and confidentiality.
(6) All staff should receive instruction about procedures that involve a risk of infection and how to minimise this risk. In particular, clear advice about: (a) the disposal of needles and other sharps; (b) avoidance of re-sheathing needles; (c) covering of broken or lacerated skin and appropriate use of gloves, goggles or aprons when dealing with infected or potentially hazardous material; (d) cleaning and disinfection procedures including simple hand washing after contact; (e) handling infected linen, clinical waste and equipment and disposing of them in biohazard bags.
(7) All staff should receive instruction about procedures to follow in the case of incidents where other staff or patients might have been put at significant risk of infection, as in the case of accidental innoculation with infected blood or contact with contaminated fluids. In some health districts, the possibility of having prophylactic zidovudine for a limited period in time in cases of proven contact with infected fluids is available.
(8) Staff who are HIV infected have the same rights to adequate care and confidentiality as any other HIV infected individual. However, they also have responsibilities because of their job, both in the public interest and on ethical grounds. It should be stressed that in spite of public anxiety about the possibility of doctors or others putting patients at risk of infection, there is no known case of infection with HIV having been transmitted by an infected doctor to a patient in the course of treatment.

The GMC has given guidelines for HIV infected doctors, stressing the need for such individuals to seek confidential medical advice to the extent to which they should alter, if at all, their practice, and the need to act upon the advice of the specialist. In cases where a change in practice or employment may be required, it would become necessary to involve health authority managers to facilitate the provision of alternate employment. Contractual rights of employment should be protected so that voluntary reporting can be encouraged.

V. Recommendations

(1) Each Mental Health Unit should address the psychiatric implications of HIV infection by ensuring that all staff are aware of the range of psychiatric problems likely to occur, and the possible effect of patient care and organisation of services.
(2) All staff should be aware of the practical aspects of infection control, as well as of the ethical and legal issues that arise in the context of HIV infection. This can best be achieved by developing educational programmes at local level.
(3) Specific policies related to the needs of each Mental Health Unit may need to be developed, in collaboration with the policies established in the health district and at national level.
(4) Psychiatrists should ensure that local health planning takes into consideration the likely psychiatric implications of HIV infection. This can best be achieved by involvement in district and other HIV task forces responsible for planning and resource allocation.
(5) The implementation of the above recommendations will be more likely to take place if each Mental Health Unit establishes a working group or team of professionals to monitor the local implication of HIV disease, ensuring that staff education and service provision reflects local needs.

Further reading

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Approved by Council
March 1989

Further copies of this document are available from the College at a price of £2.00. Cheques should be made payable to the Royal College of Psychiatrists and forwarded to the Office Services Department.

District-level services for drug takers

The role of the general psychiatrist*

The advent of HIV infection among injecting drug misusers reinforces the need for the rapid expansion and increased availability of a comprehensive health care service for drug misusers. This will require development of a broad range of local services, with the capacity to respond quickly to new referrals, and to arrange long-term supervision. Regional services will continue to provide treatments and to offer advice, support and training, but cannot offer therapy to all drug users.

A service must be available in every district. District Health Authorities must recognise and accept their administrative and financial responsibilities for this provision. The Central Funding Initiative and subsequent earmarked fundings (HC 83/13 and subsequent) have in many districts achieved successful expansion of the non-statutory and *non-medical* components of drug services (e.g. voluntary agencies and community drug teams). However, this expansion has often not been accompanied by an adequate development of local specialist medical input, which should include provision for prescribing.

In developing adequate provision, every district requires a consultant psychiatrist, with identified responsibility for drug services and who has designated sessions for this purpose. In some districts it may be more realistic for this consultant additionally to hold responsibility for alcohol services, for which a separate allocation of sessions are required. The Royal College of Psychiatrists has recommended that in an average district there should be at least four sessions of consultant time specifically set aside for drug services or four sessions set aside for drug and alcohol services. The general policy from the Department of Health is that District Health Authorities should ensure that adequate consultant time is available for the provision of a comprehensive service to the drug using population and that this should be gauged accordingly to local circumstances.

It is likely that there will be a need for at least two identified drug sessions within an average district, that more are required in districts with a high prevalence of drug misuse and in large districts, and that the number of sessions will increase in step with a general expansion of consultant posts.

At district level, the consultant with identified sessions would expect to be a member of the District Drug Advisory Committee, and to be involved with district management and other relevant agencies (local authority and non-statutory agencies) in the planning and implementation of local drug services. The role of the consultant would include advising on the adequacy and appropriate nature of both statutory and non-statutory provisions (including community-based facilities), planning and service input into provision for HIV and AIDS, and continued monitoring and development of services as new needs arise.

Within every district access to the following components of comprehensive health care for drug takers should include:

(1) **Management of physical complications**
Management of acute intoxication, overdose, pregnancy associated with drug taking and other medical complications is primarily dealt with by accident and emergency departments and general medical wards including obstetrics.

*Discussion document issued on behalf of the Substance Misuse Section of the Royal College of Psychiatrists.