



## The Oral Effects Of Methadone Use

### Retention in treatment is the key



*Methadone has no significant affect on dental health  
See page 2*

Retention in treatment is fundamental to treatment effectiveness – this is something we know primary care can do very well. UK evidence by the National Drug Evidence Centre now demonstrates what we have known for a long time – a key factor on treatment outcomes is avoiding early drop out and keeping patients in treatment through their ups and downs. Retention in treatment is to become a fundamental message in treatment effectiveness promoted by the National Treatment Agency. Primary care is ideally suited to retaining patients as we are set up to provide longitudinal health care for local communities. Keeping patients engaged past the first few weeks and beyond is important, yet patient drop out seems to be much more down to the nature of the service rather than the client. In a nutshell work with where each individual patient is at in a supportive, non-punitive relationship and see relapse as part of the nature of working with substance misuse. Better in treatment than out.

*See the key points from the NTA Treatment Effectiveness paper, page 12*

**network**

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## Crack - treatment options in the surgery

- 1. Psychological interventions, such as Cognitive Behavioural Therapy (CBT) and Motivational Interviewing (MI)** are arguably the most useful, improved by a positive, non-punitive, relationship with a key person, such as the GP or drug worker.
- 2. Prescribed medication:** never to be used outside a package of care, including relapse prevention, is only effective for the most part in treating individual symptoms such as depression or insomnia (short-term only) after crack or other stimulant use has ceased. There is no substitute medication.
- 3. Harm reduction:** Some cocaine users for whom abstinence is not yet an option may want help to be able to better manage their drug use. There are a number of principles and safer practices that can be discussed with the patient in order to reduce crack related harm.  
Route of administration and dosages are the most important factors when assessing problematic cocaine/crack use.

*Find out more on the three forms of crack treatment on pages 4-5*

# The Oral Effects Of Methadone Use

- Methadone clients have a high level of oral disease and a low uptake of dental treatment.
- Methadone in its sugared or non-sugared formulas has no significant effect on the person's dental health. Methadone is not the main factor leading to dental decay.
- There is an extensive need for treatment amongst methadone clients.
- Access to services is an issue for clients – in some areas there may be a need for innovative dental services.
- Dentistry has its role to play in the rehabilitation of heroin use, not only in the treatment of pain and disease but also in enhancing people's confidence by improving their appearance and self-esteem, encouraging social-inclusion.



## Methadone and Dental Health

Methadone users when entering a dental surgery inevitably start the conversation with “ever since I started the Phyl (methadone) my teeth have rotted”. The almost fatalistic perception, by both clients and medical staff, is that methadone is the major causal factor of tooth decay. The functions of oral health are important on many levels for speech, mastication, taste sensation, pain relief and aesthetics. This is universal, no-one wants to have tooth ache, halitosis, obvious oral disease such as roots, abscesses and staining; this is inclusive of methadone users. A multidisciplinary approach has been promoted in the health care of substance users but dental health initiatives have often been overlooked, therefore isolating the person's oral health from their general wellbeing. A small survey of methadone users in North Dublin first drew my attention to their oral health needs. When prioritising a series of talks for the methadone support group, users chose dental health and hepatitis as main concerns.

### Oral health is important to methadone users

Many users in their late teens to early thirties are embarrassed about their teeth. They feel judged, claim it makes it more difficult to gain employment and have less confidence in forming

relationships. Their teeth are a beacon to their drug using past. Many methadone users feel their teeth are so poor that they are embarrassed to even seek treatment from dental surgeons. Self-esteem is at an all time low and can also be associated with guilt from past neglect. All of this leads to an inevitability of disempowerment, that methadone users cannot change their situation.

### Oral Health Survey

In 2002 an oral health survey was conducted amongst 220 randomly selected methadone users in Dublin, subjects aged 16-34 years were selected. The sample was stratified by age and gender. The subjects were clinically examined by a single trained

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and calibrated examiner for the number of teeth present, denture status, tooth wear, trauma to permanent incisors, dental caries, periodontal status and treatment need. A structured interview questionnaire was used to investigate oral health habits, dental attendance, barriers to care and habits of drug misuse.

The study revealed poor oral health among the sample population. The level of dental caries was high compared with the general population. The prevalence of untreated trauma and dental erosion was high, as was the need for denture provision. (30%) The unmet treatment need was high with 99% of subjects requiring some form of dental treatment; the average number of teeth requiring intervention was 14. Using logistic regression it was shown that methadone in its sugared or non-sugared formulas had no significant effect on the person's dental health. Methadone is not the main factor leading to dental decay but plays only a small part.

### Dental Disease

Dental caries manifests after years of exposure to sugar and poor oral hygiene. The years of neglect during heroin use, coupled with the high sugar cravings and xerostomic effect of opiates leads to poor oral health. (Dry mouth being an increased risk factor for decay.) The analgesic effect of heroin often masks the symptoms of dental decay and pain is experienced once the person commences methadone with its reduced analgesia. It is at this point that methadone users are most aware of their dental disease and also become more aware of their appearance and legacy of drug use. This is the most opportune time to assess a person's oral health and make provision for treatment.

Roots and abscesses are a common complaint and have far reaching implications. Dental pain can lead to drug relapse. Methadone users and medical staff anecdotally claim that some users, who have been stable on methadone programmes, relapse back

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***It is therefore vital that dental health is taken into consideration in the primary assessment of a new methadone client and dental treatment made accessible***

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onto heroin due to untreated dental caries. The pain of the abscess can only be relieved by dental intervention or an increase in analgesia and in the case of a methadone user, heroin with its increased analgesic properties will take the edge off the pain. It is therefore vital that dental health is taken into consideration in the primary assessment of a new methadone client and dental treatment made accessible.

### **Accessing Dental Services**

Patients who do seek dental treatment can often find difficulties accessing services. In the Dublin study the main barriers to care were; fear, missing appointments, fees and lack of information. Many respondents were unsure of their entitlements and health schemes available and were paying for treatments, which they could receive without payment. The education of methadone users and their support staff is necessary to improve access to services.

The main service providers in Dublin for methadone clients were the Dublin Dental Hospital and prison services. Both of these offer mainly emergency services leaving clients with many more untreated teeth. Prison dental services are vital in providing healthcare to this marginalised group. Substance misuse units in prisons should assess oral health and refer to dental services.

Another major prohibitor of dental care is the attitudes of dental service providers. Many respondents felt unwelcome and were told waiting lists for emergency appointments would

be 6-8 weeks (longer than general public waiting times.) Methadone users found that when they disclosed a positive status for Hep C or HIV, that they would be refused treatment, with many excuses being made [Ed. Note: Similar with Hep C and HIV across the UK. Also hard to get free dental care in the UK]. This situation leads to a major public health problem with clients learning non-disclosure of infectious diseases in order to receive dental treatment. Leaving the reliance on dental surgeons to stringent adherence of universal precautions. If clients are knocked back from treatment this again lowers self-esteem and causes disempowerment.

### **Dental Service to Homeless People**

Presently in Dublin a dental service dedicated to the treatment of homeless people has opened in a homeless drop-in centre as part of a primary health care facility. In its first year, 265 people have attended for treatment, 61% of patients use heroin or are on methadone programmes. Most people have attended for complete courses of treatment using either appointments or open access services. Patients who undergo treatment, increase in confidence and with support should promote eventual use of mainstream services and move a step closer to social inclusion. Partial funding has been given to setup a similar onsite service in a methadone clinic (prescribing to 600 people daily) and a collaboration between the two dental teams will promote further treatment, education and research.

**Oral health has an important role to play in harm reduction; in the management of pain, the continued stabilisation on methadone, the user's self-esteem. A multidisciplinary approach including local dental teams will greatly enhance medical services to substance users.**

**Dr Ruth Gray**, senior clinical dental surgeon, Dublin, Ireland.  
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## **NEWS DIGEST**

### **Cannabis anyone?**

#### **GPs should ask patients about cannabis use**

At a recent conference in London, Dr Clare Gerada, head of the RCGPs Substance Misuse Unit said that GPs should look to reduce the harm caused by cannabis. Pointing to the mental health and respiratory consequences of increasingly high strength cannabis she said 'there is evidence that high levels of use, especially among teenagers who are physically and mentally still developing, carries with it the increased risk of psychosis and respiratory conditions such as asthma'.

GPs have not always felt comfortable questioning patients about drugs both due to lack of knowledge and concerns about confidentiality. However Dr Gerada said that GPs should be talking to their patients about cannabis in the same way that they do about smoking and drinking.

Dr Gerada's comments were welcomed by a spokeswoman for the national drugs charity Drugscope.

"GPs are often the first point of call when people have problems, they are trusted and well-respected so they are the right people to address these issues".

### **Tackling Drugs Saves Lives**

#### **Tackling Drugs, Changing Lives: Keeping Communities Safe from Drugs**

##### **Drug Strategy Progress Report 2004**

The Government's ten year Drug Strategy is now in its seventh year and this report charts the progress of the policies that have been implemented which have aimed to reduce the harm caused by drugs. It also outlines future planned action. This cross-governmental report is primarily concerned with England.

The report covers the areas of law enforcement and reducing the availability of drugs, the impact of drug education, the progress of the rehabilitation of offenders by offering treatment packages, statistics suggesting recent reductions in acquisitive crime and the increase of 50,000 more people in drug treatment and large reductions in waiting times. It may not be the most exciting read, but it does offer a few interesting statistics, and give a broad overview of the Drug Strategy.

<http://www.drugs.gov.uk/reportsandpublications/NationalStrategy/1101307094>

# Working with cocaine and crack users in primary care

By Chris Ford

The use of cocaine in the UK has been rising steadily over the past decade. As the price has fallen, all the other indicators of use have been rising including the number of those coming forward for treatment. The drug comes in two main forms: cocaine hydrochloride powder, which is usually snorted, but also injected – and crack, which is usually smoked, but also can be injected if converted back to base. Cocaine is a powerful stimulant whose effects wear off quickly, prompting the user to repeat the dose. Many users do not get into problems but high dose users, especially of crack, are likely to need treatment for a large range of physical and psychological problems.

It is important that GPs and other primary care practitioners, have a working knowledge of the problems faced by cocaine and crack users, while at the same time not working in isolation or outside their level of competence. The published evidence base is small and much from the US, but there is an increasing wealth of experience both in people who use the drug and professionals.

## The drug

Cocaine is extracted from the leaves of the coca plant and processed into cocaine hydrochloride powder. To transform cocaine into crack, the cocaine base which has to be freed from powder is heated up in a microwave with bicarbonate of soda and water. Crack is easily melted and vaporised, so can be smoked, but it can also be injected by adding acid. Cocaine is a stimulant drug. Users feel more alert and energetic, confident and physically strong, and frequently believe that they have enhanced mental capacities. When smoked as crack, it has more intense and immediate effects because in this form the drug is delivered to the brain much more quickly. Excessive doses can cause severe medical problems, and even death, from pulmonary oedema, heart failure, myocardial infarction, cerebral haemorrhage, stroke and hyperthermia. The after-effects of crack use may include fatigue, depression, paranoid ideation and depersonalisation as people 'come down' from the high.

## Caring for the cocaine user in the surgery

The patient may present in a medical crisis and receptionists and other staff should be made aware that these users may need to be seen as an emergency. Less acutely, they might be presenting with a specific set of symptoms such as asthma, chest pains and weight loss, which turn out to be a result of their cocaine problem. Patients who are already known to have another drug problem e.g. opioid dependence, and be currently in treatment at the surgery may present with symptoms of crack use as a new problem.

**Assessment:** The patient should receive an initial assessment to identify problems and assess immediate needs. This should normally include: current drug and alcohol use, method and route of drugs used, drug and alcohol history including previous treatment as well as current and past medical history, psychological and mental health, social situation and forensic history. They should then undergo a physical and mental health examination, be offered screening for drugs, hepatitis, HIV and sexually transmitted infections (STIs), after appropriate pre-test discussion. Drug users should be notified to the relevant agencies in the four UK countries for the purpose of monitoring drug use and highlighting trends.

## Treatment options in the surgery

**There are basically 3 forms of treatment that are best used in conjunction:**

- 1. Psychological interventions, such as Cognitive Behavioural Therapy (CBT) and Motivational Interviewing (MI):** which are arguably the most useful of the treatments, but will for the most part be conducted outside of the surgery. All treatment is improved by a positive, non-punitive, relationship with a key person, such as the GP or drug worker.
- 2. Prescribed medication:** which should never be used in isolation from a whole package of care, including relapse prevention. In light of the results of trials on a large number of drugs, it would seem reasonable to conclude that drug therapy is only effective for the most part in treating individual symptoms such as depression or

insomnia (short-term only) after crack or other stimulant use has ceased. There is no substitute medication, although many have been tried.

**a) Benzodiazepines short term, low dose** can be useful to help agitation, to relax and to help sleep.

**b) Antidepressants** are important only if underlying depression is confirmed.

**3. Harm reduction:** Some cocaine users may have got to the point where they want to stop and for them, abstinence is the only feasible way to appreciably reduce harm. However, others will want help to be able to better manage their drug use. Patients may well present with a problem for which they need support, and it would be unhelpful to exclude them because they plan to continue their drug use. Although this is sometimes more challenging, especially as there is no easy substitute medication, it can also be extremely rewarding. Harm reduction is still a debatable area in the treatment of crack use. Some practitioners and users believe that no harm reduction is possible with crack because of the nature of the drug and the way it induces intense craving. However, because of this it could be argued that it is even more necessary. There is a body of experience to support harm reduction including a number of principles and safer practices that can be discussed with the patient in order to reduce crack related harm. It is important to accept that route of administration and dosages are the most important factors when assessing problematic cocaine/crack use.

**Key messages for harm reduction:**

- There is no completely safe way to take cocaine/crack but much advice can be given about how to use the drugs more safely.
- Explain about possible health risks: local burns, damage to the lungs, heart and liver.
- Because cocaine needs to be injected frequently and acts as a local anaesthetic to the skin this increases the risk of damage to the tissues, local and systemic infections and DVT.
- Always advise about sharing any injecting, piping or snorting equipment, particularly injecting equipment.
- Advise pipers to switch from using plastic bottles or cans to glass pipes, and to avoid inhaling ash, paint, dust, water and other particles into the lungs.
- Encourage the move towards non-injecting routes of use, such as chasing or piping.
- Get the patient to set themselves rules and stick to them. For example put off the first pipe of the day for as long as possible.
- Overdose - Understand the signs of overdose, which may be: sudden rise in body temperature, flushed face, hot skin, muscle cramps, stiffness in arms and legs, know how to manage it and always call for an ambulance early.

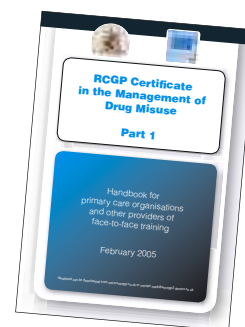
When discussing harm reduction with an individual, encourage them to bring their paraphernalia in to the surgery. Get them to show you what they do and work together to minimise the harm caused by using the drug in that way.

**Ongoing care in the surgery**

It is recommended that regular health checks, including monitoring of weight, nutrition and peak flow rate, take place to monitor progress and provide appropriate interventions, (e.g. on a 3-4 monthly basis).

**Adapted from Guidance for working with cocaine and crack users in primary care by Chris Ford November 2004. Copies can be obtained from our website <http://www.smmgp.org.uk/download/rcgp/rcgp023.pdf> or paper copies from the SMMGP office.**

## Update on Part 1 to the RCGP Certificate in the Management of Drug Misuse



The pilot stage for the **Part 1 to the RCGP Certificate in the Management of Drug Misuse** will shortly be nearing completion. Both the on-line and face-to-face elements of the course have had rapid uptake and positive feedback.

Over 2965 GPs have completed online modules (Harm reduction 2016, Treatment Planning 949) and over 450 have completed the face-to-face day. Currently 211 GPs have applied for and received a certificate. The revised Part 1 will be launched from April 2005.

**From April 2005**

- **The Part 1 course fee for 2005-06** will be £150 per candidate for national events, and £100 for local events. This is in order to help make the course self-financing.
- **Successful completion of the Part 1 training will serve as the single entry criteria into the RCGP Certificate Part 2.** All GPs irrespective of previous experience or training will need to complete the Part 1 prior to Part 2.
- **The RCGP accredited Part 1 will be able to be devolved to local trainers** We will actively support anyone who wishes to deliver the Part 1 course. Trainers will need to apply to the RCGP Part 1 Office,

use the RCGP course structure and materials, liaise on course delivery and standards and attend a National Part 1 Face-to-Face Training event. We will not be able to accredit locally designed courses or courses that have previously run. This has proved problematic in terms of accreditation of equivalent learning outcomes.

**National Part 1 Face-to-Face Training**

- Taunton on Wednesday 16th March
- Manchester on Wednesday 13th April
- Further national events will be scheduled for the remainder of the year and the Part 1 office will have details of other locally delivered Part 1 face to face days.

Additionally an **RCGP/RCN accredited Part 1** to the Certificate for Nurses is being developed. A **Pharmacist CPPE accredited Part 1 equivalent** has also been jointly accredited by the RCGP as a Part 1 equivalent and is currently being revised to an on line format to be available in the e-learning section at <http://www.cppe.man.ac.uk/openlearning>

For further support or information please contact :

**Part 1 Certificate** - Mark Birtwistle at SMMGP, mark@smmgp2.demon.co.uk, 0161 772 3546

**Part 2 to the Certificate** - Martin Thompson at the RCGP SMU,

**NEWS DIGEST****Audit Commission Report**

Numbers starting treatment for drug misuse increase by 20% over two years...but... 'Many more drug users in England and Wales are starting treatment programmes than two years ago, but there is still a major problem with people dropping out in the first 12 weeks. That is one of the messages to emerge from a report by the Audit Commission as quoted in the BMJ. It sounds like another message supporting retention in treatment. To read more see <http://bmj.bmjournals.com/cgi/content/full/329/7474/1066-e>

# GP appraisal - what on earth is it anyway?

## Widening out the debate

The function and future of appraisal is confusing. We are currently operating in somewhat of a vacuum as the Chief Medical Officer carries out a review post publication of the 5th Shipman Inquiry. It is likely that criteria for revalidation will not be agreed for at least another 6 months, and implementation may take up to 18 months

This article attempts to clarify what we do know and widen out the debate.

A key theme to emerge out of a national training day\* on the topic is that the term 'appraisal' is widely misunderstood. Dialogue regarding appraisal for doctors undertaking Enhanced Services (ES - NES/LES) or GP with Special Interest (GPwSI) is often about quality indicators (e.g. prescribing, mortality and referral data), criteria or evidence required for revalidation of practitioners (e.g. clinical audit, significant event analysis, attendance at CPD activities) or performance management (e.g. numbers of patients seen). Clinical governance can be seen as an umbrella term, that contains elements of all of the above such that clinicians and health organisations can provide high quality care.

Appraisal is a formative development process. As such it is underpinned by clinical governance as the mechanism whereby standards of patient care are constantly being reviewed and improved. This is in order that health organisations can discharge their duty of quality imposed by the 1999 NHS Act. Clinical governance uses mechanisms such as significant event analysis, reviewing complaints, working with national agreed standards – e.g. NICE and other clinical guidance etc. As such appraisal comes within the clinical governance framework through which the NHS organisations are accountable for continuously improving the quality of their services, safeguarding high standards of care and promoting excellence in clinical practice (A First Class Service – Quality in the New NHS. Department of Health, 1998).

Performance management refers specifically to measuring activity against targets as a means of fulfilling contractual obligations as often defined in service level agreements. It can also overlap to include the appraisal process as part of those obligations,

and performance management itself fits within overall clinical governance framework.

### Appraisal

Appraisal is a process that gives doctors an opportunity to formally discuss their professional roles and clinical practice (Supporting Doctors, Protecting Patients. Department of Health, 1999). It has a dual role to improve on performance and also to recognise poor performance at an early stage. Appraisal is based on the seven headings set out in Good Medical Practice (GMC, 2001), which sets out the standards required of all doctors:

- 1. Good clinical care.
- 2. Maintaining good medical practice.
- 3. Relationships with patients.
- 4. Working with colleagues
- 5. Teaching and training.
- 6. Health.
- 7. Probity.

The Good Medical Practice headings are applicable to all aspects of clinical practice, including private practice and periods spent in locum appointments.

Appraisal is a supportive and reflective process that in its present NHS form is not assessment driven. There is debate as to whether assessment can form part of appraisal, but current NHS appraisal does not have a 'pass-fail' element. Assessment is a test of performance or knowledge as currently found within GP education and training. An assessor clearly requires specialist knowledge. Whilst a trained appraiser should have some experience in the appraisee's work, this may not actually be the case in a GPs chosen special interest area. If anxieties arise about the doctors performance the

appraisal should be stopped and other clinical governance mechanisms used. Appraisal though is primarily concerned with being a structured two-way discussion intended to support the development of standards though encouraging reflection and self identified Continuous Professional Development (CPD), or learning. Intended learning needs will be written up as part of a Personal Development Plan (PDP) within appraisal. The bulk of discussion remains confidential but an appraisal summary is forwarded to the PCT to demonstrate completion and to support CPD. The PCT needs to ensure it's completion and the GMC, after five appraisals, is then able to sign off that doctor as 'fit to practice'.

### How does CPD fit in with appraisal?

CPD is a life-long learning process. CPD should not be prescriptive and can reflect a variety of learning styles (Activist, Reflector, Theorist, Pragmatist) through means such as reading, meetings, conferences, didactic and distance learning. For a GP completing the certificate Part 1 or working at a generalist level in a LES/NES, the RCGP Substance Misuse Unit (SMU) recommends six hours of self identified CPD per year. For a GP completing the Certificate Part 2 and or working in what is considered a GPwSI capacity, the RCGP SMU recommends 15 hours of self identified CPD per year.

As such, appraisal and CPD are not something separate, but part of a wider integrated approach to the governance of the drug treatment system of which competencies and updating of the GPs is just one aspect.

### Appraisal 'plus' – should we expect appraisal to change in the future?

There is speculation regarding appraisal 'plus' (additional quality indicators to appraisal) which will



appear in 2005 as part of the review of the GMC revalidation system. This will revisit the role of GP appraisal in the wider scheme of things in relation to assessment and fitness to practice. It is likely to be based on the seven core headings of Good Medical Practice previously listed. Beyond that it is uncertain where things are heading, but the RCGP SMU and SMMGP are inputting into the debate where it pertains to substance misuse.

Appraisal contributes towards the five year GMC revalidation process for GPs. This covers broad criteria but will in the future include [we think], evidence of 5 appraisals, and evidence of engagement in clinical governance activities. The practitioner will need to produce a portfolio of nationally validated evidence, standards and criteria (and this may include a video or a knowledge examination) and a certificate from the PCT to the effect that there are no clinical governance concerns. It will then be for the GMC to sign the doctor off as fit to practice. For now GPs should take care and get into the habit of documenting their personal development in an up to date portfolio, auditing what they do and undertaking other governance related activities such as critical incident reviewing. On an individual level, GPs need to recognise and work within their own competencies and levels of confidence.

Additionally, the future role of the Healthcare Commission (HCC) may need to be considered. Currently it is in the first phase of piloting a performance monitoring mechanism, which is due to be rolled out to all DATS as from April 2005. It is possible that the HCC review process will start to extend into the area of clinical governance and therefore may start to request evidence from DATs as to how they execute their duties in this regard. Given the fact that substance misuse is an area of high risk, this may be an area of priority. An integrated clinical governance strategy could include the appraisal, supervision and other elements of GP performance. Examples of the latter where there is already activity include: 1. PACT data and medicines management 2. Relevant areas of the Quality and Outcomes Framework (QOF) of nGMS. 3. Clinical audit 4. Those aspects of the National Drug Treatment Monitoring

System (NDTMS) that measure care coordination, retention into treatment, access and waiting times etc. 5. The elements of HCC reviews which intend to measure specific areas such as prescribing patterns.

Whilst awaiting future guidance we encourage GPs to utilise the appropriate part of the RCGP Toolkit. **'A Toolkit for General Practitioners and Primary Care Organisations - Criteria, Standards and Evidence Required for Practitioners Working with Drug Users'** is recommended to ensure the highest possible standards of clinical governance for GPs and PCOs with a stake in the management of drug users. It supports the provision of appropriate training and professional development in primary care substance misuse. It is mapped to the same set of competencies, criteria and standards as the RCGP Part 1 and Part 2 courses and can be used by GPs, commissioners and service leads. It is available on the SMMGP / RCGP websites [www.smmgp.co.uk](http://www.smmgp.co.uk) or [www.rcgp.org.uk](http://www.rcgp.org.uk)

### Does appraisal specifically address substance misuse?

Appraisal is intended to encourage GPs to identify all areas of their work and as such can address any special areas of work such as substance misuse for their CPD (reflected in their PDP). However, substance misuse is not a prescribed topic in appraisal and GPs can choose which areas to focus their appraisal on. In reality, the onus is with the GP, and this could mean that in some instances very little or no substance misuse or any other special interest area may be covered in an appraisal and if it is, the appraiser may have no specialist knowledge of the area of work.

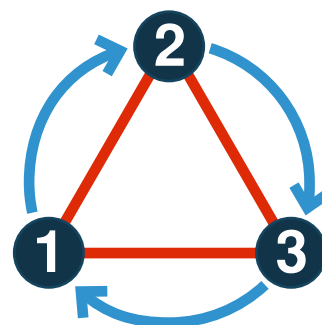
Nationally, clear reinforcement by PCTs is needed clarifying the role of the GP appraisal within the wider and integrated approach to the governance of the drug treatment system. PCTs need to ensure that they have elements in place to support the GMC revalidation of practitioners. Appraisal is only one element. Commissioners need to cost in governance activities including competency training, updating and any commitment to provide locum time for GPs time to attend educational activities. Other costs relate to the resources needed

to support CPD opportunities such as shared care forums, action learning sets and protected learning time. PCTs may already earmark funds for GPs to prepare for and undertake an appraisal. This might have to be "topped up" in the case of senior practitioners with an interest who require in depth appraisals of this area of work as well as more sophisticated clinical supervision or video analysis of their consultations. In short quality is the next big NHS issue, not least within the substance misuse field.

**Further information on appraisal and revalidation** can be found at [www.revalidationuk.info/](http://www.revalidationuk.info/)

**Skills for Health** - GPs may also be wished to be signposted to the skills for health website which has information on governance in relation to workforce development <http://www.skillsforhealth.org.uk/>

**(\*) Appraisal & CPD training day Monday 4th October 2004 at the RCGP London, organised by The Pan London Primary Care Network for Substance Misuse (PANN) & the RCGP SMU**



Revalidation is no doubt going to include a triangulation of data

- 1 Evidence of five appraisals**  
Undertaken by a trained appraiser and ending with a PDP
- 2 Production of a portfolio**  
Evidence, standards and criteria relating to a number of clinical governance areas - including audit, significant events analysis, complaints, CPD activity, prescribing data, patient involvement
- 3 Certificate from PCT**  
No local concerns

### Jean-Claude Barjolin

Acknowledgement to Drs Clare Gerada, Linda Harris and Berry Beaumont



# Drug Testing in the Workplace

## Testing issues - should primary care take note?

### Introduction

During the last couple of years the issue of drug testing in the workplace has received a lot of attention in the UK, with the publications of 'Drug Testing on Trial', the report of the All Party Parliamentary Drug Misuse Group, and 'Drug Testing in the Workplace', the report by the Independent Inquiry into Drug Testing at Work.

'Drug testing in the workplace' is a highly contentious issue. This is probably the only consensus amongst the parties involved, arising from the moral, ethical and legal issues it addresses. Needless to say there is differential emphasis reflected in the solutions proposed amongst the proponents and the opponents of drug testing.

In what follows, I summarise the evidence and arguments in favour of and against drug testing, before addressing some relevant primary care issues.

### The case for drug testing in the workplace

Proponents of drug testing argue that it is needed because of:

#### The scale of the problem

¼ of help seekers for severe drug problems are in employment, and ¼ of professionals report illegal drug taking.

Its' importance in safety-critical working roles (for instance in pilots)

#### The cost of the problem to employers

Anecdotal evidence shows drug misusers being less punctual, having more days off and more work accidents than their colleagues. Furthermore employers are concerned with the damaging effect on a company's reputation, resulting from accidents involving a company car and a driver under the influence, employees becoming aggressive in an aeroplane etc. A survey showed that 1/8 of London retailers have experienced adverse publicity for similar reasons, explaining perhaps why more than 1/3 of UK businesses test their staff for drugs and alcohol.

#### The cost of the problem to employees

Anecdotal evidence shows drug misusers experiencing more accidents, job changes and dismissals. However the Independent Inquiry did not find any conclusive evidence for a link between drug use and workplace accidents with the exception of alcohol misuse.

#### Anticipated benefits of drug testing in the workplace

It is expected that it could be used as a deterrent. However the Independent Inquiry did not find research evidence supporting drug testing as either a significant deterrent, or as a means of enhancing performance.

### The case against drug testing in the workplace

Opponents of the drug testing argue against it because of:

#### Invasion of Privacy

Drug use is usually an activity engaged in one's private time and place, and article 8 of the Human Rights Act 1998, respects privacy. Furthermore drug testing yields data falling under the Data Protection Act 1998, and the Information Commissioner, who is responsible for implementation of data protection laws, perceives regular drug testing as rather unjustifiable in the absence of impact on safety.

#### Difficulties in interpreting drug testing findings

Drug testing can distinguish neither between occasional and habitual use leading to impairment (one could be fit to perform only hours after smoking cannabis while drug tests remain positive for weeks after a single use) nor between illicit use and everyday medicine taking (for instance between cold medicines and amphetamines, ibuprofen and cannabis, co-codamol and morphine)

#### Drug testing was not proven to have a deterrent effect in drug use

Half the prisoners subjected to mandatory drug testing in England & Wales, reported no subsequent change in their drug use. More importantly concerns were raised that drug testing pushed users from cannabis to heroin which has a shorter window for detection.

#### Drug testing remains to be proven as cost effective to employers

It is expensive, it can cause a climate of mistrust amongst staff and can compromise risk management through non-reporting of near misses for the fear of drug testing. Finally data from USA shows that drug testing in the workplace

lead to less than 10% decrease on absenteeism, accidents, thefts and violence, suggesting that staff appraisal and supervision might be better means of addressing any performance related problems. [Ed. At last, a clear role for GP appraisal.]

#### Drug testing has serious ramifications

On the individual level, drug testing could reveal physical/mental conditions against the person's wishes, while on the societal level it might lead to the exclusion of illicit drug users from the workforce and significant costs in social benefits.

#### Drug testing in workplace and primary care

It is doubtful whether a consensus could be reached on who, why and when to drug test in the workplace. It is within this vacuum of consensus that the accessible primary care setting is more likely to come across employees that are either concerned by their substance misuse, or want to ask advice for an upcoming drug test at their workplace. It is important that the clients are offered both the bigger picture of the issues involved in a balanced argument and, if appropriate, an opportunistic substance misuse treatment intervention. Since, however, attitudes in the workplace shape interventions, it is equally important for primary care to examine arguments for and against initiating drug testing on staff employed by the surgeries themselves.

#### References:

A report of the All-Party Parliamentary Drug Misuse Group: 'Drug Testing on Trial', House of Lords, July 2003  
Independent Inquiry into Drug Testing at Work: 'Drug Testing in the Workplace', Drugscope 2004

Dr Kostas Agath, Jan 2005  
Consultant Psychiatrist, Westminster Treatment Centre, CNWL NHS Trust  
16 South Wharf Road, London W2 - 1NY

# Pharmacy Fix

## Team working with a pharmacist

**SMMGP** asked some pharmacists these questions and blended you a response.

### What is the pharmacist role in working with GPs and other healthcare professionals?

The pharmacist is a key individual to drug treatment being successful. We will see the patient on a regular basis and more frequently than the prescriber and other healthcare professionals. We provide additional support to the patient including: advice on harm reduction such as overdose prevention and treatment; safer injecting and blood-borne virus prevention; advice on conditions common to drug users such as constipation, sleep and nutrition; general healthcare advice and treatment of common ailments in addition to advice about opiate substitution therapy when appropriate. It can be very rewarding to see the improvements that people make on opiate substitution therapy such as methadone and buprenorphine. Often their overall appearance starts to improve and they seem happier in themselves, particularly if they start jobs, engage in courses, obtain housing and generally become more stable. It can be very satisfying to get to build rapport with people, and feel that you are part of a team that is helping to make positive changes to people's lives.

As a pharmacist you can have a role in feeding into the treatment team both when things are going well, and when things appear not to be going well. This might include whether people are picking up their medication regularly, discussing whether a change or increase in medication may be helpful, whether they have been presenting intoxicated with alcohol and/or other substances, their general well-being and appearance. For example, if a patient has not presented in three or more days for opiate medication, by informing the healthcare team and not supplying the medication, the pharmacist is preventing or reducing risks of overdose related deaths that could result from a loss in tolerance.

On one occasion I was dispensing to someone who was on a reducing benzodiazepine prescription, and they were coming in regularly asking for night nurse, or smelling of alcohol. In that case I made the worker aware and elements of their treatment changed for the better as a result. Communication with GPs and other workers is essential. There have been times when I have been worried about patients. Here the system works best if

you can easily communicate with the key worker and doctor, and if you have a good relationship with the patient. If any of these relationships are not working, and you do not feel part of a team then you can lose your motivation, and the patients will not get the best service.

### Can GPs better understand the role of the pharmacist?

It helps if GPs have a good understanding of what we do. Some GPs say they feel far more confident to prescribe because they know that I don't just dispense the medication but that I monitor the patient and where possible, discuss any issues with them. For example the pharmacist can check for any drug interactions with prescribed and/or over-the-counter medication, and where necessary the GP can be informed. The GPs see me as part of the team, and not just someone who dispenses the medication. Once I had a disagreement with a GP who felt I was being inflexible when I refused to dispense someone's medication. Through a discussion he understood that the law and my own professional guidelines did not allow me to dispense to the patient who was on twice weekly pick up, where he had failed to pick up his medication on the day stated on the prescription, presenting instead the following day. In this way pharmacists can work with the GP and other healthcare professionals to ensure that prescriptions satisfy requirements as outlined in the Misuse of Drugs Regulations.

### What helps when starting a new patient on medication?

It is helpful and good practice if the GP or key worker contacts the pharmacist to check whether they are able to register a new patient and to confirm dispensing arrangements. It is helpful if key information is provided at this stage, for example any medical conditions. This will enable better overall care to the patient. During the initial stages of treatment the pharmacist can play a vital role advising and encouraging patients, for example by providing information on precipitated withdrawal in initial stages of buprenorphine treatment. Such support can also help to improve compliance.

As the supply of substitute medications for the treatment of opiate dependence are not part of NHS General Pharmaceutical Services contract, a pharmacist is under no obligation to dispense methadone or buprenorphine (They are obligated to dispense if the NHS script is for organic disease i.e. pain) or to supervise consumption and therefore this should be

agreed in advance. The exception to this is if the pharmacist, GP and key worker are registered on a shared care scheme with agreements in place.

Some pharmacists limit the number of people they are able to take on and / or supervise in a day, and some shared care schemes work on the basis of available supervised spaces per pharmacy. This is to ensure effective clinical governance arrangements and therefore reduce the risks to patients.

### When is it the right time for a patient to come off a supervised script?

I would not feel it was my decision when a patient should stop daily supervised consumption, however the pharmacist can play some role in this. This is generally through discussions with members of the team about how the patient is doing. I would expect discussion to be around the patient's attendance, stability, housing situation (for example if they are homeless and cannot store their medication safely), medical condition, and possibly if they are working and it may have become impractical to attend on a daily basis.

The key message is we are here, we are part of the healthcare team and so use and include us – we can help you to provide optimal patient care.

## NEWS DIGEST

### Hep B & C testing

#### If you can't get blood do oral fluids – simple!

**In a report by the North Nottinghamshire Hepatitis B immunisation clinic on hepatitis B & Hepatitis C testing, the Orasure collection device was trialled from January 2003. In summary '...the collection of oral fluids by the use of Orasure Collection device has proved to be an effective alternative to blood collection in those with poor venous access. Many Intravenous Drug Users are reluctant to consent for blood samples to be taken as they may have had negative experiences of blood samples being collected in the past. The oral mucosal transudate method for Hepatitis B & Hepatitis C testing is an effective procedure, which has the added benefit of waylaying many past fears & anxieties, which help to increased the numbers of clients coming forward for testing and vaccinations.'**

March, S. (2003) North Nottinghamshire Hepatitis B immunisation clinic report on hepatitis B & Hepatitis C testing using the orasure collection device. East Midlands Health Protection Unit – North. Health Protection Agency



**Dear Dr Fixit**

*Colin, aged 31 years, is a patient of mine. He has been in treatment for about six-months and is currently on 90mls of methadone. Before this he was injecting about 1.5-2gms of heroin a day and using crack at least two times a week.*

*He has done well on maintenance and only occasionally uses on top of his script. He has never stayed in treatment this long before. He has been a patient of the local specialist prescribing service on four occasions but has always been discharged after short periods, usually for non-attendance.*

*He has several health problems, such as symptomatic hepatitis C and a systolic murmur from previous endocarditis. He has also been in prison twice for drug-related offences.*

*He is very likeable but does have a habit of missing appointments and failing to collect prescriptions. In the last two-months he has missed two appointments and eight prescription pickups (out of 48). He has a good relationship with the pharmacist, as do we, who always informs the surgery if he fails to pickup.*

*We tend to call him when he has missed an appointment and usually we see him the following day. We have only had to re-titrate him on one occasion when he was out of treatment for five-days. We feel he is better in treatment, but are we being too accommodating? How should we manage these problems? Would this be different if he was on buprenorphine maintenance?*

**Answer by Dr Jenny Keen**

One of the principles of good maintenance treatment, based on the best available evidence (Ward 1998;

Bertschy 1995; Ward et al 1999) is that patients need to be retained in treatment if best harm reduction results are to be achieved. You have successfully retained in treatment a highly 'at-risk' patient with a poor previous retention record and this is one indicator of the success of your overall approach.

The fact that Colin is using heroin only occasionally even at this early stage of treatment suggests that he is benefiting from an adequate methadone dosage (Brestchy 1995; Ward et al 1999) which will help him to avoid further health problems deriving from his heroin use. In general, therefore, you can be reasonably confident that some harm reduction goals are being achieved.

A further strength of your treatment package is your excellent relationship with the pharmacist which enables you to maintain safety, as you can respond to repeated missed doses which may compromise Colin's tolerance—a situation which has occurred once already.

On the other hand, it is problematic that Colin is not always keeping appointments and is not picking up his prescription regularly. This may be indicative of poorer overall stability.

Colin may be missing appointments in order to avoid producing urine samples and he may be missing pickups in order to use heroin on those days. These are issues which need to be raised urgently with Colin, as they could not only be compromising his overall benefit from treatment, but ultimately this pattern of behaviour could prove disruptive to the surgery and the pharmacy.

It is generally unwise to renew a prescription without seeing or contacting the patient. In Colin's case, he may have been in custody or lost tolerance for some reason and may need reassessment or re-titration. However, you may not always be able to see Colin the next day. It is likely that repeatedly chasing up patients will not only undermine responsibility for their own treatment but will very quickly prove unsustainable as a practice.

One approach would be to discuss the problems with Colin, explaining once again the importance of regular methadone doses to maintain his blood level and the problems caused by failure to keep appointments. Elicit from him any specific problems he has with attendance (for example appointments may be too early or the bus service to the pharmacy on Saturdays may be poor).

Once these have been discussed it may be a good idea to explain to Colin that if he fails to attend without phoning to rearrange appointments you won't be able to renew his prescription until he has made and attended a further appointment. This should not normally entail fitting him in as an emergency, and may unfortunately mean that he has to wait a few days.

You could also remind Colin about the risks of overdose if doses are missed and heroin is used. Underline the fact that if a number of consecutive doses are missed (say for 3 to 5 days) then he risks losing tolerance and for safety reasons you will need to suspend his script until you have seen him for a re-assessment. This again may mean he has to wait a few days.

While it is very important to continue to retain Colin in treatment, and to avoid being punitive, he needs to recognise his own responsibilities in the process and to understand the boundaries of the system. Excluding patients from treatment for this sort of problem is almost sure to be counterproductive (Ward et al. 1998; Bell et al 1995), but harm reduction is unlikely to be seriously compromised at this stage by Colin having to wait for the next available appointment if he fails to attend – even if this means missing his script for a day or two.

These principles remain exactly the same for buprenorphine patients although its more favourable safety profile means that re-titration after a short period without the prescription becomes less of an issue (see the Dr Fixit response to buprenorphine prescribing in Network Issue 9).

If you have a number of drug using patients in maintenance treatment, some of these points could be summarised in a patient information leaflet for patients when they first come for an appointment. This way new patients know what to expect from you and the pharmacy.

**References**

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 Bertschy, G. Methadone maintenance treatment: an update. *Eur Arch Psychiatry Clin Neurosci* 1995; **245**: 114-124.  
 Ward, J., Mattick, R.P. and Hall, W. (1998) *Methadone maintenance treatment and other opioid replacement therapies*. Harwood Academic Publishers, Amsterdam, 1998.  
 Ward, J, Hall, W and Mattick, R. (1999) Role of maintenance treatment in opioid dependence. *Lancet*, 353: 221-226.



### Dr Fixit on cocaine use with methadone

#### Dear Dr Fixit

*I have been prescribing methadone to Allan for 3 years. He was doing well on methadone maintenance of 100mg and all urine tests have showed methadone and cannabis only until the last one, which showed cocaine. He came today for his script and said his asthma was much worse. When asked about cocaine use he admitted that his crack use was becoming more problematic. He still enjoyed his crack and did not want to stop. He wants help in managing the drug, which he only smokes on a can, never injects and is using almost daily at the moment. Previously he was using occasionally and he would like to return to occasional use. Unfortunately the local specialist service will not see crack users and there is no generic service locally. I am happy with opioid prescribing and harm reduction and I would like to help my patient but I am unsure how to advise him. Can you help?*

Answer by Dr Chris Ford

I hope we can. You have started really well: you have heard him, not discharged him for use on top of his methadone, checked out local resources and asked for help. You seem to have a good therapeutic

relationship, which will be helpful.

I would next check his current drug and alcohol use and method and route of drugs in detail. It is useful to ask about a current 'typical using day' and a current 'typical using week' (this can help to establish present patterns of drug use that might otherwise appear harmless or innocuous to the cocaine user). Also ask about recent change in weight, breathing problems, chest pains, sexual health, mood, sleep pattern and any suicidal thoughts. As he says his asthma is worse you need to examine his chest and do a peak flow and blood pressure.

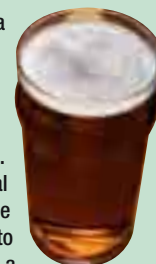
I would then check that he understands how crack works and the health risks associated with its use and how to reduce them. Explain to him that there is no completely safe way to take crack but that much advice can be given about how to use the drugs more safely. Explain that cocaine is a stimulant and acts as a local anaesthetic so when using it by inhalation, paint, dust, and foreign bodies can enter the lung without being noticed. Advise him not to share any equipment and to switch from using his cans to quality glass pipes to avoid inhaling any foreign particles into the lungs. Suggest he brings in his equipment so you can see how he is using and explain the risks. Get Allan to make a set of rules for himself such as putting off the first pipe of the day for as long as possible, use less rocks in each sitting and move towards no daily use.

I would also refer him to the practice counsellor, if available, to work on behavioural change using motivational interviewing techniques.

Long term prescribing does not really have a role and there is little evidence base to support it. This sometimes makes us feel more incapacitated as doctors but remember that there is lots you can do to support Allan with his crack problem.

## The ABC of Alcohol

This article provides a concise and competent outline of a brief interventions approach to treatment for alcohol related problems. It includes practical advice on appropriate medications, and how to engage effectively with a patient with an alcohol related



problem. Ritson's suggestions are relevant and achievable in primary care (offering 10 minute appointments with 1 or 2 weeks follow up) though he does suggest that time may have to be set aside in order to offer the intervention within normal practice.

Ritson advocates the use of motivational interviewing, a technique which seeks to help the patient identify their own reasons for change and strategies for achieving realistic goals. The technique aims to avoid conflict using an advisory rather than a prescriptive approach to informing patients of the risks they may be placing themselves at. Motivational interviewing suggests that a Doctor should expect both resistance and relapses from a patient who is trying to change their drinking patterns, and to treat these as part of the process to recovery rather than to view them as problematic or a failure.

Ritson covers appropriate detoxification regimes, and advice on the prescription of vitamins, disulfiram and acamprostate to problem drinkers. He also provides tips on how to prevent relapse, and when it is appropriate to refer on to other agencies. He advocates joint working with nurses and alcohol workers, and emphasizes the importance of involving patient's families where possible.

The article provides a series of neat summaries on range of relevant concepts including motivational interviewing, alcohol withdrawal syndrome, factors indicating need for referral to secondary care and common triggers to relapse. It provides an excellent précis of all the relevant factors involved in providing brief interventions in a primary care setting for people with problem alcohol use. The article is adapted from the 4th Edition of The ABC of Alcohol which will be available in February.

Kate Halliday, SMMGP Advisor

BMJ 2005;330:319-414 Clinical Review of treatment for alcohol related problems

Bruce Ritson, former Consultant Psychiatrist  
Royal Edinburgh Hospital, Edinburgh EH10  
5HD (drbruceritson@zoom.co.uk ).  
<http://bmj.bmjournals.com/cgi/reprint/330/7483/139>

## NEWS DIGEST

### Comorbidity on the up

Research carried out by Frisher, Collins, Millson et. al (2004) has concluded that GPs in England and Wales are seeing more patients with a comorbidity (drug misuse and mental health) each year and that the figures are growing. The figures show that in the case of chronic co-morbidity in 1993 the average practice would have seen 3.5 patients who possibly had comorbidity in any year; in 1998 the figures had risen to 6.8. By extrapolation the authors set the 2003 figure at 11.3. The authors then calculate that by 2006 the 1998 figure will have doubled to fourteen patients per practice. This latter figure is based on information provided by 230 practices in England and Wales in a period from January 1993 to December 1998. The patients of these practices represent 3.1% of the population in England and Wales.

Frisher, M. Collins, J. Millson, D. Crome, I. Croft, P. (2004); Prevalence of comorbid psychiatric illness and substance misuse in primary care in England and Wales; Journal of Epidemiology & Community Health; December 2004 Vol 58 No 12.

Thanks to David Harding-Price RCGP Nursing Lead, RCN

## NOTICE BOARD

**Update for primary care professionals on HIV infection and Hepatitis**  
 HIV infection in drug users, latest hepatitis C treatments and launch of the *Guidance for hepatitis A and B vaccination of drug users in primary care*.  
 Speakers include: Professor Graham Foster, Dr David Young and Dr George Scullard. Cost for the day is £60 for past and current certificate applicants/graduates. Other delegates £75. Tuesday 8th March in London - for further information and an application form, contact Terri Myers: 020 7173 6090/6093 or [tmyers@rcgp.org.uk](mailto:tmyers@rcgp.org.uk) RCGP, Substance Misuse Unit.

**10th GP Managing Drug Users in General Practice Conference – 10 Years On: looking back; moving forward** - a celebration of progress on Thursday 28th and Friday 29th April 2005, Novotel Convention Centre, Hammersmith, London. **Application form enclosed or contact Health Care Events**, 2 Acre Road, Kingston upon Thames, Surrey, KT2 6EF, Direct Line: 020 8481 0350, Office Line: 020 8541 1399 Fax: 020 8547 2300 Email: [kerry@healthcare-events.co.uk](mailto:kerry@healthcare-events.co.uk) [www.healthcare-events.co.uk](http://www.healthcare-events.co.uk)

**Next round of RCGP Certificate Part 2**  
 Currently taking applications for GPs, other doctors, nurses, shared care workers, user advocates and prison staff. The course starts with unidisciplinary days for user advocates on the 15th March, nurses on 14th March, pharmacists 17th March, prison staff on 16th March. GPs will join the other candidates at regional masterclasses which will follow in April. Application form enclosed or contact Terri Myers: 020 7173 6090/6093 or [tmyers@rcgp.org.uk](mailto:tmyers@rcgp.org.uk) RCGP, Substance Misuse Unit, Frazer House, 32-38 Leman Street, London E1 8EW.

**16th International Harm reduction conference Belfast**  
 Back in the UK for the second time since it all began in Liverpool. To be held March 20-24th 2005 in Belfast – title Widening the Agenda – not to be missed. More details from [www.ihrcebelfast.com](http://www.ihrcebelfast.com)

**Drugscope training**  
 The training programme includes the following courses:  
 The effective worker: core skills and models for drug and alcohol workers.  
 DrugScope guide to commissioning in substance misuse  
 Domestic violence: practice issues for drug and alcohol services  
 Planning a service for young people: an overview  
 Drugs and crime - the interface and many more.....  
 DrugScope Tel: 020 7922 8688 Fax: 020 7928 1771  
 Email: [dagmarap@drugscope.org.uk](mailto:dagmarap@drugscope.org.uk) Web: [www.drugscope.org.uk](http://www.drugscope.org.uk)

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## NEWS DIGEST

### The importance of retention in treatment

Treatment effectiveness: demonstration analysis of treatment surveillance data about treatment completion and retention

National Drug Evidence Centre (NDEC), The University of Manchester

This December 2004 bulletin by the National Treatment Agency (NTA) shows their commitment to support treatment programmes that promote patient retention. It highlights important findings on retention that have come out of the National Treatment Outcome Research Study (NTORS). This confirms for England what research has already shown for north America, that 'retaining clients in treatment (beyond 90 days where possible) considerably enhances the benefits to clients and reductions in crime and infections that have an impact on public health. Furthermore, early treatment drop-out is associated with increased overdose risk, and with high risk of relapse to problem drug use.' The NTA will be collecting data to support targeting to 'increase year on year the proportion of successful users successfully sustaining or completing treatment programmes.' The key messages for practice offered by the NDEC and NTA are the following:

- Clients are most likely to drop out of treatment in the first two weeks, and services must consider their options in preventing this unnecessary loss of drug users who have started the treatment process.
- After the initial client loss, the process of attrition is rather more gradual. It seems clear that what happens at or just after that very first contact with the agency is crucial to the way in which clients are engaged by the treatment service.
- Not all services are equally adept at retaining clients, and it is more likely to be factors about the service rather than factors about the client that will determine who drops out.
- High risk groups more likely to drop out are younger drug users, males, those who are new to treatment and those who are referred by the criminal justice system.