Substance Misuse Management in General Practice (SMMGP)

Towards a Primary Care Network

November 2000 **Newsletter No. 18**

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Department of Health Funding for National Primary Care Training Enhancing the Stature of Substance Misuse Management in Primary Care

The Department of Health is making significant funding available for a national programme of primary care training in substance misuse management, to be spent by the end of this financial year. The intention is to give a kick-start to training and accreditation and begin to address the void left following the recommendations in the Clinical Guidelines. Some of this funding may be linked to the formation of Shared Care Monitoring Groups. This was a key recommendation of the Clinical Guidelines, intended to help in the planning and co-ordination of shared care and training (see newsletter p.7). Funding will be made available through a range of approaches designed to cover the *generalist*, including members of the primary health care team and junior hospital doctors, the *specialised generalist*, and those involved in the planning and commissioning of substance misuse services within primary care.

Generalist training - Department of Health funding is to be directed at the baseline training of *generalists* in substance misuse. Most of this funding will be available for primary care training (GPs and other members of the primary health care team) with 25% allocated for training of junior hospital doctors. The funding will be made available through regional Directors of Medical Education who will oversee and co-ordinate training delivery in response to training proposals. It is likely that training proposals for primary care will be in partnership with clinical and training providers of local services.

RCGP to lead on 'Certificate' and 'Diploma' training for primary care - The Department of Health has made significant funds available to the Royal College of General Practitioners (RCGP) to develop and co-ordinate the delivery of training. This will consist of a *Specialised Generalist Certificate* and a *Management of Substance Misuse Diploma*. The RCGP has already begun work on these given the very tight time-scale. Funding was officially announced in late October to be spent by April.

An RCGP Expert Advisory Group (EAG) will be set up by late December 2000 to develop and oversee core curriculum, evidence base collection, course delivery and accreditation means. The EAG will be responsible for the piloting, implementation and evaluation of both courses, whilst also providing links to regions and faculty based peer support.

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RCGP Specialised Generalist Certificate - *The Specialised Generalist Certificate* for GPs is likely to entail attendance of an 8-10 day course with some form of assessment and accreditation to be decided by the EAG. This could consist of a certificate of satisfactory completion or a more rigorous assessment process. The intention is to enhance the stature of GPs choosing to extend their involvement and training, by providing a recognised and accredited *specialised generalist* 'badge of honour'. Completion of the certificate may provide accredited prior learning which can be taken into the *Management of Substance Misuse Diploma*. Post Graduate Education Award points will also be awarded for certificate attendance.

The RCGP will award bursaries to support up to two GPs per Primary Care Group (PCG) area for attendance on the certificate course. These will be offered for uptake over a fixed period, possibly three months. Where they are not taken up, they may be withdrawn and offered to areas of higher demand. The bursaries are intended to be used to help cover locum costs, travel and subsidised course fees. The RCGP will subsidise the cost of the certificate course. PCGs will be expected to provide additional support to applicants if needed.

The certificate course will be developed and piloted at the RCGP to be then transferred to local settings with EAG guidance and support. The certificate will be available through two routes, master-classes or clinical attachments, offered regionally. Some central master-classes will also be offered at the RCGP. The master-class format is likely to consist of some core curriculum classes and some flexible to local needs. The clinical attachment locations will be established by the EAG along with 'curriculum guidance', but attendance will be organised by the individual or their PCG. Arrangements will be agreed with the EAG prior to placement and bursary allocation. The EAG will identify and support trainers for clinical attachment and master-classes.

RCGP Management of Substance Misuse Diploma - The RCGP has been funded to develop, deliver and accredit a *Management of Substance Misuse Diploma* in conjunction with an academic partner. The academic department (yet to be chosen through a bidding process) will organise and run the teaching. Curriculum guidance will be given by the RCGP EAG. The diploma will run over a two-year period, with the first diploma students starting in the 2001-2002 academic year (September - September). ***(Continued page 2)***

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RCGP Diploma ***(continued from page1)***. There are likely to be 16 diploma places, aiming at 2 per Region, with a key aim being to skill up sufficient people to provide a commissioning lead on a Primary Care Trust level. Applicants from multidisciplinary backgrounds will be encouraged to apply for places. The diploma will include epidemiology and commissioning and will not be restricted to clinical content. The EAG will decide on the most appropriate means for assessment and accreditation. Post Graduate Education Award points will also be awarded during the duration of the two-year diploma.

Academic Partner Wanted by RCGP

Bidding Process for RCGP Management of Substance Misuse Diploma

The RCGP will recruit an academic department, the details of which will be announced shortly. The bidding process will be open to all academic institutions, not just to medical schools. The College will cover course set-up costs in the first year, with the diploma intended to become self-funding thereafter. The RCGP EAG will continue to oversee and accredit the course.

Further details will be announced in the BJGP

RCGP Committed to Enhancing the Stature of Primary Care in Working with Substance Misuse

Last year the RCGP, in association with the General Practitioners Committee (GPC) of the British Medical Association, released a policy statement which was highly significant in terms of endorsing the move towards normalisation of managing drug users in general practice, much in line with the 'Clinical Guidelines' and central policy. The statement reflects pragmatic and balanced support, and a formal recognition of this area of work (*). Here the RCGP was supporting the case for all GPs and PHCTs being able to provide general health care to all patients on their lists including substance abusers, and for some GPs and primary care colleagues to extend their expertise and involvement in treatment of this patient group. This suggestion reflects recommendations made in the 'Clinical Guidelines' which categorises practitioners into levels (*specialist*, *specialised generalist* and *generalist*) depending on their expertise, training and involvement with this patient group. The RCGP acknowledges that there is often a perception that such work is not 'core' to general practice or primary care, and that some services require targeted training and support. In some respects, provision of support to substance abusers has been regarded as a 'Cinderella' service. The RCGP supports the belief that with the provision of appropriate accredited training and support, it is possible that the stature of these services and those who provide them can be enhanced within the healthcare community. **(*For RCGP statement see SMMGP No.16 at www.smmgp.demon.co.uk)**

Dr Maureen Baker, Honorary Secretary to the RCGP

Let's Debate a Syllabus for the National Specialised Generalist Training

"…the profession clearly needs a syllabus and accreditation under the aegis of a suitable academic institution as a benchmark standard." Dr Gordon Morse

The "Orange Book" GP Guidelines made it clear that GPs have a duty to supply medical services to addicts, but also implied that it would be appropriate to refer to colleagues more experienced in treating addiction, so called "Specialised Generalists". So far an adequate definition of a Specialised Generalist does not exist [See page 5 of the 'Clinical Guidelines'], nor has his experience or accreditation been specified. Indeed although I have many friends and colleagues with very extensive experience of treating addicts, I am not aware of any one who yet describes themselves as a Specialised Generalist and who deliberately invites fellow GPs to refer patients to them in General Practice.

There are of course many GPs who have become known for their interest and to whom patients arrive on an ad hoc basis because they know they will get caring, humane and appropriate service. There are also GPs who work in Specialist Treatment services (such as myself) who are paid by that treatment service, but not through GMS. It seems obvious that if the Department of Health is serious about wanting general practice to deliver a quality service to addicts through the formation of Specialised Generalists, then these individuals will have to receive appropriate reimbursement as a reflection of that skill and the time that such a quality service demands. It is also reasonable that the Department in return can expect that GPs will undergo appropriate training and accreditation, to satisfy the needs of such a service provision.

Up until this recent Department of Health initiative, structured and accredited national training was not to be found. There were numerous drug awareness lectures given by DATs, good books to read and some excellent conferences to attend, but the profession clearly needs a syllabus and accreditation under the aegis of a suitable academic institution as a benchmark standard. This is new territory, it requires new thinking, and it is an exciting opportunity for those of us who have experience in the field to make a contribution to our professional training. I became interested because my organisation trains many addiction counsellors and also offers both a diploma course and an MSc in Addictive behaviour with Kings College. This syllabus is highly complex and involves extensive psychology studies, but there are many parts of it which are germane to a GP running an addiction service. My "syllabus" as it stands so far, would be as follows:

Proposed 'Syllabus' Outline for Specialised Generalists

- **A thorough knowledge of addictive substances, their modes of use and their effects**
- **A thorough knowledge of direct and collateral damage to the physical, psychological and social health**
- **An understanding of the reasons for using substances**
- **An understanding of the multi disciplinary nature of the work**
- **A thorough understanding of accepted harm minimisation strategies**
- **An understanding of non drug therapies**
- **A thorough understanding of all agencies involved in addiction treatment, their roles and responsibilities**
- **An understanding of the law as it relates to substance misuse**
- **An understanding of how to commission effective and cost effective locality service provision**
- **I would also intend that alcohol and stimulant misuse receive no less priority than opiate addiction and that blood borne viruses be included**

An all encompassing substance misuse syllabus – beyond an 'opiate fog'

There is good evidence that management strategies as modelled in the orange book guidelines, are very useful, and we have many in the SMMGP network to sincerely thank for putting methadone on the wider general practice agenda in this country. Their work has undoubtedly saved many lives. But there is a lot more to treating addicts and addiction than methadone, which is nothing more than a harm minimisation strategy; for all their undoubted benefits, we need far more to treat a problem properly than harm minimisation strategies. We need to understand the aetiology of the problem, which in the case of addiction means understanding the person and his psychosocial background. And with that knowledge we need strategies beyond containment that go toward helping the patient deal with his problems instead of simply obscuring them in an opiate fog. And if a psychosocial approach disquiets the pure physician in us, it is worth remembering that methadone only has a value in treating those who inject heroin. Quite apart from anything else, opiate addicts seldom use heroin alone, so what does the SMMGP have to say about benzodiazepine, amphetamine and cocaine addiction? With the total number of deaths from drug abuse dwarfed by the 34000 that died from alcohol excess last year, where is the RCGP debate on alcoholism treatment? It is my belief that at a time when the profession is looking for more formalised training and perhaps accreditation in treating addiction, that the syllabus should be all encompassing. This should be based upon the physical, social and psychological tenets that we apply to all our patients, and embrace a wide range of management strategies. There are many strategies to be found in the evidence that has so far been published, and critical evaluation is neither speedily reached nor simple. Addiction is as complex and heterogeneous as it is fascinating and confounding. Like so many problems in medicine it demands much understanding, and a multiplicity of strategies to manage not simply the diverse number of addictions, but also and more importantly, the diverse nature of people. I think the time is now right that as a group/conference/newsletter, we start to broaden our horizons.

Syllabus delivery and accreditation - I envisage that a syllabus could be effectively offered in distance learning form, perhaps on CD, with a final weekend meeting and examination. I think also because of the rapidly changing nature of both drug abuse and addiction services, that some sort of re-accreditation would be necessary, rather as GP Trainers now undergo, perhaps with small courses or Personal Portfolios. My colleague Tom Gilhooly of the Lanarkshire Drug Service has also been working on such a syllabus, and I am sure there are others who can also make a contribution. So let us start the debate, perhaps we can have a workshop at the next annual meeting to review progress and implementation. It seems obvious that it should be the profession that sets the agenda for the profession.

Dr Gordon Morse - Contact the author by Email at drmorse@detoxification.co.uk or via www.detoxification.co.uk

Give your views on primary care training and accreditation

- **SMMGP wishes to collate views on training, a national syllabus, and accreditation**
- **These will be fed into the RCGP Expert Advisory Group (EAG) and DoH and help inform developments. *The EAG will be meeting on 20th December so initial feedback should be prior to this date.* A synopsis will be printed in our next newsletter.**
- ***SMMGP* proposes to use the next annual conference, *Managing Drug Users in General Practice Conference* (May 2001*)* as focus for a review of the development and early implementation of the training proposals**

Views on the national training initiatives, on curriculum and accreditation for primary care training are best sent before 20th December 2000 to our mail address on the back page or via e-mail to: PCNet@smmgp.demon.co.uk or via www.smmgp.demon.co.uk

'Nurse Prescribing' for Controlled Drugs Pilot

"It is acknowledged that current practice often involves GPs 'rubber stamping' prescriptions following advice on a patient's prescribing needs by a specialist nurse."

CADAS, the Community Alcohol and Drug Advisory Service is a multi-agency team of senior clinicians who work within the philosophy of shared care for people who have substance misuse difficulties. We have no direct medical input to our service so work in partnership with each client's GP and community pharmacist. Our primary role is to assess the client's needs and monitor the on-going treatment of clients requiring methadone scripts. Where titration of a reducing script is involved it would offer a far more seamless service to clients for specialist nurses to be able to do this without direct GP involvement. This may be possible under 'group protocol', and CADAS have begun to research the viability of nurse clinicians being able to do this. This project is embryonic and a draft protocol will be ready by April 2001. To call it nurse prescribing is perhaps misleading, a more appropriate term would be nurse management.

In 1992 the *Medicinal Products: Prescription by Nurses... Act*, was passed leading to amendments of the *Medicines Act 1968* and the *NHS Act 1977* (Diamond 1995). The advisory report describes three classes of prescribing, the third being "Altering the timing and dosage of medicines within a patient specific protocol." It is acknowledged that current practice often involves GPs 'rubber stamping' prescriptions following advice on a patient's prescribing needs by a specialist nurse [or often non-clinical drugs worker, Ed.]. Giving nurses the legal authority to titrate methadone levels downward without GP involvement at every change would ensure the care was patient centred, holistic and incorporated treatment education and health promotion in a continuous fashion. 'Patient group directions' or 'group protocol' will legitimise practice that has been going on for years. They will alleviate waiting times and go toward fulfilling the outcome targets as set out in the NHS plan. It is intended that by 2004, that over half of all nurses will be able to supply medicines.

Conversely, methadone prescribing in primary care is currently a large issue nationally and the importance of GP input via the shared care model cannot be understated. Whilst many benefits can be seen for clients being treated within a service where the specialist nurses have autonomy to reduce a methadone script, this must not be viewed by some GPs as the let out clause for those who currently do not believe methadone prescribing belongs in the primary care arena. Caring for anyone in the substance misuse arena must be done on a partnership basis.

Diamond, B (1995) 'The Legal Aspects of Nurse Prescribing' – J.C.N February 1998 legal and ethical perspectives of nurse prescribing Volume 12 No 2.

Fran Hawkins, CADAS Manager - If anyone has previous experience or would like to work with us on this project please contact us: CADAS, 28 High West Street, Dorchester, DT1 1UP, 01305 265635 cadas@dorsetc-tr.swest.nhs.uk, see www.cadas.com

Is UK Harm Reduction Under Threat?

"Is treatment done with and for patients, something they chose to enable them to lead better lives, or something done to patients? … Are clinicians clear about why they are providing treatment and care? "

Following concerns about the changes being implemented through our national drugs strategy, an emergency meeting was called by delegates at the '11th International Conference on the Reduction of Drug Related Harm' in Jersey in April this year. This was followed by a one day meeting in Manchester in August convening drug users and people working with drug users, including doctors, commissioners, psychiatrists, and prison and police officers. This was an oversubscribed and passionate meeting that saw the beginnings of a UK Harm Reduction Alliance similar to those that exist around the world. Issues being addressed were the following:

- **Are we losing the strong base of harm reduction and public health gain in the UK?**
- **Is the UK drug policy becoming too weighted towards crime reduction?**
- **Concern about the growing legal ambiguities surrounding the provision of treatment and care**
- **Is there increasing erosion of human rights for drug users?**

The meeting reviewed the current direction of the UK drug policy and the threats this could pose to effective harm reduction initiatives. These threats were perceived to be happening at the same time as people working with drug users are under increased risk of 'criminalisation', with the arrests of GPs in Cumbria and Essex and the jailing of two homeless/drug workers in Cambridge. The current climate was also perceived as one where patients with substance misuse problems and drug users more generally, are being increasingly scapegoated for all manner of social and political problems.

Speakers included Professor Gerry Stimson, from the Centre for Research, Martin Blakeborough, Director of Kaleidoscope, Matt Southwell from the National Drug User Network and Mike Smith and Ian Smith from Trafford Substance Misuse Services. Dr Chris Ford, Chair of the Methadone Alliance, chaired the day. The speakers were interspersed with workshops to further explore and feedback responses to each presentation.

An Unhealthy Drugs Policy? In a speech entitled "Blair declares war or the unhealthy state of British drugs policy", Professor Gerry Stimson from the Centre for Research, strongly criticised the drugs strategy on many counts. He labelled it as an 'unhealthy' strategy based on moral panic and increasing politicisation of drugs. He claimed the strategy is a dismal turn around from a previous pragmatic public health approach for which the UK was renowned.

Professor Stimson's principal concern is that treatment is now justified with reference to crime reduction. He claims that treatment agencies will have to increasingly buy into the new criminal justice agenda through new funding criteria related to changing treatment outcomes. This will result in a distortion of treatment provision and relationships between patient and doctors – with treatment agencies having to increasingly act as agents of the criminal justice system. He asked some fundamental questions:

- **Is treatment done with and for patients, something they chose to enable them to lead better lives, or something done to patients?**
- **Does treatment work best when it is for the 'criminal needy' or those voluntarily seeking help?**
- **Are clinicians to clear about why they are providing treatment and care?**

The speech highlighted an increasingly tough political climate, reminded us of the need to review what we believe treatment is about and value of human dignity and human rights for patients.

An opportunity to influence local practice and policy development - There was general recognition that for the moment at a national strategy and policy level the course is set, but that the best opportunity for influence is at a local level:

- **Good provider and user networking and dialogue with local commissioners and policymakers, with greater input into local DATs to influence local treatment outcomes and funding decisions**
- **The strengthening of Drug and Alcohol Reference Groups. Developing provider and user forums as a source of local expertise**
- **Strengthening the DAT against susceptibility to political rhetoric by improving its knowledge base and understanding of operational and clinical issues**
- **Feeding local good practice and policy recommendations up to central policy makers**

A national representative voice is needed - Attendees generally thought that those involved in the delivery of drug dependency treatment needed a national voice to air their views. No national representative body presently fulfils this role. As most agencies rely on government funding, there has been a limited willingness from individual organisations to speak out. Proposals were made for an independent umbrella organisation that represents those committed to harm reduction, to respond to policy and operational concerns on behalf of organisations and individuals. It was felt that any such alliance would need the support of major treatment providers to have significant impact. Unfortunately not all were represented on the day, but an inclusive approach is being adopted.

Launching the UK Harm Reduction Alliance (UKHRA) Since the August meeting and subsequent discussions, an alliance has been launched which will bring together individuals and organisations. The name finally arrived at is the *UK Harm Reduction Alliance – Toward Healthy Drug Policies* (UKHRA). Gerry Stimson has been asked to chair the UKHRA until a conference planned for next year. At the meeting, a declaration to which 'members' could sign up to was agreed.

For further information, to read the declaration, to join the mailing list or to register your support: www.ukhra.org.uk
Or by mail write to UKHRA, C/O Mainliners, 38/40 Kennington Park Road, London, SE11 4RS

Drug Treatment and Testing Orders and 'The Strategy' May Be Working

"…tackling a root cause of crime and attempting to break the link between drugs and crime is vital to the mental and physical well being of both the addicted perpetrator of crime but also the victim of crime." Dr Linda Harris

Criminal justice interventions can harmonise with public health - Thank you for another very informative newsletter. I'm writing just to highlight my slight disappointment with your editorial piece (Newsletter No.17) concerning perceived threats to the management of substance misuse in primary care posed by the increasing links between drug treatment services and the criminal justice system (CJS). As we await the final details of DTTOs perhaps it would be better to present a more balanced view. The new "enforced treatment" programmes will need to recruit experienced and caring doctors who will be able to show strong leadership and excellent clinical skills in the area of drug abuse. It is vital that the programmes linked to the CJS are skilfully integrated into the overall pattern of local services and practitioners need to be made aware that far from threatening our public health role it is strengthening it. After all I would argue and many would agree that tackling a root cause of crime and attempting to break the link between drugs and crime is vital to the mental and physical well being of both the addicted perpetrator of crime but also the victim of crime.

I have been involved in such a project for over two years now, the STEP Project, Wakefield. This drug treatment programme has evolved but by having a role at strategic level (I co-manage the project) I have been able to influence not only the clinical protocols but also ethical policies, the training of staff and court professionals such as the clerks and the magistrates. The early outcome measures give some positive indications.

Early outcome measures - This is an early stage of analysis of those clients who either complete their 1A6 probation orders or who have their orders revoked for one reason or another. The STEP project is two years old now and many of the clients who were given orders in the beginning were given an 18 month to two year order. We are now beginning to see a steady flow of clients completing their orders each month. Each month we will acquire clients as a result of their being granted an order. Some clients will graduate the programme and some will be breached. Over the past six months there have been 9 orders completed. Of these, 1 client graduated drug free, three have been retained in treatment services and their care has been seamlessly transferred to a voluntary treatment service with ongoing prescribing and five were documented as continuing to use illicit drugs. Val Barker, our Assistant Director of Public Health and local DAT Chair, conducted a comparative study of patients who access treatment in one of my voluntary clinics and STEP clients as part of her Masters. She used a questionnaire, and whilst acknowledging the differences between the samples, found STEP clients more likely to be retained in treatment through relapse, and reported greater personal and social change particularly with respect to offending, injecting behaviour and health.

My own personal experience over this time has not found me in a position where I felt my ability to care or advocate for my patient has ever been compromised. For certain patients such programmes have significantly improved retention into treatment. Despite my own positive experience I have reservations about its overall impact on outcomes and have suspicions about the political agenda. I would not be prepared to work in a system with a two tier treatment service and where resources were shifted towards projects working with offenders only. If good practitioners put themselves forward now in their own localities to work in multi agency teams that include probation services, then what better way to influence the way DTTOs are implemented and also lobby for equal resourcing of voluntary drug treatment and harm minimisation approaches.

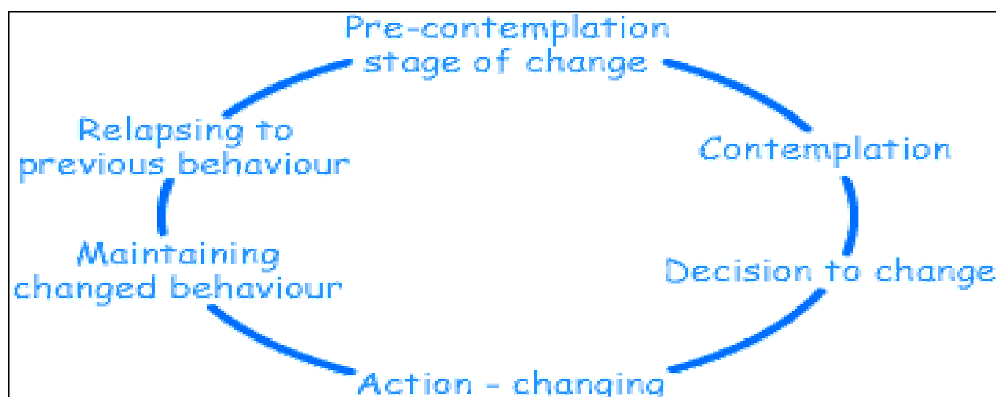
Lets debate this important area but lets also work to ensure that a balanced message from practitioners currently working in DTTO pilot/ comparison sites is heard. These practitioners (myself included) are working in a relatively new area and we are having to adapt to meet changing guidance from the Home Office. There is a need for practitioners interested in this exciting area of work to be able to communicate their concerns and positive areas of work. The fledgling organisation International Association of Drug Court Professionals (IADCP) is also an excellent way of finding out more about drug treatments and the court, but also to network with professionals from many different agencies all of whom are committed to helping people into recovery.(Details of IADCP on request.) I look forward to the response from the editorial board.
Dr Linda Harris - The STEP Project,1st Floor Grosvenor House, 8-20 Union Street, Wakefield WF1 3AU, 01924784999 every Friday or alternatively via drlinda@doctors.org.uk.

Editorial Response - The points raised by Dr Harris are valid in that there are undoubtedly positive aspects evolving from development of this work. There are various national and local agendas operating with regards to the new strategy, there are still many unknowns and it is unclear where the direction of practice and policy is going to go. We do not support the view that crime reduction is not an acceptable result of treatment or that all the treatment through the courts is bad. We are aware that DTTOs are serious offence orders that are agreed to by an offender, sometimes providing the only viable alternative to custody. We need to monitor the impact of central developments on the balance of local treatment provision, in terms of treatment outcomes and funding criteria, client access to treatment, issues around clinical freedom and the relationship between treatment and social control. The strategy is bringing significant changes, and at some stage individuals and organisations need to be clear about why they provide treatment and care, and decide which aspects of national drug policy they may wish to challenge or support.

Motivational Interviewing

Motivational Interviewing (MI) is considered by many to be an effective tool for working with people with “compulsive” or “addictive” behaviour. It has been regarded by some as the most influential model in assisting theoretical understanding of change and the most important and innovative therapeutic intervention of the 1980’s.

When clients/patients attend for treatment it is often presumed that they have resolved their ambivalence about change, are prepared to give up old established behaviour, have made a decision and are keen to get on with a change process. What is often recognised is that many drug users are clearly unresolved and in conflict about many behaviours in their lives. MI is a client centred approach that strategically directs clients to examine, explore, and resolve the ambivalence they have about their behaviour. It works on the assumption that people have implicit attachments to the behaviours they engage in, in other words they are functional to the person. In order to assist people to change it is important to be able to work strategically with the client to support them override their attachment to the behaviour, resolve their ambivalence before moving onto change. In other words as a practitioner we work with the natural resistance that is characterised in people with addictive behaviours, using techniques and strategies to direct towards change based on the “Stages of Change Model”, developed by Prochaska and Diclemente. This simple six staged model describes a cycle through which people progress. They begin to consider and recognise that they have a problem, weigh up the pros and cons of change and decide to change (or not!).



1. Pre-contemplation: A stage where people do not identify that they have a problem, and are not thinking about change. Others, or external agents may perceive that there is a problem but it is not internalised by the client.
2. Contemplation: A stage where someone begins to weigh up the pros and cons of their behaviour, thinking about whether there may be a problem or not, and whether change is either necessary or desirable.
3. Decision: A stage where someone decides to do something to change their behaviour - a point at which there is a conscious decision to do something.
4. Action: The process of actively doing something. The person chooses a strategy for change and pursues it, taking steps to put their decision into action.
5. Maintenance: A stage of actively working on and maintaining change strategies. This is a stage of conscious effort and attention to sustaining change strategies.
6. Lapse or relapse: A stage where the client either slips (lapses) back from a strategy to change, or return to previous levels and patterns of behaviour (relapse).

Practitioner strategy - It is important to be able to assess in which stage a clients is in, in relation to each behaviour. Strategies for pre-contemplation are different from strategies for a client in action. Practitioners should initially work in areas of least resistance i.e. where the client is furthest in the cycle. The goal of MI is to elicit self-motivational statements from the client about change, and direct these statements towards change. As practitioners we actively seek out statements that reflect 5 key motivational areas;

1. ***Self esteem***: Statements from the client that they are OK. People have to believe they are OK to be able to change. Raising self esteem is a cornerstone of MI.
2. ***Concern***: Statements from the clients that express concern about their behaviours.
3. ***Competence***: Statements from the client reflecting an ability to do things.
4. ***Knowledge of problem***: Statements from clients recognising problem behaviour.
   Knowledge of strategies: Statements reflecting strategies for change
5. ***Desire to change***: Statements that reflect a desire for things to be different.

Motivational Interviewing We actively use these *self motivational statements* to create a state of *internalised conflict* in the client, to allow them to experience the conflict between present and desired behaviour, and to assist them to make informed decisions about change. However it is important that clients are the ones who articulate the need to change and are able to attribute change to themselves. *Supporting self esteem* and *self efficacy* becoming central strategies in this process. As practitioners we *“roll with resistance”,* finding positives in no change, and encouraging the client to be the one who tells us that they have a problem and want to change. In other words as practitioners we leave *clients with the responsibility* for their behaviour, to be the ones who talk of change, but are active in reflecting any *conflict* we hear about their behaviour, and actively “*developing discrepancy”* wherever it is heard. In MI we *elicit* self motivational statements in order to encourage the client to identify whether there is a problem or not. Once a client recognises that there is a problem, with the strategic gathering of *information* about that behaviour and the gathering of objective data about that behaviour,

clients can decide whether to change or not. Once a decision to change has been reached with the support of the professional practitioner appropriate strategies for change can be *negotiated.*

Further Reading: Miller, W. Rollnick. S, (Eds). (1991) Motivational Interviewing. Guildford Press.
Brian Whitehead Counsellor in General Practice, Lonsdale Medical Centre, London, NW6 6RR

What is the National Treatment Agency?

The government has outlined the development of a National Treatment Agency (NTA) to provide a cohesive central approach to treatment for problem drug misusers. The Department of Health and the Home Office will be working together with the aim of ensuring that those requiring treatment are able to access services that have a positive impact on health and crime, regardless of their route of referral. The proposed functions of the NTA have been briefly outlined as:

- **Direct commissioning of residential rehabilitation placements.**
- **Setting quality standards for treatment and inspecting agencies to ensure quality standards are maintained.**

The Department of Health has appointed a project team to establish a structure for the NTA. The team has been conducting discussions over the past few months with a number of organisations. They have hosted a focused meeting for a sample of about 80 commissioners, providers, DAT Co-ordinators, government officials and others to inform their thinking. They have continued these discussions in order to develop a detailed proposal on the functions and tasks of the NTA. These proposals are going out for consultation with the entire field in early November before final decisions are made. The NTA will be in place by 1 April 2001.

Don't let the coming of the NTA cause a local 'planning blight' - Commissioners and DATs may be tempted to delay making decisions and taking actions until the NTA is established. However, in reality, it will be some time before the NTA is in a position to impact on current practices. It is vital therefore that commissioners and DATs continue to develop local strategies, and shape local services.

It is tempting to put DAT Template Reports on the shelf and let them sit there for another year. But don't make that mistake. As flawed as the reports are, they are still one of the best commissioning tools you have available to you. They represent the best audit of services most DAT areas have and they will improve as services and DATs become more familiar with information gathering.

Although submitted to UKADCU as a requirement and a start towards creating a central return, the real value of the DAT Reports is as a tool for local planning. Joint Commissioning Groups should leap on these reports and use them to understand their local network of services, the roadblocks they face and how they should fashion commissioning intentions to improve services.

Primary care should look to use these reports in developing its role in the joint commissioning process. Joint Commissioning is still the way forward. If you have not already established a joint commissioning group, now is the time to start one up. **Don Lavoie** Substance Misuse Advisory Service, 46-48 Grosvenor Gardens, London SW1W OEB 020-7881 9256

Primary Care Advisory Service from *SMMGP*

This service has been expanded with the addition of a new worker. The service is available to all those involved in the development of primary care based drug dependency services. The service draws on the collective knowledge of the SMMGP network, the commissioning expertise of the Substance Misuse Advisory Service (SMAS) which manages the service, as well as the expertise and knowledge of the SMMGP Advisory Group. Areas currently being worked on include: the setting up of Shared Care Monitoring Groups, the development of local shared care strategies (including the thorny issue of GP payment), and the development of local training programmes. Considerable knowledge of schemes and protocols nationally has been built up which provide a resource to draw on for problem solving. If input would be useful in your area please contact Jim Barnard on **0161 905 1544** or e-mail on smmgp@freeuk.com. This service is provided free and advisers are able to travel to any part of the country, if necessary. If you have the funds to pay travel expenses this would be appreciated but is not essential.

Delivering advice across the country has allowed us to build up a national perspective on shared care development. We will write these up more fully in the next issue, but some key points include the following: It is becoming apparent that services, particularly in urban areas, which have fully embraced primary care, are typified by 'no' or 'short' waiting lists. Often these services are perceived positively by other professionals and clients, whereas, many of those which have not engage with primary care are often typified by long waiting lists and a poor image in their locality. We are also noticing that newer shared care schemes are increasingly likely to be paying GPs to support their involvement. The need for Shared care to be given a high strategic profile, through the establishment of Shared Care Monitoring Groups, and GPs feeling that there is specialist medical backup behind schemes are other key issues proving to be of great importance.

Shared Care Monitoring Groups?

"It is therefore recommended that a local shared care monitoring group be set up. This should relate to the Drug Action Team, and should comprise the Director of Public Health (or deputy), representatives from specialist treatment agencies, general practice, the Local Medical Committee (GP Sub Committee of the Area Medical Committee in Scotland) and other members as required. The monitoring group should agree to approve local agreements and protocols, review training needs, clarify performance indicators and monitor the delivery and effectiveness of shared care service provision in the area."
'Clinical Guidelines' p.14

Sad News - Josie Hicks passed away recently. She was a star of a GP, a 'one in a million' working with drug users and the ACORN Community Drug and Alcohol Service based in Frimley. Josie was known and respected by many people around the country. She was a wonderful person and her kindness touched every one she came into contact with.

Dr Fixit - Benzodiazepines

Why do drug users use benzodiazepines and is there a case for prescribing them as maintenance? Benzodiazepine use is a very large problem, especially for poly drug users. Drug users use benzodiazepines to help with anxiety, insomnia and depression, and to potentiate the effect of methadone, to help come down from amphetamines, ecstasy or cocaine use, and to reduce 'voices in the head'. Many doctors are more comfortable with prescribing benzodiazepines than methadone to problem drug users, whereas the reverse should be true. The evidence for the value of methadone maintenance is overwhelming. There is no such evidence for the value of substitute maintenance prescribing of benzodiazepines.

Short term prescribing of benzodiazepines may have some benefit in supporting drug users to control their intake of benzodiazepines and stabilise their lives. The benefit of long term prescribing of benzodiazepines to drug users is more questionable. Drug users often continue to buy benzodiazepines in addition to their prescribed drugs and often continue to use chaotically regardless of how much is prescribed. We can offer support and advice to benzodiazepine users so they can control and reduce their use. This does not always need to include the prescribing of substitute drugs.

Possible Harm - There is an absence of evidence of benefit, and there is increasing evidence and concern that long term prescribing of benzodiazepines causes harm. There is some evidence of cognitive impairment and neurological damage in those prescribed high doses of benzodiazepines over a long period. There is a high risk of dependency and it is more difficult coming off benzodiazepines than opiates. Withdrawal symptoms usually occur, and the risk of withdrawal symptoms increases with length of use. Great care should be taken before deciding to initiate a prescription for substitute benzodiazepines. It is also easy for a short course to become a longer prescribing regimen which inadvertently becomes maintenance prescribing. The Clinical Guidelines highlight the risks of such prescribing, and recommend the gradual reduction of existing maintenance scripts that are more than 30mgs per day (Clinical Guidelines p.41).

Maintenance prescribing of benzodiazepines has not been shown to have any definite medical value, and it is difficult to justify. A controversial view is that a few people may benefit from being left on a small dose. They include, those with an alcohol problem who have come off alcohol using benzodiazepines and who find it difficult not to relapse without a small dose of benzodiazepine. However, this sort of prescribing decision is contentious, and not for the non-specialist.

If a decision is made to prescribe benzodiazepines, then:

- **Prescribing should be for a short time and with a clear goal in mind**
- **Benzodiazepines need to taken daily (rather than binge consumption)**
- **Urine screen should confirm the presence of benzodiazepines and there should be evidence of dependency from history and symptoms**
- **There is no indication for prescribing two benzodiazepines rather than diazepam alone.**
- **Only prescribe one benzodiazepine at a time. If using more than one benzodiazepine change to one preparation.**
- ***Change all benzodiazepines to diazepam* (stability better because of longer 1/2 life).**
  Benzodiazepine conversion equivalents: Diazepam 10mgs= Temazepam 20mgs = Lorazepam 1mg
- **Aim at lowest dose possible, start at no higher than 20-30mgs daily of diazepam**
- **The patient should not be intoxicated, 'stoned' or drowsy during the day**
- **If insomnia continues to be a problem, use a non benzodiazepine hypnotic for a short period (+/- 2 weeks)**
- **For dose reduction, change to an equivalent dose of diazepam and taper the reduction**
  With more than 30 mgs of diazepam use, start reduction at 5-10 mgs / month
  With 20mgs use or less, reduce by 1 mg every 1-2 weeks
  When reduced to 5 mgs, continue reduction by 0.5 mgs every 2 weeks
- **Dispensing must be daily. Blue MDA FP10 *cannot* be used but repeat computer prescriptions can**
- **If prescriptions have been lost or the drugs have been used before the next is due they should not be repeated**

Adapted from SMP guidelines. If you would like a copy of the complete guidelines please contact Ines Corcoran, Brent & Harrow Health Authority, Harrovian Business Village, Bessborough Road, Harrow, Middlesex HA1 3EX Tel 0208 9661109

SMMGP PRODUCTION GROUP

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