Substance Misuse Management in General Practice (SMMGP)

Towards a Primary Care Network

December 1999 Newsletter No. 15

Towards a Primary Care Network

Substance Misuse Management in General Practice is a developing network to support GPs and other members of the primary health care team who work with substance misuse. The network produces the *Substance Misuse Management in General Practice* newsletter (*SMMGP*), and organises the annual conference 'Managing Drug Users in General Practice'.

A developing network

The idea for a national primary care support network gave rise to an annual conference, 'Managing Drug Users in General Practice', first held in 1996. The network has been evolving steadily since. A number of recent changes are highlighted below, including changes in the newsletter itself.

For those not reading the newsletter for the first time, *SMMGP* will look somewhat revamped. From December 1999, the newsletter is being produced by the SMMGP production group (see back page) with the support of the Substance Misuse Advisory Service (SMAS)

Developing the network

The conference initiative led to the appointment of Jean-Claude Barjolin as Primary Care Development Adviser' in August 1999. The key functions of the post are to co-ordinate and to develop the network and work in an advisory capacity with primary care. The principal project aims are to support and encourage GPs and other members of the primary health care team to work with drug users. The post-holder is based at the Substance Misuse Advisory Service (SMAS) and the post is initially funded until March 2001.

New readers - expanded network

One of the aims of the post is to expand the readership of *SMMGP* and to encourage new participation in the network. It was felt important to open discussion, support and information sharing to a wider group of GPs and members of the primary health care team.

If you would like to be on our direct mail-out for our next March 2000 edition, please let us know – See back page for details

The newsletter has been distributed to about 300 regular readers mainly working in primary care, most contacts from our annual conference. The newsletter is often copied and distributed via other local networks. This edition will see a much larger direct distribution of 3000 copies with a view to expanding the network.

SMMGP web-site - *smmgp.demon.co.uk*

One of the recent initiatives has been to establish a web-site (***site currently under construction***), which will be further developed as the project grows. The *SMMGP* newsletters and conference reports will become available on the site, with new web-site facilities and information appearing in 2000.

Readers views - comments and contents

As the newsletter and network further develops, comments and suggestions on SMMGP newsletter and web-site content and format would be most useful. Contributions in the form of discussion articles, points of view, questions or news items would also be extremely welcome. *See contact, web-site details and editorial board on back page.*

'Managing Drug Users in General Practice' Conference 2000 10th & 11th of May in Leeds

This annual conference organised by the Primary Care Network has been running since 1995. The conference is designed for both those who have little or no experience with managing drug users and those more skilled in this area. The themes for 2000 are to include social inclusion and individual need verses public health, criminal justice and community safety. For more information contact RCGP Courses on 0171 823 9703, **courses@rcgp.org.uk** (e mail), **or http://www.rcgp.org.uk** (web page)

Working with the national drug strategy

'Tackling Drugs to Build a Better Britain' places a great emphasis on the role of GPs in the treatment of drug users. The new *Guidelines on Clinical Management'* have identified the role and responsibilities of GPs as well as the support they need to conduct this work.

SMMGP* aims to support this general strategy, but also to act as a *constructive medium for questioning and debate around policy and practice.

Department of Health Discussions with Primary Care on the Drug Misuse and Dependence Guidelines

The Department of Health published the "Drug Misuse and Dependence – Guidelines on Clinical Management" (detailed in the previous newsletter) on 12th April this year to which there was a mixed response. Clare Gerada, Senior Medical Officer at the DoH, felt that there was a need to further explore some of the issues of contention highlighted by correspondence with the DoH, together with ways of implementing the Guidelines recommendations.

To this end a series of discussions with primary care have taken place across the country. Representing *SMMGP*, I attended two of these discussions in October, one in Leeds and the other in London. Attendees reflected a random invitation of 'non specialist' representatives drawn from Primary Care Groups, Local Medical Committees and other primary care organisations.

A re-occurring theme that emerged in both days, was the need to harmonise drug misuse services with the needs of primary care. There was considerable agreement that specialist services should be more 'primary care led' in terms of focus and approach. This could be reflected in more structured arrangements for delivering shared care and primary care training and support:

Formalised support

Good shared-care (more than a referral letter) must involve a structure that adequately meets the need of primary care, ideally with a links worker. Services need identified GP support or liaison workers, and easily accessible support. Good and accessible ancillary services such as urine testing, and services for stimulant users should also be available to GPs. There was felt to be a need to include other treatment modalities in services and to broaden the focus from methadone based programs.

Suggested shared care models

Some models suggested for implementing shared care involve a tiered triage central assessment function. This may have a possible single or rationalised point of entry into the service. The community tier would assess, stabilise and then facilitate appropriate patient access to primary care and then continue to offer support to the GP. As drug users often present to GPs in crisis (e.g. impending court case, family or legal issues, housing crises) what is important is that the GP has easily accessible advise and information and a relationship with specialist services that allows for a quick response in these times.

Specialist services will need to adapt from a traditional referral model, to see patients within a *continuum of care* that includes primary care as central and fundamental. In many cases GPs will remain the central co-ordinator for care, with the patient's continuum of need met between specialist services and primary care.

On going training and support for primary care

However for such a model to work, training would need to be reciprocal for primary care, specialist practioners and support/liaison workers (to learn from each other). GP training, recruitment, support and retention, all require dedicated time, resources and co-ordination. Provision should be made for training to be on-going and stratified according to levels of expertise. Primary care training and development often benefits from being GP led, with regular opportunity for peer group support.

Minimal service framework

One significant theme to emerge on both days was the need for more explicit central guidance on service frameworks to support recommendations on shared care. It was felt that there were a number of good models in operation in different parts of the country, but that many areas were struggling in terms of implementing shared care. This is particularly so in terms of not being able to achieve a balanced and bi-lateral development and integration of primary and secondary care.

It seemed that useful lessons learnt in some areas for supporting the development of shared care were not implemented because either they were not known, not understood, or not held as a 'real' priority to be acted on. Other experiences were that of 're-inventing' models from scratch at greater expense of time and resources.

What the guidelines amount to involves significant changes and development in both primary and secondary care. A national service framework and minimal service level agreement could help clarify service roles, responsibilities, and delivery structures. For some, shared care is presently an unclear, sometimes daunting, sometimes low-priority area.

Jean-Claude Barjolin

Models for Treating Drug Misusers

Dr Clare Gerada at the Department of Health is very interested to learn about ***different models for treating drug misusers that involve primary care*** in any way. If you think your service is noteworthy could you please e mail a brief summary of your service, including **how it is funded** and **whether it uses any of the new flexibilities in primary care** ('New Flexibility and Funding for Primary Care' article, see next page)

cgerada@doh.gov.uk

New Flexibility and Funding for Primary Care

The national drug strategy relies heavily on primary care for its delivery, especially in relation to improving drug user access to treatment services. The changes around the organisation of primary care (Primary Care Groups, Primary Care Trusts) and new flexibility around the delivery of primary care services, are likely to have an impact on the implementation of the strategy.

HSC 1999/O36 Drug Misuse Special Allocation 1999/2000 Funding and Guidance on the Modernisation Fund Element. This circular is for action by Health Authorities and NHS Trusts following analysis of drug expenditure in the Comprehensive Spending Review. The circular claims that funding will be used to shift the emphasis from anti-drugs activity towards treatment and prevention. The modernisation fund element makes additional funds available to be used in three key areas; *primary care development*; young peoples' services; and hepatitis B immunisation. This funding represents £12m in 1999/2000, £18m in 2000/01, and £20m in 2001/02 (totals are cumulative)

Health Service Guideline (96) 31 'A national framework for the Provision of Secondary Care Within General Practice'. NHS Executive. This guideline is a little known option, which allows Health Authorities to contract secondary care services in primary care. This could be where primary care can demonstrate competence to deliver services to drug users that exceed that normally provided to drug users as part of general medical services.

Paying GPs for 'Enhanced GMS' – 'Local Development Schemes' Outside of Normal Terms and Conditions

Systems are now in place whereby General Practitioners can be paid for providing services that are considered to be *enhanced GMS*. This can include services to any drug misusers, services aimed at young people or for any group where there is a case for enhanced services being needed and provided. Model schemes have been written, and one for drug misuse services are to be found in HSC 1999/107 pages 27 –29. The 'umbrella term' for these schemes is *Local Development Schemes* (LDS). This term does not identify the source of the funding for the enhanced GMS service, rather it is used to describe the service provided and agreed by key professions within a health authority and PCG area. These professionals should liaise closely with GP representatives through the Local Medical Committee format.

It must be remembered that prior to the formation of PCGs, few opportunities were available to pay GPs outside the normal terms and conditions of services available through the 'Red-Book' - which lays down the way GPs can be paid. It was through the flexibilities brought about by the 1996 Primary Care Act, in particular Section 36 of this Act that meant GPs could be paid outside the Red Book arrangements. Where a Local Development Scheme is used under this Section, it is often referred to as 'Section 36 LDS'. Other means of funding Local Development Schemes have been introduced, such as part of the DDRB (Doctors and Dentists Review Body, i.e. GPs and Dentists pay) £60m pay award. Five million pounds has been allocated towards paying doctors for providing enhanced GMS services, in particular those looking after drug misusers. This method of payment is often referred to as LDS-DDRB. The new flexibilites brought about in primary care means that other means can be found of paying GPs to provide Local Development Schemes. Part of the combined General Medical Services/Hospital and Community Health Service budget can be used if PCGs wish.

If health authorities or PCGs wish to pay GPs for providing enhanced GMS the flexibility now exist to do so. It may be that some PCGS will look again at the services provided by primary care to these patient groups, and devise local schemes that suit their local needs. In all cases however, all key professional groups must be involved including secondary care, public health and the non-statutory sector. This is especially important if 'non-new-money' is used, as removing monies from one part of a service will inevitably impact on another part. Nevertheless, PCGs and HA's can now be imaginative in providing services across the continuum of care and GPs can be paid for providing services over and above 'normal GMS'.

Primary Care Act Pilots (PCAPS)
PCAPS enable GPs to devise new ways of delivering health care through the development of personal medical services (PMS). This allows for the possibility of salaried doctor, nurse practitioner and primary care services to be run by acute, community or mental health trusts

Health Action Zone (HAZ)
HAZ funding is given to highly deprived areas, around 20 Health authorities, to enable them to develop new partnerships to address the big issues, including drugs. Different HAZs have varied priorities and bidding criteria. PCGs /primary care can access funds or be involved, either bidding directly or being part of an arrangement with another lead agency e.g. drug agency.

Walk- in clinics – Nurse run clinics, open from 7 - 9am, 6-9pm to operate as 'commuter clinics', but nothing should prevent drug users accessing them.

Beacon Practices - Billed as the Oscars of the NHS, Beacon awards were given to NHS Trusts, NHS bodies and Primary Care earlier this year in recognition of services that enhanced patient care. One higher 'Nye Bevan Award' went to Primary Care, for innovative shared care provided to drug users (the Trinity Project and Wellington Square Medical Centre, Hastings). Awards identify and support dissemination of good practice and range from £4,000 to £50,000. Nominations for 2000 /2001 - contact Nigel Zaman, NHS Beacons Co-ord. on 0113 254 5311.

NHS Direct – 24hr nurse run phone line for advice and information. This has the potential to link with out of hours chemists for including those willing to do supervised consumption, and GPs willing to see drug users.

Criminal Justice Interventions

As part of the Government drug strategy *Tackling Drugs to Build a Better Britain*, a number of criminal justice interventions are likely to play an important part in accessing more offenders into treatment. Three key criminal justice initiatives, which are likely to have an impact on both specialist services and primary care have been highlighted below.

Drug strategy implementation

The UK Anti-Drugs Co-ordination Unit (UKADCU) has a role to support monitoring and effective implementation of government strategy, including support to the UK Anti-Drugs Co-ordinator (The 'Drug Czar'). Drug Action Teams (DATs) are intended to be the main mechanism for ensuring local resource collaboration and strategy implementation.

DAT templates: DATs will be required to report annually on action being taken across the full range of the strategy. These reports (DAT Templates) will serve as a transparent appraisal of current local activity and will be used to set priorities for future action.

Impact on primary care: Specific template questions are asked on treatment, including GP prescribing and formalised shared care arrangements. The three criminal justice initiatives highlighted will have a big impact on client referral to specialist services. In turn this is likely to impact on primary care through shared care, or even directly with primary care through the expanding range of primary care providers that are emerging, such as specialised generalist clinics. For specialist services to cope they are likely to increasingly call on primary care.

1. Arrest Referral

For the first time the police service is to spend 1% of its budget on treatment. This is often likely to be through arrest referral.

Arrest referral can provide information and put people in touch with local services. At arrest people are invited to take up the opportunity to address their drug misuse, including referral to an appropriate treatment or other services.

A typical pro-active arrest referral scheme would employ dedicated workers based at a police station or on call and would target all persons regardless of offence.

***Mandatory drug testing at arrest** has been recently announced and may well have an impact on targeting class A drug offenders (heroin, cocaine) into treatment via arrest referral or through coercive bail conditions. Further official clarification is awaited.*

2. Drug Treatment and Testing Orders (DTTOs)

The first national systematic treatment pilot funded by probation

The new DTTO pilot was introduced as part of the 1998 Crime and Disorder Act. This gives the court powers to impose drug treatment, some terms of treatment (but not treatment content) and a treatment progress review. However, the court powers rely on the initial consent of the offender.

'Drug Treatment and Testing Orders are being piloted and will provide a means for sentencers to require drug misusing offenders to undergo treatment as part of a community sentence ...Where a probation order does not include treatment conditions there is still scope for probation officers (or drugs workers operating in probation satellite clinics) to refer drug misusing offenders to specialist treatment facilities.' (Drugs Interventions in the Criminal Justice System, Guidance Manual, Drugs Prevention Advisory Service, p.3)

Probation has the ability and funds to purchase DTTO services, which creates the potential for contracting treatment with primary care.

3. CARATS

The new national prison funded treatment programme

A range of treatment programmes have been developing in prison establishments since 1995, but the needs of the majority of prisoners who have misused drugs will now be met by 'counselling, assessment, referral, advice and through-care services' (CARATS).

CARATS is available in all prison establishments through both The Prison Service and outside service provider contracts since October 1999. The Prison Service drugs strategy includes assessment, detoxification and prescribing services, and a range of support, rehabilitation and post sentence arrangements with agencies in the community. Throughcare and referral to community agencies will impact on specialist agencies and primary care.

Source: Drugs Interventions in the Criminal Justice System, Guidance Manual, Drugs Prevention Advisory Service

Release

Release offers advice, information and support to drug users, their families and friends in relation to drugs and drug related legal issues

Release, 388 Old Street, London, EC1V 9LT.

Telephone 0171 729 5255 Mon –Fri 10.00 - 1800

Viewpoint

We look forward to responses and discussion on these or other important topics

Evidence base and appropriateness of treatment

The new clinical guidelines have brought into question valid approaches to managing drug users in general practice, such as dihydrocodeine and injectable preparations. The possible treatment options in general-practice appear to be narrowing to methadone mixture. This is partly due to a political decision, and partly to an increasing reliance on an evidence base approach. Evidence base should be generally welcomed as contributing to better practice. However, an over-reliance on this approach can be hampering due to the narrow range of evidence that currently exists. Fear of stepping outside of the current evidence base can lead to an inability to respond to individual needs, and can act as a disincentive for practitioners to develop good alternative clinical practice.

Jean-Claude Barjolin and Dr Chris Ford

Short term criminal justice funding for long term treatment?

Much of the new money for drugs services seems to be coming in via the Criminal Justice System. In many ways, this shift of funds from criminal justice to health seems very appropriate, as it has been evident for a long time that much of the money spent in the criminal justice system on processing and incarcerating people whose criminal activity feeds a drugs habit is totally wasted. Both the offenders themselves and everyone else would get better value from improved treatment services. However some potentially problematic issues are raised. These include ethical problems such as coercion into treatment and prioritisation of patients on the basis of offending behaviours, neither of which I want to deal with here. However there also seem to be practical difficulties involved in meeting the criminal justice agenda. The most awkward of these from our point of view is the fact that the money seems to be targeted at identifying people who need drug treatment rather than paying for any realistic course of treatment. This is particularly true of the arrest referral schemes and the fixed-term 'prolific offenders' schemes. This is OK where there are adequate treatment services available to take over their care, but here in Sheffield (and I suspect elsewhere) we could not readily 'assimilate' these patients into our normal treatment services when their criminal justice funding runs out. As the only treatment that I know to have an evidence base for crime reduction is long-term methadone maintenance, we can hardly be expected to attempt a quick 'cure'!

Personally I do not have a problem with treating offenders referred via criminal justice, not least because I believe that one of the worst health outcomes for any individual and family is imprisonment and there is evidence that treatment can reduce imprisonment dramatically. But how do we reconcile short-term funding with people who need long-term treatments? Has anyone else run into this problem?

Dr Jenny Keen Primary Care Specialist, Sheffield Institute of Primary Care – see 'Research Contacts' on back page

Shared care - A GPs view

There is a steady increase in opiate misusers seeking help from health services, resulting in overwhelmed specialist services, and demanding patients presenting in practices wanting help and access to licit prescriptions of opiates. Many practitioners feel threatened, or under-skilled.

Clearly one solution is for the specialists to work with primary care to provide co-ordinated services for this group. This is the essence of shared care services. It enables hard pressed primary care services to call upon the experience of specialist drug workers, to help with assessment, treatment, monitoring, service development and education. The specialist services are then able to work with practices to provide the patients with care at their GP's surgery (which research has shown these patients to want). This enables the specialists to concentrate their resources on the chaotic clients, which is more cost-effective use of scarce resources. Primary care staff gain experience, benefit from the knowledge and network of the specialist services helping them deal with the problem on site. The practice is then better able to tackle the other health needs of such patients and their families, who are at risk in many ways, physical, psychological and social. One can, for example, provide them with access to preventative measures such as screening and immunisation.

A shared care approach ensures that services are co-ordinated, communicating, utilising appropriate and complementary practitioner skill mixes, and hence cost effective.

Practitioners can call upon the advice and support of specialists for all their team members, and have ready access to them for help with particular problems and concerns. It should also ensure quicker access to specialist services for patients most in need of them. For this work there needs to be give and take on both sides, both primary care and specialist staff will learn from each other. **Dr Mark Gabbay**, Senior Lecturer in General Practice, Department of Primary Care, Liverpool University, Whelan Building, LG9 3GB. Article first appeared in 'Enhancing Shared Care' Project Newsletter, Greater Manchester Drug Action Partnership

Amphetamine Problem - How can primary care and other services respond with people who are regularly presenting, agitated and unwell, using large amounts of stimulants?

Tackling Stimulant Use

Two recent research studies have highlighted the major problems associated in Manchester with stimulant use, in particular crack cocaine. Both studies found some users spending in excess of £1,000 a week on their crack habits. In a study of female crack users in Manchester conducted by Lifeline it was found that 40% had committed a violent crime (robbery, mugging, assault) when high or needing to get high. 68% of respondents were involved in the sex industry. In a study by the Waterloo project of street drug users in Cheetham Hill and Lower Broughton, it was found that use of crack cocaine was as widespread as heroine use. This caused concern not only because crack usage can be more problematic for the individual and society but also because the vast majority of the crack using respondents were not in touch with any treatment agency.

Aside from the greater cost and resultant crime incurred by a cocaine habit, stimulants certainly have the potential to be more problematic than opiates. Injecting users often inject more often and less safely than opiate users, and stimulant users generally are more likely to engage in sexual activity (often in an unsafe manner). In addition, the appetite suppressant qualities of stimulants lead to a high incidence of malnourishment and vitamin deficiencies. Stimulants are also implicated in the incidence of both psychosis and depression.

The findings have worrying public health and criminal justice implications particularly because there is not as yet a generally accepted treatment response as there is for opiate dependency. Work at the Piper project in Stretford has shown that a user friendly, confidential service that responds rapidly to requests for help can attract stimulant users. Also there is some evidence that prescribing dexamphetamine to amphetamine users can be effective. There is a regionally accessible clinic at Prestwich hospital that provides this service. The Department of Health clinical guidelines acknowledge a possible role for this sort of prescribing and state that it should be provided either, by specialists or experienced GPs (Specialised Generalists). Research has shown that a sympathetic response from a GP (NB not a prescribing response) is highly valued by stimulant users. As yet there are no prescribing options for cocaine users apart from the possible use of anti-depressants during abstinence.

Jim Barnard

First appeared in 'Enhancing Shared Care' Project Newsletter, Greater Manchester Drug Action Partnership

'The Task Force'

'Klee's study shows that treatment from GPs was the service most used by amphetamine misusers. Despite high levels of amphetamine misuse in the Manchester area studied by Klee, clients rarely attended community drug agencies, and even less commonly specific drug dependence clinics.' ('Task Force' p.76)

Problems and difficulties included:

- Physical health problems: 40 % of the sample
- Psychological health problems: paranoia, aggressive behaviour, suicidal ideas
- Breakdown and deterioration in social relationships
- A loss of control that leads to panic and depression ('Task Force' p.75)

'specialist agency staff working with GPs ("GP liaison workers")' can provide effective support to both GP and amphetamine misuser; this can result in misusers obtaining access to experts whilst maintaining the status of "normal" person with a health problem seeking help through normal channels.' ('Task Force' p.30)
(DoH: 1996 Task Force to Review Services for Drug Misusers: Report of an Independent Review of Drug Treatment Services in England HMSO)

'The Clinical Guidelines'

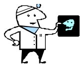
'Dexamphetamine prescribing should only be initiated by specialists and specialised generalists with adequate experience in this technique...The aim is not to give an equivalent dose to that used illegally but to minimise withdrawal symptoms and craving.' ('The Guidelines' p.43)

Service Responses to stimulant use

Because of the fast moving and hectic nature of stimulant use, services need to be able to respond almost immediately to presenting stimulant users. Confidentiality seems to be particularly important to stimulant users, and staff need to be knowledgeable and credible.

Primary Care Experience?

- **How do you attract patients into treatment without the lure of substitute medication?**
- **Are there any potential substitute medications (someone suggested coca tea)?**
- **How useful is substitute prescribing anyway? What other interventions are attractive & work?**
- **What are the merits of alternative therapies?**
- **What is possible in primary care?**



Dr Fixit's advice

A Friday night challenge

Dealing with drug users presenting in crisis for opiate replacement treatment

Most importantly there is no need to respond immediately: Patients with drug problems often present in a crisis and want you to respond immediately. While the patient may genuinely feel this, they are not usually in a life threatening position.

Most patients in this situation have been obtaining and using drugs, and managing 'living in crisis' for some time. The drug user will want to know that they have been listened to, that they will receive care and that something is underway.

The GP may feel pressured or unsure. While substitute prescribing may be a *preferable early option* there is no need to be rushed into it by the patient's apparent desperation. The patient need not come to any additional harm by having to wait a short time for **a planned response.**

Asking a patient to come back with a view to giving a proper assessment and making a planned response, demonstrates both willingness to care and professional parameters.

You may have several options:

1) Prescribe yourself after taking a urine and assessment. Your assessment needs to inform you that the patient is dependent. A low starting dose and daily pickup is the best option. If necessary the dose can be gradually adjusted, and pickup reviewed when the patient stabilises. Initial supervised consumption can be considered in areas where this facility exists.

2) Take a urine and partial assessment on the initial consultation and ask the patient to come back to complete the assessment. The patient will feel that they are receiving care, being taken seriously, and that things are underway. This will give you more time for your assessment, and allow for you to confirm that the patient is dependent. It will also allow you time to take advice, confirm any given patient history with other providers, and arrange support for you and the patient - make a more planned response.

3) Refuse to prescribe but offer general health care. You may not feel you have sufficient training, competence or support to offer more at present. You could also conduct an initial assessment and arrange for referral to specialist services, and provide or arrange for additional support around non-prescribing or other needs.

4) *If you have* - a local specialist service or a shared care scheme, look to enter into shared care. Determining whether to prescribe or not, or if this particular patient is appropriate to treat in general practice, or if they would be better managed initially or ongoing in the specialist service, can be decided jointly.

- Ask for help or advice on prescribing
- Ask for an outreach worker to come and assess the patient and suggest a prescribing regime
- Refer to the local specialist service for urine screening and/or assessment and/or initial stabilisation and/or on-going management or other support needs and therapeutic input.

Consider taking the patient back once they are stable on a script and their other priority needs are met. Ask for advice and support and negotiate *rapid access to worker support, or access to the service for the patient during relapse/difficulties.*

If prescribing independently:

Don't forget at the outset to send a urine for a drug screen (others at intervals). *Use screening supportively not punitively.* Only prescribe methadone if the urine tests positive for methadone or morphine.

Notify the patient to the regional database

Arrange non-prescribing support/therapeutic support for the patient where required

Dr Fixit's advice

Dihydrocodeine detoxification?

I have a patient who is asking for dihydrocodeine for outpatient detoxification. She says it is easier to detoxify from this rather than the methadone I am currently prescribing. Is she right? Is this an urban myth? Or am I just being conned?

Answer: Supplied by Jim Barnard
You are probably not being conned. This does not mean your patient is right, however. Many drug users and some clinicians genuinely believe that dihydrocodeine is easier to withdraw from than methadone (and this is an option worth considering). This is because it is a shorter acting opiate so that the withdrawal period is usually shorter but possibly more intense. However, it is possible to get more of a 'high' from dihydrocodeine than methadone thus making the psychological process of withdrawal more difficult. It is also worth considering other, possibly better alternatives to methadone such as lofexidine, which is not an opiate but reduces the symptoms of withdrawal from opiates. Ask your local Drug Service for more details about prescribing this drug, or other alternatives to methadone.

Primary Care Training - SCODA

The Standing Conference on Drug Abuse (SCODA) were charged, by the Department of Health, with the task of developing **a training package for GPs** and other primary care staff working with drug using patients. The training pack is designed to reflect the revised clinical guidelines and has the development of primary health care teams in mind. It is probably most suitable for trainers, shared care co-ordinators, or GPs with a specialised interest. **A CD-ROM** version, which is probably more suited for self-learning/reference by individual practitioners, is now also available.

The pack is priced at £55 and the CD-ROM at £15. They can be ordered from SCODA, 32-36 Loman Street, London SE1 9EE01. Telephone 0171 928 9500. www.ncvo-vol.org.uk/scoda.html

Research Contacts - Our research team at the Institute of Primary Care has recently been awarded £500,000 by the European Commission to study the outcomes for **children of heroin addicted parents**, when their parents enter a variety of treatments. Is anyone else conducting research into children of addicted parents and if so, have they developed or discovered any validated outcome measures? Dr Jenny Keen, Institute of G P & Primary Care, Community Sciences, Northern General Hospital, Herries Rd, Sheffield, S5 8AU. 0114-271-5925 0044-114-242-2136 (fax) j.keen@shef.ac.uk

SMMGP PRODUCTION GROUP

SMMGP is edited by Jean-Claude Barjolin, Chris Ford, Jim Barnard and Claire Higson. The newsletter is produced with support, editorial and steering group input from the following people:
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Dr Clare Gerada
Dr Jenny Keen
Don Lavoie
Brian Whitehead

What do you think of SMMGP? Contributions please!

This is *your newsletter*, which has been re-vamped in this 15th edition. The idea is that the newsletter keeps developing and the GP network keeps expanding. If you have any ideas or comments, or views or contributions for our next March 2000 edition please let us know.

Do you want to join the mailing list?

We have asked a number of organisations to help distribute this edition of the newsletter as we are keen to expand the SMMGP network. If you have been given a copy and are not on our regular mailing list and would like to be, please let us know.

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We look forward to hearing from you