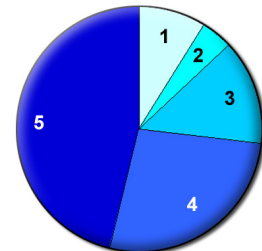


Analysis of SMMGP Membership Clinical Guidelines Survey December 2007

This survey was e-mailed out to all SMMGP Members registered to receive twice yearly consultation documents. It concerns the 2007 Clinical Guidelines on Drug Misuse & Dependence.

1) Do you think the new Clinical Guidelines on Drug Dependence are going to be helpful to you in your care of drug users (5 = very helpful)?

| | | |
|---|---|-----|
| 1 | = | 9% |
| 2 | = | 4% |
| 3 | = | 14% |
| 4 | = | 27% |
| 5 | = | 46% |



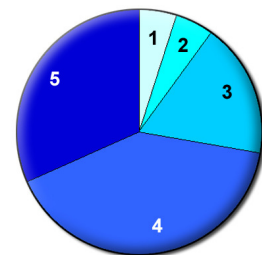
...In what ways?

- Translating evidence into practice and backing up advised best practice in governance.
- I think it is always useful in clinical practice to have guidelines, which have been developed by experts through research. It also adds to consistency in the approach of professionals in the field.
- They will again be a useful tool whilst advocating for clients who are unaware that guidelines such as these even exist and have never been made aware that there are actually guidelines out there that prescribers are meant to work to I think that more information on Suboxone would have been helpful. I also think that the group that put these guidelines together did not have enough user representation. Pregnant females for example did not seem to figure on the working group, but we have welcomed more detailed information around pregnancy in this edition of the guidelines.
- They will make prescribing of Dihydrocodein, Diazepam, Temazepam, Clonidine, Disulfiram, Naltrexone, Dexamfetamine, and Morphine much less acceptable. These drugs do have their uses. There is great variety within the spectrum of addictive disorders and these guidelines leave little opportunity to stray from very standard treatments. Instead of encouraging doctors to look at new developments in addiction treatment these guidelines are regulatory and conservative.
- Comprehensive document that provides a practical guide to prescribing issues easily accessible for non-medical clinicians in drugs team. Good back up for conversations with clients about clinical boundaries.

- New out looks will help the care of users.
- At times concerned that guidelines are too prescriptive and restrictive. GP's adapt to patient needs and absorb risks when treating patients in all clinical areas, with increased experience treating addiction patients GP's probably also take on increased risk within their confidence limits, guidelines seem to hopefully allow a little more flexibility than old guidelines.
- Uniformity of prescribing.
- They give clear structure around interventions and practice.
Easy to read & refer to quickly
- Medico legal protection for next DRD.
- As support in sticking to protocols. Practical advice e.g. going abroad
- Very general but good to know that what you are doing as a clinician is good.
- Excellent guide to best practice.

2) Do you think these clinical guidelines will be of benefit to the further development of treatment in primary care (5 = great benefit)?

| | | |
|---|---|-----|
| 1 | = | 5% |
| 2 | = | 5% |
| 3 | = | 18% |
| 4 | = | 41% |
| 5 | = | 32% |



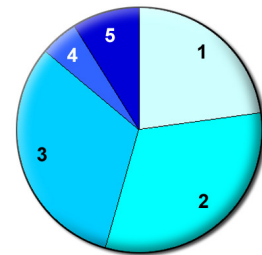
...How?

- I think clear guidelines will be useful for less experienced GP's in surgeries, which prescribe and hopefully encourage more surgeries to consider prescribing.
- Legitimises primary care still further as platform for treatment.
- Only in that they make GP's more confident in their practice and more liable to participate.
- These guidelines will prevent some GP's carrying out maverick prescribing for those drug users who are not fortunate enough to live in areas where shared care is available especially in Wales. We receive so may advocacy cases from Wales that we feel that this new publication will be welcomed so much in this area of the UK by drug users, drug workers, practitioners of all kinds and maybe even the Welsh Assembly, if anyone bothers to read them.
- The principles of care of addicts in general practice are well established already and I don't think these guidelines would change things that much. The GP contract did probably change things (but not for the better). Putting care addicts back into mainstream primary care, perhaps with some QOF points attached would have a vast impact.
- Very comprehensive and readable. Plenty of scope for audit in Primary care.
- Gives more insight into changes that are constantly being learnt through trial and error.

- Helping to set down ground rules for simple prescribing. Making prescribing for addiction the norm rather than the exception. Need some flexibility in bending the rules as some difficult patients.
- Bringing existing guidelines up to date and encouraging/supporting practitioners who are new to the field.
- May help GP's to feel more competent. Although the induction of Methadone remains a problem.
- With everyone working to guidelines it will identify shortcomings.
- Perhaps they will be of use but they won't persuade our local GP's to opt into the scheme.
- All the main information needed to treat drug users in primary care is covered.
- Specific guidance may help to have confidence to prescribe.
- Could do but I feel SMMGP is the "driving force".
- Aid best practice.

3) Are the new clinical guidelines going to change your clinical practice (5 = change a lot)?

| | | |
|---|---|-----|
| 1 | = | 23% |
| 2 | = | 32% |
| 3 | = | 32% |
| 4 | = | 5% |
| 5 | = | 9% |



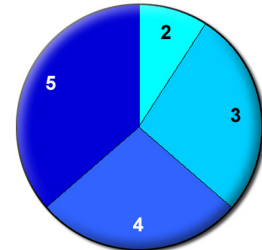
...How?

- Consider use of Lofexidine. Improved management in pregnancy.
- The appendices and advice on certain applications is most useful.
- The only change I can see is that I may use Subutex more in pregnant women while before I might have tried to change them to Methadone.
- The new information regarding prescribing for pregnant drug users will be of great use and the more detailed information around Subutex this time is most welcomed.
- More referrals for Hepatitis C.
- All will continue as normal.
- Not sure how much the guidelines will change current practice. Current practice is not of a brilliant standard. Failings are due to failures of shared care provision by so called community drug teams.
- I often use Lofexidine during detox alongside substitute opiates, with good results, this has no mention.
- Supervision, monitoring and testing.
- Not really, I think we are mostly in line with the requirements.
- Psychosocial interventions and strong reference material.

- As a pharmacist it will be a good reference book so the sections on prescribing patterns and supply i.e. supervised consumption will be of most use.
- No but will help in discussions with GP's.

4) Do you feel that the new clinical guidelines are going to be easy to implement in your practice (5 = very easy)?

| | | |
|---|---|-----|
| 1 | = | 0% |
| 2 | = | 9% |
| 3 | = | 27% |
| 4 | = | 27% |
| 5 | = | 36% |

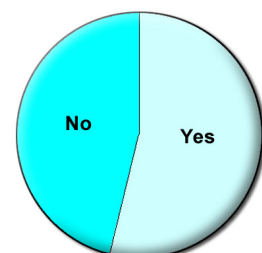


...Comments?

- Yes as we already try to follow the evidence.
- They will be easy for me to implement in carry out advocacy cases and advising users on their rights, but whether or not they influence either specialist prescribers or GP prescribers remains to be seen. I also think that it should be necessary for Pharmacists to swot up on these guidelines too as they seem to like the cash that goes with dispensing for drug users but a lot of them do not believe wholeheartedly in the medication they are dispensing or the reasons behind HR prescribing.
- There is very little in the guidelines that make me want to consider changing current practices.
- If the training is in place for the GP's to undertake substitute prescribing there should be no problems implementing it in the practice. One should have the RCGP training first and not rely only on the guidelines.
- Area of concern is some views regarding value of testing, also prescribing of Benzo's to Benzo dependent patients. Area is backward in shared care provision. Secondary care is totally out of touch and so makes implementing guidelines fully a considerable hurdle, but secondary care has shaped many local GP's attitudes to prescribing and so many GP's unwilling to prescribe.
- Most of the recommendations are already in practice.

5) Can you see any barriers to their implementation?

| | | |
|-----|---|-----|
| Yes | = | 54% |
| No | = | 46% |

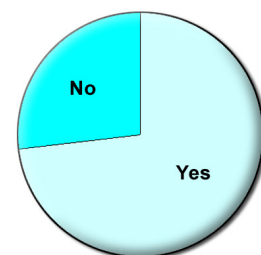


...If yes, please outline the barriers you envisage:

- General lack of enthusiasm in primary care for this work so accessing ECG difficult and appropriate treatment of mental health problems.
- It is always difficult to persuade clients that supervised consumptions anything other than punitive and they definitely don't seem to see any benefits to it.
- Again those GP's in non shared care areas that prescribe that have not yet been trained by the RCGP or do not really believe in HR prescribing or take no notice that Valium is not an evidence based treatment programme for heroin addicts.
- Yes – I don't want to implement some of it.
- Yes – backward practices and views of secondary care. Whole tendering process up for grabs and so little point at present until tenders have been sorted out. Once tenders are decided then hopefully guidelines will help to drive rapid changes in local attitudes assisted by changes in PCT attitudes regarding LES and primary care prescribing.
- Yes – availability of resources.
- GP's will only offer Methadone due to cost so client choice is irrelevant. There are still some very old-fashioned ideas around which are difficult to change, despite these guidelines.
The general lack of specialised training within the pharmacy environment, the stigma surrounding substance misuse and the willingness of pharmacists to involve themselves in supervision.
- The biggest problem with primary care is persuading GP's to see drug use as part of their job. Mostly they are resistant in taking on the care of such patients.
- Being a prison we are limited to the prescribing patterns we can follow and have to follow policies.
- Limited availability of funding for Buprenorphine locally.
- PCT funding.

6) Do you feel that there are things that can be done at a strategic and commissioning level to aid implementation?

Yes = 73%
No = 27%



...If yes, please give examples:

- More money for alcohol services.
- Up to the clinician leads in primary care to make their influence known.
- More funding for alternatives to methadone.
- Short summary document for daily use.

- Awareness days perhaps and overview of research in the best practice etc.
- We need to renegotiate our primary care contract with the PCT.
- I feel pharmacists and pharmacies are a wasted resource and more work could be done to raise the role of pharmacists in substance misuse.
- In primary care the cost of treatment should be separate from the surgeries drug budget.
- Not much really – as long as contingency management is not embraced too enthusiastically.
- Commissioners need to wake up to the fact that a single drug service cannot meet the needs of drug using population and commissioners need to allow and encourage GP prescribing to increase from present small foundations. Training program for interested GP's and GP registrars will include electronic distribution of new guidelines. Training will help develop beneficial attitudes to treating patients with drug and alcohol problems.
- Training opportunities (including protected time) for all clinicians – medical and non-medical support for prescribers in implementing guidelines within a wider clinical team.
- NDTMS returns could be automated similar to the QOF if the DET was compatible with GP computer software like EMIS and vision. Some standardised Read Codes should be introduced to populate the fields required for the NDTMS returns.
- Updated training on the new guidelines to be made compulsory for any prescriber who has signed up to their LES this year already. Cash to cover their surgery work etc will prevent this, but if a prescriber is interested in what they are doing they should be making it their business to read them thoroughly and take advice from organisations like yourselves to put any changes necessary to comply with the new guidelines in place. Perhaps the DOH should make cash available to ensure that GP's receive the same info and training that NICE are giving across the UK regions within their set training on the new guidelines that are beginning in Nov/Dec as it will leave a gap, one DAAT employee, one user rep and one specialist prescribing staff member from each DAAT area may not be enough to cement these new guidelines in place for the next few years. It may result in it taking another 10 years to get those who did not entirely welcome the last set of guidelines to see the reasons for the guidelines and put them in place again this time round.
- Briefings on the guidelines should be sent to all GP's. Commissioners should monitor their services and make sure the guidelines are being implemented.
- Hepatitis C policy framework for making changes.
- More funding for psychological treatments. Better relationships between drug treatment services and GP's.
- More shared care schemes.

7) Please make any other comment regarding the new clinical guidelines and their implementation:

- About time!

- Users all over the UK will again welcome a set of guidelines that they can use as a tool to steer their own treatment and to advise others on their treatment options.
- Making comments during the consultation phase was a waste of time. All my comments certainly seem to have totally ignored while unambiguous mistakes remain in the text. For example: 0.02% is not 1:50 but 1:5000 and 1:25 is not 0.04% (page 14).
- Incorrect references are made: Caplehorn and Drummer wrote many articles about Methadone induction deaths, but the article quoted here is not one of them (page 47).
- Taking a history of withdrawal symptoms should form part of the assessment to make a diagnosis of opioid dependence but this doesn't feature in the state of the art assessment described in these guidelines (page 49).
- A document well worth waiting for.
- Remember that it is a guideline, not something written in stone.
- Are they significantly different in regards to drug treatment?
- Not aware of changes in Home Office regulation regarding taking treatment abroad.
- I think that many clinicians will read these guidelines and use them in their work. However it does not matter how many guidelines are produced, if GP's do not wish to treat this group of people they are not obliged to do so. This is what needs to be changed.
- Will have to wait and see whether all agencies adopt the new guidelines. I would ask the questions: will everyone get a copy of the guidelines? I had to give my spare copy of the old guidelines to probation services, as they didn't have one!
- I found it easy to read and understand. It has helped stop identify where clinical roles and duties should be and were they stop. It is very informative and is really saying what we have been pushing for some time now.
- Please issue short summary document for daily use.
- Well set out, nice new sections on prisons and role of nurse prescribers. As usual I do not like the section on 3 months compulsory supervised consumption.