



network

A national newsletter on substance misuse management in primary care

Vexed, perplexed or delighted...your views on the new GMS contract



Primary Care treatment target met

Latest Figures Show Over 30% of GPs now treat Drug Dependency

Latest figures from the National Treatment Agency's (NTA) analysis of Drug Action Team treatment plan returns shows that the target of engaging 30% of GPs nationally in the treatment of drug dependency has been met. The figures from 2003/4 showed 31% of GPs are involved in treating drug users, a 50% increase from 2 years ago. NTA projections suggest that the figures will rise to 40% in 2 years time, although this does not take into account the effect of the new GMS contract. There were considerable regional variations with 2 regions (out of 9) still under 15% whilst 5 regions were above the 30% mark. Anyway this is encouraging news for all of us that want to see more drug dependant patients treated in primary care.

Part 1 of the RCGP Certificate Course in the Management of Drug Misuse to launch in Cardiff on 20 May - see page 4

Last November the NTA hosted a Summit on the New General Medical Services Contract (nGMS) and Commissioning Primary Care Services. Representatives attended it from the NTA, the Department of Health, the RCGP, SMMGP and the Royal College of Psychiatrists. A consensus statement was produced and is included below in this issue of Network. What the statement suggests are ways forward using enhanced services, both local and national. In reality a whole range of models are being implemented across the country, as SMMGP's website discussion forum shows. For a pretty current view of what this range looks like we sought the views of seven stakeholders.

GMS Summit Consensus Statement

The following consensus statement was agreed by delegates at the NTA Summit:

- Future commissioning of primary care services should aim to increase the quantity and quality of primary care provision.
- Such an increase should not destabilise current local drug treatment provision through disinvestment in either primary or secondary care services.
- Primary and secondary care should work together in collaborative partnerships within integrated care pathways to best meet the needs of drug users.
- The terms of reference of shared care monitoring groups should be reviewed. They should have an explicit role ensuring quality in local primary care service provision. They should have representatives from both primary care and secondary care and be in a position to recommend to joint commissioning groups.
- Commissioners should be free to commission shared care services for drug users under a locally enhanced service (LES) contract.
- GPs should not treat drug users in isolation. Where GPwSI(s) are providing drug services under a nationally enhanced service (NES) contract there should be adequate drug link/liason worker support.
- Ongoing treatment provision should be underpinned by ongoing education, training, supervision and appraisal to ensure a sustained improvement in quality of primary care drug treatment provision.
- nGMS contract implementation should compliment rather than disrupt Models of Care (MoC) implementation.
- Payment should be linked to level and quality of treatment activity.
- Drug treatment services in primary care should be underpinned by robust service level agreements with the Primary Care Trusts, which have responsibility for service provision.

continued from page 1

NTA view

Nat Wright is GP Clinical Lead at the National Treatment Agency for Substance Misuse

"It's a bit too early to say what the impact of the new GP contract will be but I think there are two possibilities. The consensus from last November's NTA Summit was that there are really two types of GPs. First, there are the generalist GPs working in a shared care scheme who will always see drug users as a core, but not a major, part of their work. An appropriate way forward for them could be a Locally Enhanced Service (LES) contract, where the GPs negotiate with Drug Action Teams around such a contract and a shared care scheme. Then there are the GPs who have a special interest (GPSI) in substance misuse, some who provide drug services in primary care. Regarding future contractual arrangements under the New Contract, they have a choice of LES or NES. If they are able to meet the more rigorous service specification criteria, then it could be that the NES (rather than LES) contract might be most appropriate for them."

"PMS contracts have been very successful in engaging drug users in primary care, and it was hoped that they would continue. So the PMS option is still open. They have been very successful where there are large numbers of drug users, or where there have been cold spots of provision."

RCGP Regional Drugs Lead

Gordon Morse is a GP in Salisbury, Wilts, Medical Consultant for Clouds House, a residential rehab unit, and RCGP Regional Drugs Lead across South West England

"In the first year the new contract is going to help those GPs already looking after drug users to get proper recognition and proper money for the work they do. But some GPs who are already looking after drug users are going to look at the new contract and say, 'It's too much like trouble' and then just stop doing this work. So my theory is that the new contract is going to polarise GPs: those who are going to get proper recognition for the work they do, and those who have put their toe in the water and decided they are just not going to do this work any more."

"But my uncertainty is what's going to happen in the years to come, and I just don't know the answer. My fear is that what this new contract does is to allow people to opt out so they don't have to do the things they don't want to do and sadly, in the end, it's going to count against seeing drug users in general practice, though I hope I am wrong."

"Addiction services are a tiny part of the new contract, and since the new contract has such vast implications for everybody, the problem is that substance misuse is almost an irrelevance. GPs have their eyes on much bigger issues. I fear that all the good work that has been done in recent years to bring substance misuse into mainstream general practice is going to be lost in the blink of an eye."

GP working in a Drugs Service Unit

Stephen Pick works half time as a GP in a six-partner practice in Reading and half time at Thames House, the Reading Drugs Service Unit. This unit operates a shared care scheme called the four-way agreement, which involves the GP, the key worker, the pharmacist and the drug user. Stephen has completed the RCGP certificate course and is increasingly involved in this area of work

"In Reading we've got a very good shared care scheme, with over half the GPs involved. The scheme has worked well but it is having some problems. So the new contract is coming at a really difficult time. We don't have enough key workers to run the scheme, for example. The number of substance misusing patients is already high and it is growing. A lot of GPs are prescribing for these patients but they are beginning to feel quite unsupported in this work. So the service is having quite a crisis at the moment."

"My worry with the new contract is that, as it's an opt-in service, GPs will think that it's too much trouble and simply won't opt in. I have already heard GPs saying this. My hope is that GPs will develop a LES, and in this way try to keep the status quo."

"Another worry to me is that we have already been designated a CJIP (Criminal Justice Intervention Programme) area so there is a huge pressure on rapid prescribing. That is going to put a lot more pressure on GPs as CJIP cannot function if it gets clogged up. Now, if the GPs decide not to opt in, where will these patients go?"

Shared Care Substance Misuse Manager

Heather Walker works in East London as the Shared Care Substance Misuse Manager covering Tower Hamlets, City and Hackney, and Newham Primary Care Trusts and coordinates the shared care scheme across these three PCTs. Heather is a pharmacist by training

"I can tell you about the new contract from what's happening locally. The main issue for me has been that each PCT has wanted to implement the changes in their own way rather than keep the uniformity we have had in the past. This will make the administration more difficult, especially as one PCT is much further behind schedule than the others."

"Two of the three PCTs will implement the new contract on the basis of NES. Those who are in the shared care scheme will be asked if they want to continue to provide services but under the new specification, so that we only have a one, not a two-tier scheme. It is anticipated that a GPSI will be able to look after patients who's GP does not want to be involved."

"My opinion about the new contract, as it relates to substance misuse services, is that it should have seen these as additional services rather than enhanced services,

especially where the patient is stable. I don't think it's all doom and gloom, though. I think the new contract gives us an opportunity to reshape our shared care scheme."

"Hopefully, via organisations such as SMMGP, we can all share what is happening in each area to make the whole process easier and get the best out of what we have been given to work with."

GP & RCGP Regional Drugs Lead

Martin Calow is a full-time GP in Hertfordshire. He works at Maple Lodge, which is a respite and stabilisation unit in Luton. He is a mentor for the RCGP Certificate Course and RCGP Drug Clinical Lead for half of the Eastern Region

"There are very few advantages for the care of substance misusing patients coming from the new contract. The new contract defines core work for GPs, unfortunately, where drugs and alcohol are concerned – these have been taken out of the core work. That means that basically it is no longer part of 'core' general practice to provide drug misuse help, whether that be to prescribe methadone or anything else."

"The contract specifies that drug misuse is an enhanced service. What that means is that officially there is extra money available to GPs who take on patients who have substance misuse problems. Unfortunately the commissioning of enhanced service is in the hands of the Primary Care Trust and not in the hands of the GPs. That gives the PCT the whip hand to decide whether they are going to commission any services. The NES is prescribed and sadly someone who doesn't really understand care of patients who use drugs has designed it. To get round all this there have been moves to set up LES's, where you can basically design your own service."

"The upshot of all this is confusion. Many GPs who have previously felt morally obliged to do this work now have a get-out clause in which they can say: 'Oh yes, this is extra services for which someone is being paid – so I no longer wish to do this'. Some GPs are taking this get-out clause. Many of them are soldiering on despite the fact that the enhanced services have not been commissioned. There isn't any way, as the NES is priced, it is going to encourage any GPs to come in from the cold and do this as a financially viable service. In general practice the impression is given partly by the RCGP but partly by others that there is a sump of GPs willing to do this work. The impression, I believe, is erroneous."

Single-handed GP

George Ryan is a single handed GP in Wolverhampton and a GP specialist in substance misuse

"In Wolverhampton, we're looking at the 'retainer' being a bursary of £1,000 per annum to cover training and locum costs. It is proposed to pay the existing, i.e. more experienced GPs £350 per patient per annum, paid in 4 x £75 quarterly instalments, and £200 per annum to any other GPs who may wish to become involved in the care of

drug users. The payments would ultimately exceed the amount available for shared care in the pooled budget, but it is proposed that the PCT would make up the difference."

"The differential is meant to reflect the greater experience of those GPs already involved and to be an incentive for the newly involved GPs (if there are any!) to become more engaged and committed. The number of 'wannabes' and their aspirations is a grey area, but the local Department of Public Health is currently working hard to identify potential recruits and find out what they may or may not be prepared to deliver."

"There is no intention of paying more for detox than maintenance - this is about the only certainty at the time of writing. These are, I must stress, all currently just proposals, and I will post the actual payment details on the SMMGP web site once they have been agreed."

NHS Confederation Negotiator

Andrew Spooner is a full-time GP in Crewe, Cheshire. In June 2002 he was appointed as an NHS Confederation negotiator for the new GMS contract quality group. This group negotiated the Quality and Outcomes Framework for the new GMS contract.

"While we were creating the Quality and Outcomes Framework (QOF) there were requests to put drug misuse into this framework. There was a lot of debate about this and a number of reasons why drug misuse is not in the QOF but is in the contract as an enhanced service (ES). The QOF is structured quite differently to ES in that there is a disease register, a series of tasks that you have to carry out, and a requirement to measure how successful these are. There are criteria for what you should measure and then standards for what you should achieve."

"What is special about the management of drug misuse is that you cannot measure quality and outcomes in the way you need to do in the QOF. If you were to set specific tasks and measurements in these areas, you would have many GPs saying: '...but I don't do it that way; I like to vary it according to the patient in front of me'. Everyone would argue about what to put in the QOF and nobody would get on and do it, largely because there is no evidence to use such specific process and then outcome measures for drug misuse and other 'soft' areas of medicine. On the other hand, we do have evidence about the management of cardiovascular disease, diabetes, and so on."

"Management of drug misuse has been put into ES on the basis that you can be paid for doing this work quite separately if you have a qualification, if you understand drug misuse, if you keep a register of drug misusing patients, and then audit outcomes with these patients. With ES there is a lot more flexibility for fitting the treatment to the patient in front of you – much more so than within the QOF."

The full interviews of the above are available on the SMMGP website

The NTA and SMMGP are monitoring changes (good and bad) taking place post introduction of the new GMS contract. Let us know about any changes in your area.

News about the RCGP Certificate in the Management of Drug Misuse, Part 1

Christina McArthur, an SMMGP Primary Care Advisor, explains how the new RCGP Part 1 Certificate Course in the Management of Drug Misuse works

The Part 1 to the Royal College of General Practitioners Certificate in the Management of Drug Misuse (previously known as the 'Foundation' course) will be launched at the 9th RCGP National Conference, 'Management of Drug Users in Primary Care', on 20 May 2004, in Cardiff. Part 1 follows on from the success of the original RCGP certificate course (now known as Part 2) which is aimed at practitioners wishing to become GPs with a Special Clinical Interest. Part 1 is ideal for GPs working at a generalist level, as part of a shared care scheme, especially those intending to provide treatment to drug users as part of a locally or nationally enhanced service (L/NES). Available only for GPs at the moment, this course is mapped to the Drug and Alcohol National Occupational Standards (DANOS), nGMS criteria and will be delivered in two stages.

- Stage 1 - Electronic learning - two modules approximately two hours each to complete.
- Stage 2 - Locally organised face-to-face training, the equivalent of six hours continuing professional development (CPD). The RCGP has produced guidance for Primary Care Trusts and Drug Action Teams to assist them to commission the face-to-face training. (Guidance available for commissioners and local training leads at www.smmgp.co.uk)

The RCGP and SMMGP are able to offer assistance and signpost commissioners to accredited trainers from their network of practitioners, comprising regional leads in substance misuse, mentors and facilitators.



Example of electronic learning module

Stage 1

This consists of two modules written by leading practitioners in the field in partnership with Doctors.net.uk. The modules will be delivered electronically and include a multiple-choice questionnaire (MCQ) and case study scenarios.

In module one you meet Tracey, a 23-year-old drug user, carry out an initial assessment and provide harm reduction advice. In module two you meet Mary, who requests a detoxification using buprenorphine, and explore a range of treatment interventions.

The e-modules complement each other, and for those who do not want a Part 1 Certificate they can be completed as stand-alone units. However, anyone who wishes to receive the RCGP Part 1 Certificate must complete and pass the two e-modules **and** attend the face-to-face training.

Stage 2

In order to complete the Part 1 successfully, and in acknowledgement of the need to assess your clinical acumen, the RCGP recommends that you access a minimum of six hours face-to-face training. This training will be organised on a local or regional basis and will vary according to the locality and course organisers. However, courses should include the following:

- Basic drugs awareness
- The principles of assessment and care planning for drug users
- The principles of management of maintenance prescribing, detoxification and relapse prevention treatments
- The principles of harm reduction, the role of talking therapies in substance misuse management, and the principles of safe prescribing, including how to write a prescription
- Case management, record-keeping, onward referral and liaison skills

Once you have satisfactorily completed and passed the e-learning modules and acquired your certificate of attendance from a locally accredited substance misuse training course the RCGP will issue you with a Certificate in the Management of Substance Misuse, Part 1.

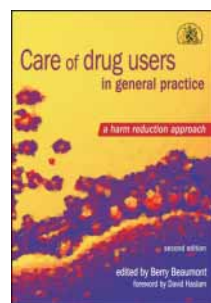
This is fully accredited training. Only those who achieve a 70% pass on both modules and complete their local face-to-face training will receive an RCGP Certificate in the Management of Drug Misuse, Part 1.

Certificate Part 1 training and its links to CPD, appraisal, and revalidation

Once you have completed the RCGP Certificate Part 1 you should be competent to participate in a local shared care scheme. The RCGP recommends that PCTs provide the necessary support and resources to enable you to deliver shared care and to participate in a minimum of six hours continuing professional development in substance misuse. This training should be reflected in your learning portfolio alongside details of other elements of your generalist services.

It does not, however, show that you are competent to provide services at GP with a Special Interest (GPSI) level. It is vital that PCTs do not place you in a position where you are providing a service for which you do not have the experience, competence or support.

The RCGP has produced a toolkit to support the appraisal process for those GPs who are involved in delivering services to drug users. This appraisal toolkit, along with further information on training standards, the courses on offer and the network of regional clinical leads, mentors, and facilitators, is available from the SMMGP (0161 866 0126) or the RCGP (020 7173 6092) or visit <http://www.smmgp.demon.co.uk/html/rcgp.htm>



The recommended reading material for the Certificate for the Management of Drug Misuse Part One is 'Care of Drug Users in General Practice: a harm reduction approach. Edited by Beaumont B. Radcliffe Medical Press, 2004 Second Edition. Oxford'

Initial overview of the Alcohol Harm Reduction Strategy for England

Six years after the initial discussions surrounding an alcohol strategy, the policy has finally arrived! The strategy identifies alcohol as contributor to a range of harms.

- **Health harms:** including harm to individual health with particular reference to binge drinking and chronic drinking. Cost to the health service of between £1.4-£1.7bn
- **Crime and anti-social behaviour harms:** including arrest for drunkenness and disorder, victims of alcohol-related domestic violence and drink driving and its impact on victims. Costs to the economy of up to £7.3b.
- **Loss of productivity and profitability:** including alcohol-related lost working days, alcohol-related deaths and alcohol related absenteeism. Costs to the economy of up to £6.4bn
- **Harms to family and society:** Social harms, including problems within families, marriage breakdown and rough sleepers with alcohol problems. (Costs not quantified).

The government sets out to reduce these alcohol-related harms by:

- Improved and better-targeted education and communication.
- Better identification and treatment of alcohol problems.
- Better co-ordination and enforcement of the current framework to tackle crime and anti social behaviour.
- Encouraging the alcohol industry to promote responsible drinking and take a role in reducing alcohol related harm.

Implementing the Strategy will be shared across the Government, with lead departments being the Home Office and the Department of Health. Progress will be measured against clearly defined indicators and will be reviewed in 2007.

What the strategy recommends

- Improvement of identification and referral of those with alcohol problems.
- Improved training for health care staff.
- The Department of Health will emphasize early identification of alcohol problems through improved communication with health care professionals, although it does not state how it will go about this.
- Initiation of pilot programmes to test how best to use a variety of models of targeted screening and brief intervention in primary and secondary healthcare settings.
- The Department of Health will conduct an audit, which will illustrate the demand for and provision of alcohol treatment aiming to develop a programme of improvement to treatment services.

- The National Treatment Agency will take the lead responsibility to draw up a "Models of Care" framework for alcohol treatment services including a review of appropriateness and effectiveness of different kinds of treatment.
- DATs will be asked to become DAATs therefore taking greater responsibility in commissioning and delivering alcohol treatment services, although their capacity to do so will have to be carefully considered.
- Special mention is made of providing an integrated care pathway for people in vulnerable circumstances who often have multiple problems.

Worth noting

- **Local Alcohol Strategies.** Although the document devotes a number of pages to local strategies (p 85-88) the document does not seek to make "compulsory strategies from local authorities". Instead they "expect to see measures for tackling alcohol misuse embedded within existing strategic frameworks" co-ordinated by crime and disorder reduction strategies.
- **Domestic Violence.** The strategy states that victims and perpetrators of domestic violence are to receive appropriate domestic violence and alcohol treatment services.
- **Alcohol Industry – voluntary support.** The Government will consult with the alcohol industry on the introduction of a three-part voluntary social responsibility scheme for alcohol producers. This will seek a financial contribution from the industry towards the harms caused by excessive drinking. To be reviewed early next year.
- **Screening.** Screening for alcohol misuse may help to identify a drinking problem. A screening questionnaire may be used to complete this, although this is not always necessary, a consultation for example at the GP surgery would also be sufficient. This then may be followed by a brief intervention, where relevant information and advice could be disseminated to the service user.

Other Points of Interest

- The strategy recognizes the individual, social and economic costs of alcohol misuse.
- The emphasis of the document is on the criminal justice aspect of alcohol misuse. It highlights public concerns surrounds alcohol-related disorder and anti-social behaviour in towns and cities at night and reducing the levels of under-age drinking.
- Improved labelling on drinks to encourage "sensible drinking".

There is no new money attached to the strategy for alcohol treatment.

To view or download the Strategy, go to:
www.pm.gov.uk/output/page3669.asp

By Mark Rees, London Drug & Alcohol Network (LDAN) Policy and Research Officer, adapted from full briefing which can be viewed on www.idan.org.uk

Management of dual diagnosis patients in primary care

Dr Kostas Agath, Consultant Psychiatrist in Westminster Substance Misuse Services, emphasises the crucial role of primary care in dealing with the dual diagnosis clients.

What is dual diagnosis?



There is no operational definition of dual diagnosis. The term is used as shorthand for clients who have mental health and substance misuse problems. It is important to distinguish between symptoms and syndromes, since many symptoms subside with abstinence. All substances cause symptoms in intoxication and withdrawal. It is important to identify whether mental health or substance misuse problems were there first. Most of the policy and research relating to dual diagnosis has considered severe mental illness.

Dual diagnosis is very common

Approximately 30 to 50% of those misusing drugs also have mental health problems¹. Amongst mental health service users, one study found prevalence rates of 32% for alcohol and 16% for the use of street drugs². Analysis of population data shows 5% drug use ever by household sample, 10% drug use ever by residential sample (hospital, hostel), 28% homeless people and 46% night shelter attendees³. In psychiatric outpatients one-third of patients have a dual diagnosis⁴.

People with drug or alcohol problems can often fall between services, particularly when neither the mental health problem nor the substance misuse alone is severe enough to trigger access to the individual service. Many of these patients are managed in primary care. Identifying a primary diagnosis for someone with co-morbid mental health and substance misuse problems can be difficult. In policies there is little correlation, however, between mental health and drugs targets.

Why do we need to focus on dual diagnosis?

Dual diagnosis is associated with: increased use of services, poor engagement with services, and poor adherence to treatment, worsening of psychiatric symptoms, suicide and violence. There is also increased risk-taking behaviour, homelessness, and contact with the Criminal Justice System and poor social outcome.

Treatment strategies with dual diagnosis patients

There *are* effective interventions, which aim at engaging and retaining patients into treatment, enhance motivation to change and facilitate re-integration into the community.

Primary care services

Primary care services should be able to assess the needs of people with mental health problems and consider the potential role of substance misuse. They need to know the

level of co-morbidity their service can deal with, when to ask for help and how to access the appropriate specialist services (Community Mental Health Team, Substance Misuse Services) when required and / or treat appropriately.

It is also important to assess mental health in *all* patients who present with substance misuse problems. The patient can be asked about dual diagnosis and many will disclose when asked. Ask in a non-confrontational style and do not try to scare the client ("If you continue to use you will die / be sectioned"). This is an intervention that does NOT work in changing habits.

Mental Health Services

Mainstream services should take the lead in the treatment of severe dual diagnosis⁵, and this should include provisions for standard / enhanced CPA arrangements. The joint / liaison treatment model is favoured to serial and parallel models, in England at least⁶.

Treatment strategies in primary care

The focus of the treatment strategies in primary care would be first of all in 'identifying cases of dual diagnosis'. This should be considered as a possibility in clients presenting to the surgery with needle marks, skin infections secondary to scratching, requests for analgesia or sedation (all signs of substance misuse); or clients presenting with an anxiety or affective disorder (where substance misuse or alcohol use might constitute a maladaptive coping strategy).

Once Dual Diagnosis is suspected the client should be asked about their drug misuse in a non-judgemental way. Clients are usually relieved to 'come-out' regarding their drug use, but it is important that they are not faced with a confrontational approach. Confrontation is not effective in changing a habit, irrespective on whether one addresses drug misuse, lack of exercising, or poor dietary habits.

A risk assessment in every case should cover suicidality, violence (especially domestic violence), childcare issues and driving licensing requirement. Harm reduction advice should also always be offered on risky sexual/ injecting practices.

Dual Diagnosis clients often prefer to be treated in the less threatening environment of the surgery rather than referred to the specialist services. If the risk management identifies no complex needs for the client and treatment starts at the surgery, safe substitute prescribing could be initiated if appropriate. Good safe practice means treatment in accordance with the guidelines⁷. The surgery should be aware of the possible lethal interaction of methadone with other drugs (such as alcohol, sedatives), especially tricyclic antidepressants, that should not be prescribed for clients on methadone⁸.

The mental state of clients with dual diagnosis might change dramatically during treatment; for instance delusional disorders might subside in the absence of stimulant use, although on rarer occasions psychosis might flourish during detoxification in the absence of the previous level of opioid use.

If you are concerned about changes in the mental state during the treatment in the surgery, or if the initial risk management identified complex needs, a client might benefit from input by the specialist services. This is more likely to be the case for substance misusing clients suffering with severe mental illness, when a referral to the local community mental health team (CMHT) and/or substance misuse team would benefit the client more than treatment offered in the surgery. When and where to refer the complex Dual Diagnosis patients is included in the next box:

When and where to refer

- If mental health problems predate the onset of substance misuse, refer to CMHT (e.g. schizophrenia predating alcohol misuse).
- If substance misuse predates the onset of mental health problems, refer to Substance Misuse Services (e.g. paranoid psychosis after the onset of crack misuse).
- If mental health and substance misuse are both of great severity, refer to both services at once (e.g. bipolar affective disorder and stimulant dependence).
- When in doubt ask your local specialist team for advice.

Dual diagnosis in the context of mild to moderate mental health problems

Emily Finch, Consultant Psychiatrist at the South London and Maudsley NHS Trust and Clinical Team Leader, National Treatment Agency discusses drug users with mild to moderate mental health problems

As Kostas Agath correctly points out, there is no one universally agreed and clinically meaningful definition of dual diagnosis. In practice the term means very different things in general psychiatry and substance misuse practice. There is good evidence, though, that many patients with severe mental illness (SMI) use illicit drugs⁹ and that the majority of those patients use alcohol, cannabis and other stimulants, such as cocaine¹⁰.

In populations with SMI, both opiate use and dependent use are rare, although the level of problems associated with non-dependent use is high. Guidance written on the management of dual diagnosis concentrates on this SMI group and recommends that their care take place mainly within Community Mental Health Services¹¹.

Primary and secondary care services that manage drug users see mainly opiate users and indeed, for many, substitute prescribing is the mainstay of treatment. In this group, SMI is uncommon but mild to moderate mental illness is not, with high prevalences of depression, anxiety and personality disorder. So an opiate user on methadone or buprenorphine treatment is likely to present with depressed mood, symptoms of anxiety or panic disorder, or some of the behavioural manifestations of personality disorder. These problems can all be complicated by an individual's substance use with, for example: cocaine use exacerbating depressed mood, alcohol withdrawal presenting as anxiety, and drug-seeking behaviour mimicking the behaviour associated with antisocial personality disorder.

In most cases, mild to moderate mental illness is treatable, although it can be difficult for substance misuse patients to gain access or be retained within Community Mental Health Teams. If substance misuse services are going to care for their own patients, what resources and training are needed first to identify need and then to treat these patients?

Diagnosis can often be difficult as the substance misuse may

complicate the symptoms. Mood disorders can usually be treated with a combination of antidepressants and cognitive behavioural therapy (CBT). However, antidepressant prescribing in opiate users on substitution treatment may be problematic with, for instance, the dilemmas between the newer and safer SSRIs and the substance user's desire for sedative antidepressants. CBT may be difficult to deliver in a client group whose compliance with psychological treatments may not be good and requires skilled specialist practitioners. Personality disorders, especially in their milder forms, can respond to psychological interventions but the level of knowledge and skills to deliver these interventions is not often available¹².

So, are skills and resources available to provide these interventions? Most GPs can prescribe antidepressants, although many will not have the specialist skills to prescribe them for a chaotic drug user. In primary care drug services, CBT is rarely available in its pure form. Specialist drug and alcohol services, run by psychiatrists, will be able to provide psychiatric assessment and treatment for mood disorders but even there CBT may not be available. Some specialist drug and alcohol services may not even have a psychiatrist available or the volume of patients may overwhelm them. Skilled treatment for personality disorders is rarely available in primary or secondary care even though many GPs and specialist services do, in practice, manage these patients.

If we are going to improve the quality of drug treatment, our patients need to have access to treatment for mild to moderate mental illness. Without it, drug and alcohol treatment may be less effective, and targets, such as those for drug treatment retention, may not be met. Substance misuse treatment is provided in increasingly diverse settings, such as criminal justice agencies, and they must have access to resources to treat mild to moderate mental illness. Models of Care offers a framework for coordination of needs in clients with multiple problems, and commissioners need to be made aware of their needs⁶. The National Treatment Agency (for England) is aware of the issue of dual diagnosis in clients of substance misuse services and is working to include it in future policy developments.

References

1. Brian Iddon, Chairman of All Party Parliamentary Drugs Misuse Group, 2 July 1999, Hansard Column 567
2. Radical Mentalities, Briefing Paper 2, Not All In The Mind – Mentality, 2003
3. Farrell M, Howes S, Taylor C et al (1998). Substance misuse and psychiatric comorbidity: An overview of the OPCS national psychiatric comorbidity survey. *Addictive Behaviors* 23, 909-918.
4. Wright S, Gournay K, Glorney E et al (2000). Dual Diagnosis in the suburbs: prevalence, need and inpatient service use. *Soc Psychiatry Psychiatr Epidemiol* 35, 297-304.
5. Department of Health (1999). National Service Framework for Mental Health. London; HKS0.
6. National Treatment Agency (2002). Models of Care. London; NTA.
7. Department of Health, The Scottish Office Department of Health, Welsh Office, Department of Health and Social Services, Northern Ireland (1999). Drug Misuse and Dependence – Guidelines on Clinical Management. The Stationary Office.
8. Oyefeso A, Ghodse H, Clancy C, Corkery JM (1999). Suicide among drug addicts in the UK. *British Journal of Psychiatry* 175, 277-282.
9. Menezes PR, Johnson S, Thornicroft G, Marshall J, Prosser D, Bebbington P and Kuipers E (1996) Drug and alcohol problems among individuals with severe mental illness in south London. *British Journal of Psychiatry*, 168(5): 612-9.
10. Miles H, Johnson S, Amponsah-Afuwape S, Finch E, Leese M and Thornicroft G (2003) Characteristics of subgroups of individuals with psychotic illness and a comorbid substance use disorder. *Psychiatric Services*, 54(4): 554-61.
11. Department of Health (2002) Mental Health Policy Implementation Guide: Dual Diagnosis Good Practice Guide. London: DOH.
12. Department of Health (2003) Personality disorder no longer a diagnosis of exclusion. Policy Implementation Guidance for the Development of Services for People with Personality Disorder. London: DOH.

Emily writes further on dual diagnosis in this month's Dr Fixit on page 11

User involvement – what we need to do

Jaye Foster is Manager of Healthy Options Team (HOT), which is part of East London & The City Mental Health Trust, and based in Whitechapel, East London. HOT is a comprehensive, low threshold, community based, harm reduction centre with specialist services for drug users with complex needs. User involvement is right at the heart of the way HOT operates. Most services have a long way to go in involving users. So why is this and what can be done now to enable services and users to work together? Jaye explains

Problems users face

Professionals consistently fail to view service users as 'customers'. So drug and alcohol services, and those commissioning them, fail to deliver or purchase services that meet customer needs and approval. The barriers to user involvement are located within a judgemental, discriminatory class system, which does not support users' rights and freedoms, and views users as a problem and not a solution.

Professionals are often unwilling or afraid to relinquish the power conferred by their 'expert' role, and equally fail to see that users have expertise of their own. On the one hand users are often socially excluded, and on the other, professionals fail to deliver socially inclusive services. Consequently there is a yawning gap between what is being provided and what is really needed.

Users are a heterogeneous group, coming from widely differing environments, subcultures, identities, health and social circumstances and economic backgrounds, and facing a range of social injustices. It takes professional, political and social bravery to acknowledge that user empowerment must work with the community and not just in it; it is hopeless if user involvement takes place in a vacuum. These considerations are complex and challenging.

Services tend to be developed from a 'top down' approach in which professionals identify what they perceive to be users' problems and then provide solutions - solutions that tend to be overly ambitious and poorly focused towards the problems as users perceive them. Across the NHS, professionals fail to empower users to define their own issues and problems and develop their own solutions. So user empowerment is ultimately under the control of the State.

Within groups of drug and alcohol users, there is simply not the infrastructure, funding and support to have a voice, be heard and make sustainable changes. Distrust and power imbalances exist between users and the professions who are supposedly 'looking after them'.

Is there anything that can be done to change this? Yes – much!

We need to develop sustainable working partnerships between users and professionals in which we see the world through each other's eyes, based on mutual trust. The needs, as service users perceive them, are paramount. Only by listening to these views can we move forward and develop appropriate services. The participation of users must be at a strategic, decision-making level, and not simply a tokenistic presence in meetings and on projects.

Users have fantastic CVs: knowledge, lived expertise, and skills. Empower them to use these now. Make space for them to have their own sense of identity and belonging in the development and management of services. Since their lives are the focus of research studies and policy development, ensure they are

actively involved in both. Ensure that all types of involvement are democratic – both within and outside your organisation.

What can be achieved

Be clear about what is to be achieved, ensure that everyone shares the same goals, get the infrastructure in place and go forward to develop sustainable resources, sustainable change and real progress. Build respect between users and professionals, develop mutual understanding and avoid at all costs, setting each other up.

An underlying purpose of user involvement is to campaign for the inclusion of people excluded from mainstream society. Campaign actively, form peer networks and user partnerships. Set realistic goals and targets, monitor and evaluate progress. Pay users, in the same way you would do for any other expert, for their time, skills, knowledge and expertise.

Ensure that there is equitable access to training, and share your skills with peers and professionals rather than hanging on to them. Listen, learn, share, disseminate, 'flexi-ate', and celebrate!

Real benefits

User involvement is not an end in itself, but a better way to develop policy, strategy and implementation and is a crucial part of quality control in the delivery of drug and alcohol services. It empowers the disenfranchised and increases the well-being of users and wider communities through active involvement.

User involvement is a human right

User involvement must be based on respect for the human rights of this group within society. Any erosion of these rights will limit the sustainability and success of user-focused substance misuse services.

Models of good practice in User Involvement

HOT in East London

The approach taken by HOT is based on social inclusion. The volunteer programme enables service users to do voluntary work at the premises and gain a sense of identity and inclusion. At the same time they contribute to the service their own knowledge, skills and experience about drug use. We see it as a two-way partnership: users have ownership of the service as well as being our customers.

Peer-based research has been carried out with the local drug-using community, training indigenous people to become research assistants. We have also worked with sex workers – setting up services for them. By working with the local drug-using community HOT is able to access hidden communities.

Everyone, including volunteers, who works with HOT is paid. All get supervision, and they can access all NHS courses. We have a number of people who have come from the using community, volunteered and successfully gone on to full-time employment, or gone to university to study subjects such as law and social work. It gives these people an opportunity to realise their potential.

DIY in Walsall in the West Midlands

DIY works very closely with the Drug Action Team Coordinator. What they have demonstrated is that, with professional commitment and support, self-organised drug user groups can go on to provide services in the community. For example, users provide the satellite needle exchange. DIY have empowered their own community but also demonstrated how drug users and professionals can work together. They have addressed structural inequalities within health and social services and the power that professionals have, and empowered users so that they can be trusted to do the job themselves.

This article is based on an excellent presentation Jaye gave at the London Drug and Alcohol Network Conference on 25 February.

New contracts – pharmacy view

Martin Bennett, Pharmacy Advisor to SMMGP, and a pharmacist in Sheffield, gives his views on the new pharmacy contract.

With the new pharmacy contract just six months down the line, I've been asked how this will change things. The short answer is that I have no idea!

On 31st March I wrote:

Details of the proposed pharmacy National Supplementary Enhanced Service, covering supervised consumption is not available, but I gather this will be optional and that local schemes will most likely continue. So for the time being it's 'as you were'.

My view today on the new pharmacy contract

Since 31 March I've attended a presentation on the new pharmacy contract by Sue Sharpe (CE of Pharmaceutical Services Negotiating Committee (PSNC)) and Chris Town

(representing the NHS Confederation). However, I can't say that I am any wiser on the drug treatment side of things!

There will be a 'national specification and this will be priced'. Individual PCTs will need to decide whether or not they wish to invest in the existing services or move to the nationally specified service. I imagine money may play a part in this decision!

A worry that PharMAG (Magazine for pharmacists involved in the treatment of drug users) have voiced is that the proposed service specification should match 'best practice' and take in the wider role of pharmacy involvement with drug users. They are particularly concerned that the service specification goes beyond a 'fee per swallow' approach!

It is not clear who is writing these 'national specifications', and surprisingly where the funding is coming from is still somewhat hazy.

I suspect that by this time next year I will have a better idea about both the new contracts and I will give you all an update ...but then again I've always been an optimist.

If you are a pharmacist reading this, what are your views? Write to us or email us at the address on page 12.



Paper review

Strang J and Raistrick D (2004) Alcohol and drug policy: why the clinician is important to public policy. *Psychiatry*, 3: 65-67.

This is an excellent and succinct overview of public policy relating to alcohol and drug misuse and the stakeholders who influence it. Who makes the policy and how does it impact on patients and on the medical profession serving them? How may doctors themselves influence policy?

Three government departments influence alcohol policy: the DoH, DTI and Home Office; with drug misuse the DoH and Home Office influence policy.

The paper also explains the role of non-governmental organisations in shaping policy, including the Royal Colleges, charities and advisory councils. How do these vie with each other, and what is their interaction on the ground with GPs and DATs, for example?

Finally the authors ask if policy make a difference and exhorts doctors to participate in the policy debate, deliver good quality evidence, and coordinate their lobbying to change public opinion and government policy.

– Review by Maggie Pettifer, Managing Editor, SMMGP Network

Anderson P, Kaner E, Wutzke S et al (2003) Attitudes and management of alcohol problems in general practice: descriptive analysis based on findings of a WHO international collaborative survey. *Alcohol and Alcoholism*, 38: 597-601.

In this paper a 14-country WHO study explored the relationship between the numbers of patients with alcohol problems managed by a GP and the GP's education and training, views and attitudes, role security and therapeutic commitment. GPs were randomly selected by country registers and sent a self-completion questionnaire.

The overall response rate was 56%: 43% of respondents scored high on education and training; 27% on own perception of a supportive environment; 84% felt secure

in their role; 27 per cent felt committed in their work with these patients.

The analysis showed that GPs who reported managing a higher number of patients with alcohol problems stated that they had received more education on alcohol, believed they had a supportive working environment, felt role security and demonstrated therapeutic commitment – all factors that should inform the strategic planning of new service models.

– Review by Maggie Pettifer, Managing Editor, SMMGP Network

Keaney F and Strang J et al (2004) Does anyone care about names? How attendees at substance misuse services like to be addressed by health professionals. *European Addiction Research*, 10: 75-79.

At last somebody has asked drug users in treatment what they would like to be called. According to these authors, the use of 'client' dates back to at least 1970, when the nursing faculty at Wichita State University considered the term 'patient' inappropriate for the healthy seeking health-maintenance advice or going for an annual physical examination. The authors quote Wing: "The recent trend to refer to people seeking health care as 'clients' implies to me a component of human interaction that I would expect in the business world rather than in a trusting helping relationship". 'Patients' also have a status and traditional rights which pre-date modern consumer laws.

In a survey of 150 mixed dependency patients, 'service user' was the least popular term, identified as the preferred term by only five per cent of subjects. 66% of alcoholics, 52% of opioid users, but only 47% of smokers in treatment preferred 'Patient'. 24% of alcoholics, 46% of illicit drug users and 41% of smokers in treatment preferred 'Client'.

While just over one third considered that they personally had a 'mental illness', most considered that 'substance misuse problems' formed a category of mental illness (59%). The authors state: "Commonly used pejorative terms such as 'alki' or 'junkie' prejudice appropriate care and add to stigmatisation". Thus the majority here preferred the term 'patient', going against current trends in dependency treatment services for the wider use of the term 'client'.

They conclude: "In a culture of 'user involvement' in substance misuse, the results of this study should prompt reconsideration and revision of our verbal and written communications with patients".

– Review by Dr Andrew Byrne, Medical Practitioner in Dependency Medicine, New South Wales, Australia

Why should opiate maintenance take place in primary care?

There are an increasing number of options available for treating patients with opiate addiction and a growing amount of evidence as to their effectiveness. However, the largest amount of evidence is around the positive benefits of methadone maintenance. Jenny Keen described how to get the best results with methadone maintenance in February's Network. But why should methadone maintenance take place in primary care? There are powerful reasons, says Dr Steve Brinksman, Lead GP in Birmingham DAT

For many years large numbers of GPs chose not to become involved in the management of opiate addiction and in some cases were actively discouraged from doing so. A result of this was that many secondary care services, such as Community Drug Teams, became involved in the delivery of primary care type services. Unfortunately, they were often ill equipped to do this work as the success of any effective secondary care service depends on the ability to discharge patients to allow new patients to be treated. If this does not occur then the system quickly silts up and long waiting lists result.

Parallels with diabetes

There are parallels with hospital diabetes care. Originally almost all patients were seen in outpatient clinics, even if only yearly. However, it became apparent that specialist services were becoming clogged up and were unable to offer effective care to those most needing it, i.e. the new referrals and those with the most complex problems. The solution was to devolve the ongoing care and monitoring of those with stable diabetes into primary care. This allowed effective interventions to be carried out with the more complicated group, who in turn became suitable for primary care treatment as they responded.

It needs to be recognised that this was only possible by providing primary health care teams with adequate training and extra resources to ensure that the standard of care provided was appropriate. An additional benefit today is that the time taken to re-refer a patient who subsequently develops complications back into secondary care has also significantly dropped.

Primary care best for all long-term chronic conditions

Primary care remains the only organisation with the capacity to deal with the long-term maintenance treatment of a significant number of patients with any chronic condition. GPs do not discharge people. We do not have 'throughput'. To us success is about retaining those

with chronic conditions in treatment, whether that is for their diabetes, hypertension or substance misuse.

Most long-term opiate users should be managed in primary care

I am not suggesting that all patients who present as opiate users should have long-term maintenance therapy. However, where as a result of careful assessment and discussion it is felt that this is the most appropriate treatment, then this should, wherever possible, be delivered in primary care. It should be possible to have systems where treatment is initiated in primary care, and also systems where a secondary care team stabilise and then transfer patients across, depending on the expertise of local practitioners and their teams. In Birmingham we have had considerable success in using a model where drug workers are affiliated to PHCTs and see that practice's patients in the surgery, supporting the GP and other team members.

Many patients may decide that they want to stop opiate use, and it would seem appropriate that they be supported in this in primary care, where there is a clear and established relationship. This may also make it easier to re-engage in maintenance treatment should the attempt to stop become problematic.

Estimates suggest that there are at least 250,000 problem opiate users in the UK. This equates to approximately 10 per GP. Whilst accepting that there is variation across the country, it at least represents a manageable number, compared to the thousands of patients each Community Drug Team would be attempting to deal with.

Efforts to encourage as many GPs as possible to become involved must continue, despite the fact that substance misuse is not seen as an essential service under the new GMS contract. Our experience has shown that if GPs' concerns about training, medico-legal issues, resources, good local support and the fear of being overwhelmed are addressed they are prepared to become involved.

As GPs operating within the Primary Health Care Team (PHCT), we are ideally placed to offer optimum care for those opiate users needing maintenance.

For more about methadone maintenance, see Steve's following answer to Dr Fixit



Dr Fixit - methadone maintenance

Dear Dr Fixit

John has been in treatment with me for two years. He is on 100 ml of methadone mixture. His urines occasionally show cocaine or benzodiazepines, which he uses infrequently, but the only opioid is methadone. He drinks a little socially. He is well and is working full-time. He is 38 years old and lives alone but has a regular partner who is a non-user. He is hepatitis C positive but his health has

otherwise improved since he was in treatment. I am happy to continue prescribing but the local commissioner wants us to have more throughput of patients. Can you advise me how to proceed? Should I encourage him to reduce or should I continue?

Answer by Dr Steve Brinksman, Lead GP, Birmingham DAT

First I would like to congratulate you on the care you are providing for this man. He is obviously on a therapeutic dose rather than a token sub-optimal dose. His general health is improving and he has a full-time job and a non-drug-using partner.

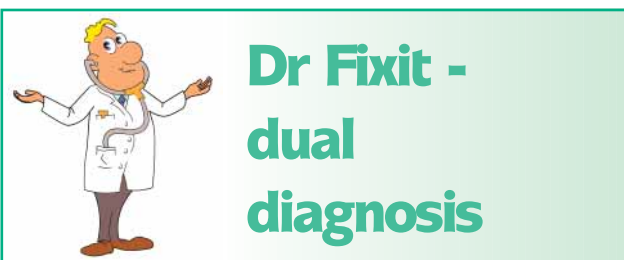
He may be using occasional cocaine/crack and benzodiazepines but as you point out this is infrequent and he has a very moderate alcohol intake. He is therefore showing all of the positive outcomes identified in the National Treatment Outcomes Research Study (NTORS) for those on adequate methadone maintenance. However, whilst there is plenty of evidence that people do well whilst in maintenance, there is not the same weight of evidence that those reducing will continue to do as well.

From your description I suspect this man is a long-term opiate user, and as he has hepatitis C it is likely that he has been an injecting user. He may well have long-term neuro-adaptation to opiates, and reducing his treatment dose may cause his current situation to destabilise.

His main ongoing problem at present is his hepatitis C, yet significant advances in treatment for this have been made in recent years. The NICE guidelines for treating hepatitis C suggest that those who are stable on methadone maintenance are suitable candidates for treatment, so it may be appropriate to consider referring him for this. However, many hepatologists would not consider treating him if he has relapsed into injecting use again. In these circumstances reducing his dose and causing a relapse would be catastrophic.

The most important factor in your decision should be what John wants to do. He may feel that after a period of stability and the significant improvements in his life he wants to try reducing. However, he may feel that change now may threaten his progress, and a forced reduction is unlikely to be associated with a positive outcome.

In terms of throughput, we don't have this in general practice! John is receiving appropriate evidenced-based treatment, and should continue to do so until both, you and he feel it is time to change, even if this may not be for many years or, as in some cases, never.



Dear Dr Fixit

Andrea, a 32-year-old woman, has recently moved into the area and registered with me. She has been in and out of treatment several times and came on 95 ml of methadone

mixture, which she has received from her GP for two months. She complains of being depressed and not sleeping. She says she has always been depressed but it has got worse since her child was taken into care four years ago because she wasn't coping. She, herself spent a lot of time in care due to her mother's drinking. She says that her previous GP has tried several antidepressants but none has worked. She has not been offered talking therapies, and doesn't feel they will help. The only thing that helps is diazepam. Could I give her some? I am reluctant to prescribe diazepam and do have access to counselling but not Cognitive Behavioural Therapy (CBT). How should I manage Andrea? I would be grateful for your help.

Answer by Dr Emily Finch, Clinical Team Lead, National Treatment Agency

Patients like Andrea are complex and always test a clinician's abilities to the utmost. I think the first step is not to do anything too quickly: continue prescribing the methadone, do not prescribe diazepam and get to know Andrea. Taking some history over time and gathering some information from her previous notes, and possibly an informant, will help you think about her diagnosis and formulate a treatment plan.

Does she have a depressive illness that is likely to respond to antidepressants, or is her low mood a manifestation of a longer-term pattern of coping strategies, which she has been encouraged to use by her past experiences? In either case is she at risk? Does she have a history of suicidal behaviour? If so how serious is it? Are there particular issues in her past that may respond to counselling, such as sexual abuse or bereavements? You don't mention whether she is using anything on top of her prescription. Is she using crack or alcohol, which may be exacerbating her low mood and poor sleep?

Whatever her diagnosis, an antidepressant is worth trying again as she may not have been compliant with previous courses. Try one of the newer SSRIs that have some sedative properties and review it regularly. Is she taking it? Can the dose be increased to a maximum effective one?

If she has a clear depressive illness, CBT would have the greatest chance of success but it sounds as if the situation is more complex than that, and the counselling you have available may be a reasonable place to start. Although she probably has a need for intensive psychotherapy she is likely to find that difficult to tolerate and a rather low-key approach may be entirely appropriate at this stage.

Does she have other problems? Is she housed appropriately? She may find contact with a non-statutory support agency helpful. A continued harm reduction approach to her substance use is necessary.

Finally, should you refer this kind of patient to a specialist service? Yes, if your assessment of the risk becomes too high and if none of the strategies described above seem to help. Otherwise this type of client is likely to continue to have problems and may be well managed in the more consistent, low-key environment of primary care. The good news is that she may well have good times when her coping strategies become more effective and she can make real progress.

Hot Topics

Alcohol and the new GMS contract

The new GMS contract specifies a 'Nationally Enhanced Service' (NES) for alcohol misusers, which is optional at PCT level. The NES includes: maintaining a register of alcohol misusing patients, delivering brief interventions, referral, detox and liaison with specialist alcohol services. Each practice contracted to provide the NES will receive an annual retainer of £1,000 plus an annual payment per patient of £200 in the first year.

Research suggests that 20% of patients presenting to primary health care are likely to be excessive drinkers (Kaner et al, 1999). Many in the substance misuse field regard the nGMS as a missed opportunity with respect to improving the identification and treatment of patients with alcohol misuse. Early indications are that PCTs are not willing or able to commission the alcohol NES on these terms; the costs look prohibitive because of the large numbers of patients involved.

The London RCGP Substance Misuse Network (PANN) and London Drug and Alcohol Network (LDAN) have arranged an event on Tuesday 29th June for GPs, commissioners and others to explore the idea of a London variable Local Enhanced Service (LES) for alcohol and to begin to see how this could be developed.

To book, or for more details, please contact **Libby Ranzetta** (LDAN) by **phone (01920 877293), fax (01920 871461) or email (libby@ranzettaconsulting.co.uk)**

Citizens say UK drug policy is based on ignorance

In a letter to the UN Commission on Narcotic Drugs, a broad coalition of civil society organisations is requesting an end to the war on drugs. They maintain that the current system of drug prohibition is completely out of sync with the opinions of more and more people around the world who wish to see an end to drug-related problems for public health and community safety. The UN strategy is based on fear, ignorance and lack of common sense, says the letter, signed by 200 organisations from 38 countries. This coalition wants to decentralise drug policies, so that every national authority can design and implement the policies that specifically fit their needs and traditions. You can read the letter at: www.encod.org/icnletter2004.html

Surprise change in benzodiazepine prescribing

In the Chief Medical Officer's (CMO) January 2004 update to all doctors (no. 37), Sir Liam Donaldson reiterates the MHNSF advice (1999) that benzodiazepines should be used for no more than two to four weeks for severe and disabling anxiety. He adds: "Use of benzodiazepines in substance misusers is still an area of concern...14 per cent of substance misusers attending drug treatment centres report benzodiazepine use subsidiary to their main drug use". The Alliance is starting to receive calls from patients who are having their benzodiazepine prescriptions suddenly changed, or stopped abruptly without notice or discussion. SMMGP have developed guidance on prescribing benzodiazepines to people who use drugs, which was last updated in November 2003 (available on SMMGP website). The CMO may have voiced his concerns about benzodiazepine use in drug users but gives no advice on how to manage this problem. See CMO benzodiazepines warning at:

www.dh.gov.uk/assetRoot/04/07/01/76/04070176.pdf

Tetanus alert

An alert was sent out at the end of November 2003 concerning a cluster of cases of tetanus occurring in England. A second alert was sent out on 26 February. Twenty cases have now been reported in the last 8 months, including one death. Cases are thought to be linked to injection of contaminated heroin. Prior to this incident, tetanus in Intravenous Drug Users (IDUs) was infrequent in the UK (2 cases between 1984 and 2002). Increased vigilance for tetanus is required among IDUs, clinicians and drug workers, to allow early treatment that may be life saving. It is probably best to give a booster tetanus vaccination to all drug users, unless documented evidence of recent booster. More detail from:

www.hpa.org.uk/infections/topics_az/tetanus/menu.htm

Bulletin Board

National Training for Primary Care Staff to Work With People Who Use Crack Cocaine

Two further days of crack cocaine training for primary care staff, will run in London on 9th June and 6th July 2004. Day 1 focuses on the practicalities of working with crack cocaine users in primary care. Day 2 builds on day 1 and tests the deliverability of the interventions described in primary care. You can book for one or both days. £60 / day for past or current certificate applicants, £75 / day for others and they open to all. Further information from: Monique Tomlinson, Tel/Fax: 020 7928 9152, email: moniquetomlinson@wdi.co.uk

Correction

The following correction has been received from DC Steve Duce, Drug Strategy Unit, South Yorkshire Police. In Issue 7 of Network (February 2004), under Hot Topics, "Important change in the law makes providing clean equipment legal", your writer states "...and everybody can now legally distribute sterile water". Sorry to be picky, but only medical practitioners, pharmacists and persons employed or engaged in the lawful provision of drug treatment services (i.e. should include nurses and employees of needle exchange schemes) would be lawfully entitled to supply the drug injecting equipment referred to (Regulation 6A of the Misuse of Drugs Regulations 2001).

NETWORK Production

Managing Editor: Maggie Pettifer

Associate Editors: Jim Barnard and Christina McArthur

Advisory Editor: Dr Chris Ford

SMMGP office:

Mark Birtwistle, Management Support Officer, SMMGP, c/o The Edge, 27-35 Edge Lane, Stretford, Manchester M32 8HN

Tel: 0161 866 0126

email: mark@smmgp2.demon.co.uk

website: www.smmgp.co.uk

NETWORK NEWSLETTER IS SPONSORED BY

 **SCHERING-PLOUGH LTD**

Network ISSN 1476-6302

SMMGP works in partnership with



National Treatment Agency
for Substance Misuse