

and energy company schemes available, which can be tapped for some people not receiving benefits.

For such a major public health problem there has been little methodologically sound research into the links between cold damp housing and ill health, although the available medical evidence has been well reviewed.⁶⁻⁸ In particular, few controlled intervention studies have been done despite the opportunities afforded by major housing regeneration programmes. After an initial pilot study this year a major evaluation study is promised. The Acheson inquiry into inequalities in health accepted the evidence linking cold damp housing and health and recommended policies to improve housing and, in particular, to improve insulation and heating systems.⁹

Cold damp houses are associated with premature mortality, physical and mental illness, and impaired quality of life. They aggravate a wide range of medical conditions, increase suffering, and make it harder to care for vulnerable people at home, thus adding to the burdens on the National Health Service. The effects are widespread across the population, though elderly people, those with chronic disabling conditions or asthma, and families with small children are the groups most immediately and obviously affected. Among the major preventable medical problems partially caused, or aggravated, by cold damp houses are the 25-45 000 excess winter deaths,¹⁰ far more than in colder countries such as Norway.¹¹ The effects on the NHS are seen in the annual winter crises, with their effect on hospitals and waiting lists. When the temperature falls resistance to respiratory disease falls and vascular complications are increased, leading, for example, to increases in the incidence of myocardial infarction.¹²

An NHS pilot study installing central heating in the homes of asthmatic children in Cornwall was associated with improvement in symptoms and reduced time off school.¹³ The English house condition survey shows fewer people in energy efficient homes reporting chest, rheumatic, and general health problems than those in colder homes.² The absence of controls and confounding variables prevents reliable quantification of the extent of health improvements, economic savings, and environmental protection from implementing the fuel poverty strategy. Nevertheless, the strategy has the potential to provide beneficial outcomes across the board. Its effects on employment, national energy consumption, and greenhouse gases are economically beneficial. Poor households may take

some of the savings due to energy efficiency in the form of extra warmth and comfort; others might improve their diet or reduce their social isolation. School students in fuel poor homes might be able to study warmly away from the distractions of the living room and its TV. But it needs engagement from the health service if those most likely to benefit are to be given priority and the programme expanded to meet the need. One useful extension would be to provide grants to pregnant women before birth, rather than only after birth when they become eligible for income support.

Local implementation should be reviewed by winter task forces and included in every health improvement plan and primary care trust plan. Doctors and other health professionals are well placed to identify patients whose illnesses are aggravated by cold damp homes. They know who has chronic disease and who has to spend long hours at home. This non-pharmacological solution is easily accessible and doctors should act as advocates for it.

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Reducing deaths among drug misusers

Tighter legal controls on drug prescribing are not the answer

Rising drug related deaths alarm treatment providers, legislators, and society. The recent report from the Advisory Council on the Misuse of Drugs, *Reducing Drug Related Deaths*, suggests that lax prescribing is responsible for a significant proportion.¹ It supports recent national guidelines on managing drug misuse, emphasising the supervised consumption of controlled drugs.² On the same theme,

the UK Home Office proposes extending the licensing system for addiction prescribing to cover all controlled drugs except NHS prescriptions for methadone mixture.³ Yet an expansion in the licensing system is likely to reduce accessibility of treatment and so increase drug related deaths. We believe that a clinical governance based solution would more successfully enhance treatment quality, safety, and accessibility.

Currently Home Office licences cover only heroin, cocaine, and dipipanone, and about 100 doctors (mainly specialist psychiatrists) have licences. The licences encompass prescriptions for about 500 patients, most of whom receive heroin. Monitoring is indirect and low key, aimed at detecting negligently aberrant prescribing and self medication, rather than enhancing quality of care.⁴

For most opiate users the most effective treatment approach is methadone maintenance combined with tailored counselling programmes.^{1 2 5} Research also supports the efficacy and relative safety of alternative treatments such as buprenorphine and lofexidine and of injectable formulations in certain circumstances.⁵ Such evidence substantiates the continuing development of a modernised “British system,” where the approach is to provide a range of management options, tailored to individual need.⁶ It has successfully encouraged many patients into treatment,² considerably reducing morbidity—for example, from HIV infection. Even though the current hepatitis C epidemic cautions against complacency,⁷ mortality and morbidity remain much higher among drug misusers outside treatment.^{1 8}

Extending controlled drug licensing will substantially increase bureaucracy without ensuring responsible practice. The inflexibility will cause a range of practical prescribing difficulties—relating, for example, to cover for absent colleagues, continuing prescriptions in hospitals, and diminished access to private health care. Restrictions are also likely to stifle prescribing of methadone alternatives (contradicting the recommendations of the Advisory Council on the Misuse of Drugs¹) and associated research.

The proposals also convey a negative message about drug misuse treatment, reinforcing the disinclination of generalists to prescribe for drug misusers.⁹ Fear of police involvement has already deterred many general practitioners, following recent high profile cases. If drug misuse treatment is singled out as requiring Home Office supervision, many doctors will consider it an optional extra best avoided. Reduced access to services would in turn have a deleterious impact on other health agencies and the wider community and increase drug related morbidity and mortality.

Licensing has failed to improve the quality of diamorphine prescribing to addicts. There are still no treatment protocols or agreed indications for use of this drug, and prescribing practice varies considerably across the country.⁴ Supervision by drug control agencies has not worked well elsewhere. In the United States both state and federal authorities closely monitor treatment, but one survey found that 68% of agencies set an upper limit for methadone dose of 50 mg/day, well below the therapeutic range recommended in their own Department of Health guidelines.¹⁰ This type of regulatory supervision tends to deter prescribing of controlled drugs rather than raise clinical standards.

The challenge is to continue developing accessible and effective services, thereby reducing the risks of all opiate related deaths, balanced against measures to reduce treatment related individual and community risks. For example *Reducing Drug Related Deaths* implicates methadone diversion as an important factor in

accidental overdoses and recommends witnessed consumption.¹ This would help ensure treatment compliance, reduce the potential for naïve users to obtain methadone, and reassure professionals and communities. Such constraints may, however, discourage chaotic patients most at risk of overdose, have resource implications, reduce treatment retention, and conflict with important rehabilitation goals such as work and family responsibility.¹¹

The relation between methadone prescribing and drug related death is complex. Toxicology suggests that fatal overdoses usually involve combinations of drugs, often at therapeutic doses.¹ Further research into diverted methadone is urgently required to establish who uses it and what role it has in overdose.¹¹

There is a general acknowledgement that clinical governance, through education, training, audit, and evidence based practice, is the best way to improve standards. This is also a better model for improving drug misuse treatment. Measures based on governance include establishing local shared care monitoring groups, as recommended by the Department of Health clinical guidelines, and reviewing the prescriptions of individual practitioners through the prescribing activity (PACT) system.¹² Studies consistently highlight general practitioners’ training needs.⁹ The royal colleges of general practitioners and psychiatrists are both currently developing specific training for doctors treating drug misusers. Primary care group and trust developments provide a clear opportunity to harness clinical governance in the cause of more effective drug treatment services. We believe that this approach will lead to sustainable reductions in drug related deaths, by enhancing treatment quality and accessibility.¹³

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