Substance Misuse Management in General Practice (SMMGP)

Towards a Primary Care Network

March 2000 **Newsletter No.16**

Will Primary Care Commission Community Drug Services?

Commissioning guidance does not rule out the ability for Primary Care Trusts to commission and provide elements of substance misuse services. This could include community drug services.

Primary Care Groups (PCGs) became established in England on 1 April 1999. Whilst PCGs have evolved out of a range of recent commissioning models such as locality commissioning and GP commissioning pilots, they are fundamentally about *improving the health of the population they serve*. They contribute to the Health Improvement Plan (HiMP), address inequalities in provision of health care and improve primary care services. ***"They are intended to bring GPs, nurses and other local stakeholders together to give them a lead role in planning, provision and development of local health services...for all patients within their area"*** (NHS Executive)

PCGs will be acting to ensure the *best value for money from the resources available, and as such informing commissioning,* directly or indirectly: ***"To advise on, or commission directly, a range of hospital services for patients within their area which appropriately meets patient needs."*** (NHS Executive)

However before April 2000, PCGs will be supportive or share responsibility in terms of commissioning. ***"Level 1: act in support of the Health Authority in commissioning. Level 2: take devolved responsibility for managing an area budget."*** After April 2000, PCGs may eventually operate at one of two higher levels, which constitute Primary Care Trusts (PCTs), involved in direct commissioning: ***"Level 3: become established as free-standing bodies accountable to the Health Authority for commissioning care. Level 4: become established as free-standing bodies accountable to the Health Authority for commissioning care, and with the added responsibility for the provision of community services for their population."*** (NHS Executive)

Commissioning guidance does not rule out the ability for PCTs to commission and provide elements of substance misuse services. This could include community drug services appropriate for meeting the needs of primary care in shared care arrangements.

What is commissioning? There is considerable confusion as to what commissioning actually involves. Purchasing and commissioning, are they the same thing, and doesn't it all just mean paying for a service? Commissioning is strategic and covers a broad range of activity from assessing needs to application of resources.
(NB See full Commissioning Cycle on page 2)

COMMISSIONING: The strategic activity of assessing needs, resources and current services, and developing a strategy to make best use of the available resources to meet identified needs
PURCHASING: The operational activity set within the context of commissioning, of applying resources to buy services in order to meet needs, either at a macro/population level or at a micro/individual level
Source: Commissioning Standards, Drug & Alcohol Treatment and Care, SMAS *(See page 2 to order)*

The primary care commissioner (Primary Care Trust) could therefore be in a key position to review, support and mould local services, in terms of their appropriateness and effectiveness. The commissioner has the ability to initiate change, within a locally agreed strategy, through re-contracting and tendering. The commissioner's role is not to simply endorse historical arrangements but to use the full range of activities in the *commissioning cycle* (page 2)to meet identified needs. Within the context of shared care development, the potential exists for primary care to take the lead and re-shape the function and structure of local community services so that they can offer the most appropriate support to Primary Health Care Teams in that work.(***Continued, Commissioning Cycle p.2)***

The Commissioning Cycle *(Cont. from p.1)*

As a 'strategic activity' for meeting needs, the *commissioning cycle* has five distinct stages and activities that can act as a process guide to fit local circumstances:

1. Strategic Framework

- Establish a common view of required future developments
- Establish shared values and broad strategic objectives
- Clarify individual agency roles and responsibilities

2. Strategic Planning

- Complete strategic needs assessment
- Identify existing services and resources
- Define priorities and agree outcomes
- Consult users, carers and providers
- Agree commissioning intentions

3. Operational Planning

- Establish contracting mechanisms
- Develop quality assurance requirements
- Undertake market management and provider development activities
- Establish infrastructure needs

4. Purchasing Activities

- Agree service specification
- Select providers
- Agree contract and monitoring arrangements

5. Monitoring and Review

- Collect performance information
- Review provider performance standards
- Review/re-negotiate contracts
- Feed information back into Strategic Review

Source: DoH 1995. *An Introduction to Joint Commissioning*

The Substance Misuse Advisory Service (SMAS) Commissioning Standards cover a range of issues, which may be of interest to primary care (PCGs/PCTs). These include the commissioning cycle and function, population needs assessment, strategic planning and developing service specifications, including shared care. **From SMAS on 0171 881 9255**

Is alcohol is a problem we should deal with in primary care?

"...unlike other disorders, (alcohol misuse) is a disease many primary care physicians do not want to detect. In addition, most alcoholics do not want their disease detected" *Malla et al., 1987*

- **£2, 400 million spent on alcohol in the UK in 1997**
- **£22,800 spent in one minute on alcohol in England and Wales**
- **Estimates for alcohol deaths per annum between 28, 000 & 40, 000, 0.5% of the drinking population**
- **Compare with ecstasy deaths of +/- 9 per year, and tobacco 110, 000 per year**
- **One third of motorists killed on the roads are over the legal limit, rising to 60% between the hours of 11pm & 4am**
- **25% of hospital emergency medical admissions can be attributed to alcohol**
- **45% of violent crime is by people who have been drinking**

Primary care has an important role. We see many people and cover the whole of the country. We can recognise this problem (frequent attendee etc.) provide help, education support and see the problem in the context of people's general health care. We are well placed to carry out prevention. Brief interventions have been shown to be effective in reducing people's drinking and the proportion of patients drinking heavily decreases in both sexes.

The broad aims of the alcohol misuse strategy

- **To encourage people who drink to do so sensibly in line with the government's guidance, so as to avoid alcohol related problems.**
- **To protect individuals and communities from anti-social and criminal behaviour related to alcohol misuse**
- **To provide services of proven effectiveness that enable people to overcome their alcohol misuse problems** White Paper *Saving Lives; Our Healthier Nation*

How are we doing in primary care? The average GP list is about 1, 900 patients. It is estimated that about 13% of women, and 27% of men fall into three groups:

1. **Potential alcohol misusers** – not yet dependent but consuming above the recommended levels
2. **Actual alcohol misusers** – signs of physical, social or psychological adverse effects but not as yet alcohol dependent
3. **Dependent drinkers** – as above but dependent on alcohol

The patients in these three groups can be between 300-350 patients on each list. We could be seeing about 38 people in these groups per month. *On average we identify about 19% of potential drinkers, 35% of actual drinkers and 43% of dependent drinkers.*

What do those of us working in primary care think? 93% of us felt we had a role but only 44% felt equipped, 39% felt motivated. We felt it was time-consuming work (77%), and that drinkers were difficult to work with (60%). They were unrewarding to treat (62%) and caused major management problems (69%). We had a lack of training (78%) and there was little work satisfaction (9%). Workers (92%) believed that self-motivation was most important factor in success.
Adapted from Substance Misuse Management Project (SMP) training course by Dr Chris Ford, SMP GP Facilitator

Ed note: Forthcoming SMMGP no.17, for alcohol brief interventions for primary care and the development of primary care guidelines. Readers willing to contribute, contact SMMGP, p.8

Primary Care Led Development of Shared Care for Drug Users

Dr Quentin Shaw PCG Chair "One crucial issue locally, seems to be whether specialist/generalist GPs involved in maintenance prescribing should prescribe only to patients who are registered with them (and thus be delivering an extended GMS service) or whether they could prescribe at a separate location for patients who remain registered with another general practice for GMS services. Personally I favour the second model as it clearly separates the two tasks of managing misuse and delivering general medical care. It has important implication, however, for sources of funding."

Ed: Personally I favour the first model as it normalises and distributes the care of drug users in primary care. However, the role of specialised generalists **who take a lead in delivering a** deputising service **can be invaluable,** if **after developing local primary care expertise they also take a lead in involving other GPs. More generally, when specialised generalists lead the development of shared care, it promotes a holistic and health based approach to care. The combination of GMS and managing drug use, can offer greater treatment and harm reduction opportunities to the patient. Developing a specialised generalist lead can fit within a Primary Care Group focus for care of this client group. Ideally, specialised generalists will offer support, training, leadership, and facilitation for other local GPs to take on manageable and stable clients.**

From Deputising to Shared Care

Ideally I believe that all GPs would look after their own patients for all services including prescribing, and this is the aim in Sheffield as elsewhere. However, just over one year ago in Sheffield there were virtually no services for the vast majority of users, and the LMC was totally opposed to GPs prescribing. The waiting list for the small and under-funded consultant service was 18 months. This made it difficult for GPs who wanted to prescribe methadone to receive any support. Against this background it was completely unrealistic to contemplate 20% of GPs prescribing and virtually none did.

'GP pump- priming' - It seemed to us that the only way to break through this deadlock was to start a service with the aim of *pump-priming GP prescribing* to provide a model of practice, become involved in training GPs and registrars, support prescribing GPs and gain the support of the LMC. The two doctors starting up the service, including myself, were well-known ex-Principals from local practices, and had links with other local GPs. We wrote a specifically primary-care based protocol which others could copy and we made a central part of our clinic the '*quick turnaround*' service whereby GPs could get a new referral seen within 2 weeks, stabilised and returned to them for long-term prescribing. Many local GPs have taken advantage of this. We also offer support for GPs and *quick intervention* should things break down in the future. Funding is assorted health authority monies including drugs development and waiting list money. The clinic is very cheap at £550 per patient per year.

Meanwhile we also have a long-term deputising caseload (GP budgets fund the drugs prescribed) although we regularly liaise with GPs about taking

patients back where possible. Our GPs have never had any service like this and have welcomed the new development. We have found a lot of enthusiasm amongst 'waverers' some of whom, turn out to have been prescribing secretly for one or two patients but with no particular protocol. We have also been able to advise prescribing GPs on latest advice regarding best practice. We have under-taken to try and find prescribing GPs for patients leaving the local bail hostel in liaison with their local practice. A few confirmed non-prescribers have started to take on the odd patient, with us doing the assessment. They may well gradually become more confident

and do their own assessments in future. We have also had patients taken back from us by GPs who had actually referred for long-term prescribing, because the patients have become so stable.

Our clinical nurse specialist and the doctors have been involved in informal training and many visits to local practices to discuss protocols and methods. I think GPs trust us because we are GPs and they ask us very basic questions and use us for quite basic support, previously unavailable.

We are also instrumental in forming part of the formal shared care structure as set out in the new Guidelines. This was not a model, which the existing consultant service was able to implement, for a variety of reasons. However, it is an essential component if prescribing is to be seen as 'mainstream' in Sheffield, which is our aim. The deadlock of GP involvement seems to be broken, with many GPs starting to prescribe methadone who have never previously done so. This would have been unlikely if we had waited for GPs to start prescribing methadone in the absence of support structures and primary care protocols. **Dr Jenny Keen** (For address see page 4)

Supervised Consumption?

"Daily Supervised Consumption, which is the requirement for some or all methadone doses to be taken under the supervision of a pharmacist, has raised controversy ever since the new Department of Health guidelines for the treatment of drug dependence (1999) recommended that all new patients starting on methadone maintenance should take their methadone under supervision for the first three months. Whilst some people have seen this as a useful safeguard, others have regarded it as an infringement of patients' rights under the NHS." Dr Jenny Keen

What the 'Clinical Guidelines' Say on Supervised Consumption (Page 61)

- **Most new patients should be required to take their daily dose under direct supervision**
- **This may be for at least 3 months, subject to compliance**
- **Daily dispensing, ideally with supervised consumption should be re-instituted for a period of time when the patient restarts methadone after a break, or receives a significant increase in the methadone dose**
- **Arrangements should only be relaxed if there is satisfaction that compliance will be maintained**
- **Relaxation of supervision can be seen as an important component of rehabilitation**

Take-home doses should not be prescribed where:

- **The patient shows a continued and unstable, or unauthorised, pattern of drug misuse, including a significant increase in alcohol intake, the use of illicit drugs, benzodiazepines or other tanquilizers;**
- **The patient has significant unstable psychiatric illness;**
- **There is continuing concern that the prescribed drug is being diverted or used inappropriately**

Other methods for improving compliance include urine testing, daily pick-up and instalment prescribing

Supervised Consumption in Shared Care

Sheffield is without a tradition of widespread methadone prescribing. Very few heroin users were able to access treatment prior to 1999. In starting our new primary care clinic, our priority was to bring as many users into harm minimisation treatment (i.e. methadone maintenance) as quickly and as safely as possible. Additionally it was to encourage very reluctant local GPs to undertake more of this work themselves: to enable shared care to be developed along safe and manageable guidelines falling within the government guidelines.

This included starting all patients on a daily supervised consumption script which would be relaxed only when the individuals concerned were stable and preferably not using illicit drugs as shown by urinalysis. Inexperienced GPs would feel more secure and that the new and very quickly growing clinic would be on a firmer base.

As a GP I did not previously use supervised consumption, and once using it I noticed immediately the sense of freedom it gave me as a prescriber. I felt comfortable about increasing people's doses of methadone where needed to much higher levels than before. I knew that to start off with it would be taken in front of a pharmacist and that I was not increasing the dose simply so that it could be sold on.
I believe that this firm protocol has also enabled patients to talk to us more freely about their illicit drug use. Within the constraints of initial supervised consumption, we will increase their methadone to whatever level is necessary, so that illicit drugs are not needed to abolish withdrawal.

The scheme has been so successful that Sheffield Health has entered into a contract with one of the Sheffield chemists to oversee the supervised consumption scheme city-wide. Most local chemists will have support from a central pharmacy if they decide to undertake supervision of methadone consumption. Patients will not have to travel so far for their daily dose.

The clinic has had a remarkably low drop-out rate and has gone from 0-200 patients in the first year. This has increased the numbers of heroin users on methadone maintenance in Sheffield by approximately 60% over that period. I believe it has also significantly increased the number of Sheffield GPs prescribing methadone. For a clinic like ours to run on deputising basis where GPs fund the methadone, both ourselves as prescribers and GPs have to be convinced that the prescribing and depensing is safe for the individual patients and the city. I believe that this pragmatic approach has worked well for us and can be recommended to others. **Dr Jenny Keen** Primary Care Specialist for Drug Dependence, Primary Care Specialist Clinic for Drug Dependence,Norfolk House, 4 Norfolk St,Sheffield,S1 2JB 0114-271-8866j.keen@shef.ac.uk

Supervised Consumption

The Wirral Drug Service

Since the opening of the Wirral Drug Service, clients have always self-administered their own medication; the large majority of prescriptions are posted or delivered to local pharmacies. The medication is dispensed and consumed by the client at home. Local pharmacists have been an important partner in the provision of this community based drug treatment system.

Although this system benefits the vast majority of clients, a small minority need more careful supervision of their medication consumption, a scheme has therefore been devised, based on others already in operation, and placed once again in local pharmacies. Medication is dispensed to certain client groups daily, under the supervision of the pharmacist, at approximately the same time each day. Client confidentiality and dignity is ensured by the provision of a segregated space within the pharmacy.

Clients using the scheme include:

- Those who have recently left prison, rehabs
- New clients who feel they need large initial doses of medication.
- Vulnerable clients who may have their medication stolen, etc
- Presenting as increasingly chaotic/problematic

- Clients whose health and welfare give cause for concern
- Those who request the service, eg. A planned daily detox regime.

Client Protocols - Clients can be referred on the scheme by pharmacists themselves, although the final decision is the team leader's. Pharmacists see clients 3 or 4 times a week and can often notice whether a particular client is not doing too well. The scheme is not used as a punitive measure, nor as a sanction for inappropriate behaviour. Clients are placed on the scheme to add stability to their drug treatment. We would normally expect a client to be on the scheme for a period of 2-6 weeks. During this period they would be reviewed weekly by the key worker to monitor progress. It has also made it much easier to safely set the required dose for those clients who are asking for large initial dose. Once some measure of stability is reported then clients go back to the more normal 'take home' dose. Clients who have already been on large doses for some time, with the worker expressing some concern that not all is being consumed properly, can also be placed on the scheme as a safeguard against leakage onto the streets.

Mark Harris **Clinical Co-ordinator, GP Liaison Team, Wirral Drug Service, St Catherine's Hospital, Derby Road, Tranmere, Merseyside l42 0LQ: 0151 604 7330 Web-site www.wirraldrugservice.org.uk**

The role of the Community Pharmacist

"Community pharmacists provide a significant point of contact as part of primary health care services and have regular (often daily) contact with the patient. Hence their role in the care of drug misusers is crucial..." (Clinical Guidelines p.67)
Their role can be much greater than dispensing. Joint working and regular communication between pharmacist and other shared care partners is to be encouraged.

- **Point of first contact for many drug misusers (general health advice)**
- **Referral to drug treatment services**

- **Dispensing prescriptions for controlled drugs**
- **Monitor compliance**
- **Shared care role with GPs/Specialists**
- **Provision of clean injecting equipment either by sale or through needle exchange**
- **Provide verbal and written information**
- **Check prescriptions for accuracy**
- **Monitor for drug interactions**
- **Identify forged prescriptions**
- **Monitor over-the-counter drugs**

"Community Pharmacists are not obliged to supervise the self-administration of controlled drugs by the patient in the pharmacy...It is recommended that pharmacists who are willing to provide this service are adequately trained and have suitable guidance..." (The Clinical Guidelines p.67)

Caution on Implementing Supervised Consumption - It may well prove to be one effective option in reducing diversion. But we need to beware of knee-jerk 'mandatory' responses to implementation. Flexibility and careful consideration are needed if implementing this area of the clinical guidelines. Good models do exist, as do ill-considered, rigid and punitive approaches. Supervised consumption may not actually be necessary or therapeutically beneficial for many clients. There is still insufficient evidence in the need for supervision. Support and resource issues will also need to be fully considered for pharmacists. Having supervised consumption in place, is not,on its own, necessarily a measure of effective or responsible care or treatment. **Dr Chris Ford**

Do you have any alternative views on supervised consumption? Let us know – contacts on back page.

Issues for Community Nurses in Substance Misuse Provision

Traditionally, treatment of drug misuse has been the province of GPs and medical specialists from the Community Addictions Team (CAT). Little acknowledgement has been paid to other members of the Primary Health Care Team (PHCT), especially community nurses. Recently published clinical guidelines follow a drug misuser through pregnancy to childbirth and then leave them and their children in the hands of yet another, not so well read document entitled "Drug Using Parents – policy guidelines for inter-agency working" **(1)**.

Risk Management - My work as a health visitor in Oxfordshire has brought me into contact with several drug misusing families over recent years. Presenting issues are complex, often necessitating referrals to Community Mental Health Teams (CMHT) or social services. I am increasingly aware of the need for more communication and liaison between agencies as well as many gaps in the service in attempting to meet their needs.

The difficulties of risk assessment cannot be under-estimated in case conference procedures designed to prioritise the welfare of children. The realities of these meetings often reflect the poor knowledge base of both social work and the health care professionals in attempting to identify the level of drug misuse in relation to parenting and coping skills. While recognising the strong emotional bonds that usually exist between parents and children, professionals are left to "carry the can" for decisions which could have major implications for their future lives. More research is clearly needed in this area to provide firmer evidence to support this process.

Primary Health Care Team (PHCT) Issues

The role of the health visitor can be pivotal in co-ordinating the care of families with children. This can go unrecognised if misusers, registering as temporary patients, are not referred to other members of the PHCT. Many are desperate to keep their children and fear contact with social services who they view with suspicion, assuming their 'policing' role in this situation. This may result in registering their children with a different GP to prevent links with a drug using parent from being identified. I am also aware of the difficulties many families face from being refused access to a GP because of their addiction. This may mean that some children are marginalised because of their GPs gatekeeping role to the child health clinics and other treatment and preventative services.

Shared Care - I welcome the recommendation for more drug misusers to be treated in primary care as long as the concept of 'shared care' is extended to other children and family services. As PCGs and CMHTs consider this issue, it is important that it is examined from a variety of perspectives, including participation from community nurses and social workers when considering referral and treatment protocols between primary and specialist providers. As new models of shared care develop, I hope they will also acknowledge the leadership and public health skills of the health visitor and other community nurses in facilitating community development between the statutory and voluntary agencies. They are well placed to contribute to both grass roots and health authority level. There is a lot more to the role of the nurse in the year 2000 in the PHCT than the "dressing of wounds and abscesses" referred to in 'the orange book'!

Rosie Winyard, Addictions Project Officer, Vale PCG Oxfordshire Rosie@rosiewinyard.freserve.co.uk

(1) The guidelines mentioned above, are a very useful starting point to help improve inter-agency working, particularly if they are adapted for the local area. Brent launched their guidelines at a successful conference opened by Paul Boeteng. The head of social services and the chair of the HA all stated how important joint working and the process of developing the guidelines was, almost more that the finished document. Training will be developed for all agencies and all members of the PHCT to help implement and understand the guidelines. If you would like a copy of the local guidelines please write requesting Drug and Alcohol Using Parents and their Families: Jane Allen, Brent & Harrow Health Authority, Bessborough Road, Harrow,HA1 3EX. **Dr Chris Ford**

Shared Care – 'Managing the Gap' or 'Shifted Outpatients'?

Insights from a presentation given by Dr Claire Gerada at a Pan London GP Prescribing Forum

Shared care is not about 'seamless' or 'integrated' services, which as jargon, may represent clever and desirable notions. Services and individuals often work in different ways and with different agendas. Explicit intention, effort and action are required to bridge differences. Shared care may be better served by another contender, **'managing the gap'**. More jargon? For sure, but where shared care works, all models display real intention, effort and action to 'manage the gap' or the differences. It also implies ongoing shared responsibility for care, which might help avoid the phenomena of unsupported referrals and **'shifted outpatients';** specialist work in primary care without the transfer of skills or sharing of care.

One ideal model would be for each Primary Care Group to identify and support the development of 2 to 3 specialised generalists. These could take a primary care lead in developing shared care; providing clinical supervision for other GPs (and possibly other agency workers who support shared care GPs), provide GP facilitation/support/training, and provide assessment and stabilisation of clients for primary care. The specialised generalists would be supervised ideally by a named consultant from the specialist services. Workers from local statutory and voluntary agencies who take on GP Liaison would see GPs as their clients, and work closely with the specialised generalists in co-ordinating shared care. Primary care need not wait for shared care to happen, but is better served by creating it itself and bringing other partners on-board. This approach is more likely to develop a model that fits with general practice, which sustains primary care involvement, and which better supports other providers in meeting the needs of primary care. Some structures are needed in place to better ensure 'managing the gap': shared care steering group; formal involvement of Primary Care Groups, Local Medical Committee and Drug Action Team; assessment of local needs and resources; new flexibility funding for primary care (December 1999 issue) Meeting attended by Jean-Claude Barjolin.
Please contact Dr Claire Gerada, DoH, cgerada@doh.gov.uk if you have found ways of setting up shared care in your area.

Alternative Treatments for Opiate Dependence

This issue we re-focus on buprenorphine, with a view to opening up discussion on *alternatives to methadone*. In future issues we will be looking at other alternatives

Buprenorphine High dose buprenorphine marketed under the trade name of Subutex, is available in the UK for prescription by any doctor for the treatment of opiate misuse. Buprenorphine has been tested in 33 trials involving over 2,500 patients in France and USA, and its effectiveness in opiate substitute prescribing has been demonstrated. In France, where methadone is only available from specialist clinics, high dose buprenorphine has been extensively used by GPs since 1996. Over 60,000 clients have been treated in community maintenance programmes. Buprenorphine acts as a partial agonist at the u-receptor site in the brain. These are the receptors believed to be responsible for non-analgesic effects of opiates such as euphoria, respiratory depression and

dependence. It is this partial agonist property of buprenorphine that gives it most of the advantages it is said to have over methadone, which is a full agonist.

It is being recommended for use in maintenance and detoxification treatments. Its role in primary care seems likely to be for younger, shorter-term heroin users. It may also be helpful for patients on longer term methadone treatment who are trying to reduce and come off - a switch from methadone to buprenorphine at the 30mg methadone level is straightforward, and the resulting detox may be easier and quicker than with methadone.

Dr Berry Beaumont, GP, 2 Mitchison Rd, London N1 3NG.

Extracts from an article previously featured in SMMGP 13.

'It is recommended that buprenorphine should be initiated by a specialist practitioner, and safeguards such as daily dispensing, with supervised consumption, should be inherent to any well-delivered buprenorphine substitution programme. The ready solubility and injectability of this substance makes it a substance that requires longer term supervised dispensing...' The 'Clinical Guidelines' p. 39

Buprenorphine Protocol - Wakefield & Pontefract PCG Prescribing Service

Background: I have been prescribing buprenorphine (Subutex brand name) on a regular basis in our PCG based community prescribing service for substance misuse for almost a year. I worked closely with Schering Plough (Subutex) developing confidence with the treatment and they then helped us design our treatment protocols.

During this time, I have set up a Clinical Effectiveness Study (Audit) of the first thirty patients prescribed. Through this we hope to look at the short, medium and long-term outcomes of this treatment as compared to others, as well as cost comparative work.

At the present time we work closely with two local pharmacists and all buprenorphine prescribed in our clinic is supervised dispensed. This means that "leakage" is minimised, improving safety and ensuring maximum efficacy of the drug.

Using buprenorphine in Practice: I tend to titrate the drug over three days and the patient is reviewed twice on the first day and daily thereafter until he/she is stable. The majority of my patients have stabilised well on between 8-10mg of buprenorphine daily. I have preferred the 32-day detox model where the patient is on a stable maintenance dose of buprenorphine for two weeks before they begin their gradual reduction programme. I have also had some patients request the more rapid detox programmes although I have had limited success.

Overall, my experience so far with buprenorphine has been very positive. It has already established itself as a reliable tool in our treatment armament, alongside other substitute opiates

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Anyone wishing to find out more about our buprenorphine (Subutex) Treatment Protocol or share their own experiences with the drug in Primary Care may contact me at Wakefield. Dr L D Harris 23 February 2000 (Druglink, telephone 01924 211113 or at the STEP

Project Telephone 01924 784999).

Dr Fixit

Relapse

Question - I have a patient for whom I was prescribing 80mgs of methadone mixture daily for some years and who has always been my patient. He successfully detoxified from this but has now presented saying that he has relapsed and is using a gramme of heroin daily. He needs his methadone script back at the same dose. How should I proceed?

Answer - This client has chosen to come back to your care and it is essential that the service supplied is appropriate, safe and based on a pragmatic assessment of the situation. This client requires to be scrutinised using the same careful protocol that is used for new patients, namely:

1. A complete history of all drugs currently used, both licit and illicit
2. A careful physical examination including injection sites
3. An agreed plan of action that is initially short term but recognised the need for a new goal

It is in the best interest of all concerned that this client is not put in the position of having too many available drugs. If you are satisfied that he is using opiates without the benefit of lab or near-point testing and you feel 'comfortable' with the responsibility of prescribing them, then:

Issue 30-40 mls with daily pick up, emphasising the need for safety. Review in 2-3 days and be prepared to alter dose gradually. Do not initiate other drugs of dependency – benzodiazepines primarily – as a sop to conscience for not supplying the requested dose. If in doubt, do not prescribe and always try to build on the relationship that exists.

Answer by Dr Charles Douglas, Davaar Medical Centre, Dukinfield, West Pennine. First appeared in *Enhancing Shared Care* newsletter, Greater Manchester Drug Action partnership

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SMMGP PRODUCTION GROUP

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What do you think? Contributions please! Join the mailing list. ***We look forward to hearing from you.***

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

For both those who have much, little, and no experience with managing drug users. Themes include health and criminal justice, the drug strategy, getting started, setting up services, shared care & models of care, the safety agenda, evidence base and treatment outcomes. Contact RCGP Courses on 0171 823 9703, courses@rcgp.org.uk (e mail), or http://www.rcgp.org.uk (web page)

Royal College of General Practitioner (RCGP) & General Practitioner Committee (GPC) POLICY STATEMENT ON CARE OF SUBSTANCE ABUSERS

A recent policy statement by the RCGP and GPC is highly significant in terms of endorsing the move towards normalisation of managing drug users in general practice, in line with the clinical guidelines and central policy. The statement is timely and reflects a pragmatic and balanced support. However, it certainly seems to signify that primary care is continuing to fully and formally embrace this area of work.

- **The RCGP and GPC believe that General Practitioners should offer appropriate care to all patients on their lists. Where patients have problems with substance abuse, appropriate care will include aspects of primary care normally provided by the practice health care team, shared care with other services and referral to other appropriate services.**

- **Certain GPs may develop particular expertise in the care of substance abusers, and the number and location of these doctors should, ideally, be sufficient to avoid substantial workload falling onto only a few GPs. In supporting the development of this expertise, the Health Departments must ensure the provision of appropriate training in this field; facilitate professional support; resource the adequate provision for support services including specialist services and appropriate financial additional remuneration for such work.**

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