

Primary Care Network Substance Misuse Management in General Practice (SMMGP)

July 2001

Newsletter No.20

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Royal College of General Practitioners Conference *Government Drugs Policy and Training – The New Agenda for Primary Care*

Delegates from across the UK gathered in Glasgow on May 10th and 11th for a conference in the annual series of 'Management of Drug Users in General Practice'. The one-and-a-half-day event hosted by the Royal College of General Practitioners (RCGP) and its HIV Working Party brought together experts and interested individuals from across the UK to discuss the changes in treatment and policy and the role of primary care. The Scottish Drugs Minister, Iain Gray, reviewed Scottish drug policy. He highlighted the importance of harm reduction in the UK backed by central support and funding for services.

Considerable focus was given to recent training developments in both Scotland and England that have given new emphasis to the treatment of patients with drug problems. Development of the RCGP Certificate for Specialised Generalists was examined, looking at the curriculum and how this related to broader generalist training developments in Scotland and England. It was acknowledged that generalist training is on the whole more developed in Scotland than in England. However, the RCGP Certificate may serve as a future model for Scottish implementation of specialised generalist training.

The aims of setting up drugs services were examined with examples from parts of the UK such as Dundee and Plymouth. This took into account the increasing role of primary care in influencing and sometimes heading up specialist services. There were also a host of workshops ranging from topics such as managing pregnancy in drug users to the legalisation of cannabis.

The conference made evident the maturing and diverse involvement of primary care in the management of drug users in the practice, within shared care arrangements, and in the delivery of specialist services. The message seems to be that in spite of a number of safety concerns and opting out by some GPs over the past year, more GPs are still choosing to do the work in a specialised and generalist capacity. This is in increasingly diverse approaches and partnerships. Often this involves formal backing by PCG/Ts within local strategic planning through forums such as Shared Care Monitoring Groups. Where the necessary support structures are not in place locally, there are many examples of primary care taking the initiative to develop specialised generalist clinics and shared care support schemes.

There seems to be greater emphasis on 'safer' and more structured generalist involvement. The pioneering approaches of some of our more regular GP delegates seems to have helped build the political backing for wider and more structured generalist involvement. Other factors supporting these trends include:

- The developing role of Primary Care Groups/Trusts in planning and commissioning
- Increased strategic planning with primary care input ie. forums such as Shared Care Monitoring Groups
- The impact of increasing numbers of specialised generalist GPs in planning and delivering services
- Increasing prominence of clinical governance in defining and delivering improved local care standards
- Improved awareness and acceptance of a role for GPs
- Greater availability of local and national training and increased official backing for the work

RCGP Conference Consensus Statement

Primary Care is perfectly placed to have an enormous impact on problematic drug use in the UK, including reducing drug related deaths.

In order to achieve this, Primary Care must be properly supported and trained. The resources to provide these ongoing supports must be urgently identified and secured.

There was a powerful presentation by Jenny Keen on her research which demonstrated that many of the circulating fears regarding methadone deaths can in fact be attributed to deaths from heroin, poly-drug use and alcohol use. Overdose deaths do not directly correlate to an increase in prescribed methadone practices. This confirmed the value of treatment in terms of reducing mortality. It also highlighted the merits of good dose initiation, correct and adequate dosing, and a pragmatic patient friendly approach to supervised consumption.

There was an interesting discussion of how the US/ global war on drugs affects local treatment policies and outcomes. Also raised was how to best mesh public health approaches with criminal justice agendas.

Dr Tom Gilhooly who has been involved in organising the conference, said: "Primary care is on the threshold of changes which will not only improve services to drug users but also to society as a whole. Do not let anyone doubt that primary care can make a difference"

Full conference reports available later in the year from RCGP

**PLEASE PHOTOCOPY AND DISSEMINATE NEWSLETTER VIA
YOUR LOCAL NETWORKS**

Royal College of General Practitioners (RCGP) Certificate in the Management of Drug Misuse in Primary Care

In November 2000 we announced that the RCGP would be developing a Certificate in the Management of Drug Misuse in Primary Care. The initiative, funded by the Department of Health, reflects the drive to improve general practitioners' responses to working with drug users. The certificate development is now well underway and due for implementation in September 2001. Those interested have applied to the RCGP via their PCG/T for bursary places or independently if they have other funding or support (e.g. Community or Mental Health Trusts). The Department of Health (DH) has financed 400 bursaries. In most cases, up to two bursaries will be awarded per PCG. The bursary covers locum costs up to £1000. All other costs, including the training courses and Master Classes, training materials and mentor costs will be covered by the College through the DH funding.

Applications Update - Over 400 general practitioners have now applied for the bursary. Places are full but GPs are still invited to make their interest known for possible future places. Of the 200 + applicants that had been received by April, about two thirds are male one third female. Most are senior GPs in the 40-50 year age group. Of those giving information, 6 have already got a recognized substance misuse qualification, and a further 33 have received training in substance misuse already. Despite this low level of background training, only one of the applicants has no current experience in the care of drug misusers. Five applicants run drug services, 100 perform at a high level such as heading up shared care services or as the GP on a Shared Care Monitoring Group. A further 95 have some additional role including working in a specialist service, sitting on a Drug Action Team/Drug Reference Group, or being a PCT lead.

Course Design Update - The Certificate course is designed to cover 5 full days study. There will be 2 or 3 formal training days, depending on applicants' prior experience. The remaining 2 to 3 days are for self-directed learning, improving skills/ professional competencies, field visits and the development of patient care. The participants will be supported by mentors/local advisors who will be appointed for the purposes of this course. They will be senior general practitioners or other individuals with proven experience in the management of drug misusers. They will also attend 'training the trainers' and will undertake some of the same assessment processes as course participants.

Key Aims of the Training Programme

- Enable GP's at Specialised Generalist/Intermediate Practitioner level to fulfil the aims of treatment as outlined in the *Clinical Guidelines on Drug Misuse*
- Develop the role of GPs in local strategic planning and Shared Care Monitoring Groups
- Create a cadre of qualified GPs who will improve standards in primary and secondary care

N.B. A broader Diploma programme is being planned. This will be run by the RCGP with a university department. To include epidemiology, commissioning and managerial skills in substance misuse. Open to primary health care team & broader disciplines.

Location of Training - Overall co-ordination of the certificate course will be through RCGP London Central Office. However, most of the training and local co-ordination will be carried out in various locations across England through use of College and other networks.

Contact: RCGP Expert Advisory Group Chair and Project Director : Dr Clare Gerada, cgerada@rcgp.org.uk
Project manager: Michael Murnane, mmurnane@rcgp.org.uk

Certificate Course Components

Pre-Master Classes Conference - To be held in different geographic locations prior to proceeding to the Master Classes. Their aim is to enhance the underpinning values, knowledge and skills in relation to management of drug misuse. They will be lecture based using expert speakers. Topics will include epidemiology, natural history and effects of drug use, drugs and the law, young people, ethnic minorities, blood borne virus, health complications, pregnancy and co-morbidity. In some circumstances qualified candidates can apply for exemption of this Pre-Master Class Conference.

The Master Class 1 - These will be held in different geographical locations. These will be mentor/local advisor led and based on directed reading. The formation of a local cohort or peer group is possible. There will be specific learning outcomes and areas covered will include pharmacological and talking therapies, and the role of the primary health care team. *Prior tasks* will include a critical appraisal of the *Clinical Guidelines*, a participant review of a reading pack of key literature and self-appraisal of participant's own practice. Participants will present and discuss the reading material and other tasks in mentored groups focusing on evidence based practice, research and examples of current practice

4 Month Self-study Period - Candidates will be tasked with completing their learning portfolio and meeting their identified learning needs prior to Master Class 2. They will be supported in identifying their own knowledge, skills or values gaps which require addressing. E.g. undertaking dose assessments, non opiate based treatments, using relapse prevention, unpopular patient groups, service development and planning issues. Educational methods can be as diverse as shadowing colleagues, specialist coaching, organised courses or conferences, research, literature review or use of experiential or peer group learning.

Master Class 2 - This will include presentation and discussion of the candidates' assignments and different reading material to Master Class 1. The day will be focused on specific learning outcomes and areas covered will include policy issues, the position and role of primary care in relation to local and national service delivery, development of local services and networks, and theory and evidence base practice for primary care.

Assessment - Course assessment will have pre-determined criteria for pass/fail. Formative assessment is a course requirement. Assignments are designed as preparation and reflective learning for summative assessment.

- Essay submission critically appraising the *Clinical Guidelines*
- Assignment presented to their peers in the Master Class 2. Examples to include 'Carry out a needs assessment of drug services in your PCG/T' or 'Define your practice (or PCG) drug protocol/guidance.'
- Logbook for reflective practice on interactions with drug using patients reviewed with their mentor. Last 10 drug using patient contacts (variations of patient/criteria). The records will note aims of consultation, indication of treatment aims, goals and outcomes.
- Completed learning portfolio signed by student and mentor
- A viva involving a critical analysis of patient management using the log book

General Practitioner with a Special Interest (GPWsi) or Specialised Generalist?

GPs are being encouraged to develop clinical interests as part of the NHS Plan. The Royal College of General Practitioners (RCGP), recognising that many general practitioners already have special interests, has endorsed this initiative. The terms and requirements for the *specialised generalist*, the *intermediate practitioner* and the *GPWsi* have all been developed separately over different time scales. The first of these, the specialised generalist, was defined by the Working Party, which developed the revised *Drug Misuse and Dependence – Guidelines on Clinical Management* (Clinical Guidelines); intermediate practitioner is included in the NHS Plan; and GPWsi has been introduced by the RCGP.

The Clinical Guidelines outlines three levels of expertise in relation to the care of drug misusers: the generalist, the specialised generalist and the specialist. The specialised generalist was defined in this document as:

'A practitioner whose work is essentially generic, or, if a specialist, is not primarily concerned with drug misuse treatment, but who has a special interest in treating drug misusers. Such practitioners would have competence and expertise to provide assessment of most cases with complex needs' Clinical Guidelines p.5

[Specialised generalist is distinct from specialists who have this work as their main clinical activity, and generalists who chose to do some of the less complex work with training and support.]

The RCGP in their analysis of the competencies of the GPWsi take the specialised generalist concept further. They emphasise that both the Practice (i.e. the context of care) and the Practitioner must fall into an accreditation framework if GPs are able to deliver good quality care within this subject domain. The RCGP has defined principals that should be followed in supporting the practice of developing the GPWsi (next column). The formalisation and accreditation of the specialised generalist concept through the RCGP Certificate will help formulate this drug misuse specialisation within a more structured and generic 'special interest' GPWsi template.

RCGP GPWsi - Key Principles

- 1.Ensuring workforce capacity
- 2.Ensuring local flexibility
- 3.Protection of general practice services
- 4.Ensuring that there is suitable resourcing for GPs and their practices to undertake this immediate work.
- 5.Protecting patients (supporting doctors, ensuring appropriate indemnity cover)
- 6.Defining expertise and competencies
- 7.Ensuring compatibility with existing practice
- 8.Ensuring the availability of formal preparation and training
- 9.Nationally defined entry criteria
10. Ensuring appropriate clinical governance mechanisms are in place

SMMGP Planned Resources to Support RCGP Certificate

SMMGP Web Site

- Course protocol, assessment criteria, assignments, Etc, displayed
- Regional leads/mentor contact details displayed
- Portfolio reading available online & for downloading
- Syllabus discussion site for course participants – also open to non participants

SMMGP Networking and Advisory Service

- SMMGP Advisors take regional networking lead for mentors and RCGP Faculty leads and course candidates
- Project Advisors provide support to course participants in local service appraisal, local service development issues for specialised generalists, and other support and advice needs

SMMGP Newsletter

- Candidates on newsletter mailing list
- Newsletter updates and discussion of topics and issues arising through course delivery

The above services are planned for delivery for the start of the certificate course in September 2001

SMMGP Primary Care Support Project Update

The SMMGP Primary Care Support Project has gone from strength to strength. In less than 2 years the project has evolved to provide a national advisory and networking service, been involved in supporting national development and policy work, increased the profile and circulation of its quarterly newsletter, and developed a frequently visited web site with expanding facilities. The project has also secured significant funding to expand its function over the next 3 years (see below)

Regular advice work includes workshops, facilitating meetings, presentations and on-going developmental support to a range of individuals and organisations including GPs and PCG/Ts, specialist drug services, Health Authorities, DAT co-ordinators, and increasingly Shared Care Monitoring Groups (SCMG). SCMG advice has now been given to over 40 Drug Action Team and Health Authority areas around the country. SMMGP has been active in supporting the development of the RCGP 'Specialised Generalist' Certificate through on-going input into materials, course design and planned development of web site facilities to be available on-line to support both course participants and non participants. SMMGP participated in helping the organising and running of the Primary Care Network's annual conference 'Managing Drug Users in General Practice', held in early May in Glasgow - possibly our best conference yet? (See page 1)

New SMMGP Funding and Project Expansion - New funding to significantly develop the project over the next three years has been secured from the *Invest to Save Budget* of the Treasury. The current capacity of the project will be expanded to take a strategic approach towards supporting the varied shared care developments that are taking place around the country. Additional staff are being recruited in a partnership between the Substance Misuse Advisory Service and the Substance Misuse Service at Trafford NHS Trust. The following project goals have been set:

- **10, 000 GPs receiving the newsletter** by the end of the third year
- The **web site** will be developed with **interactive advice and discussion** facilities and promoted through NHSnet
- **3 Advisers and a Project Officer** will be available nationally to provide ongoing and in-depth development support

GP Access to Records Scheme The service will also be piloting an electronic 'GP Access to Records Scheme' to develop communication, trust and joint working protocols between GPs and specialist services. The scheme will test the value of GPs and specialist services having access to each other's notes electronically within a formal shared care arrangement. If successful, this model will be disseminated in year three.

GP Reimbursement Schemes

'...it may be best to develop and negotiate reimbursement schemes locally than to import one directly from elsewhere. However there is a case for a more consistent national approach ... variation in quality and consistency of payment suggest that bodies such as the GPC and RCGP would need to enter into national negotiations with the Department of Health if we are to gain agreed national standards for payments.'

Increasingly GPs are being reimbursed for their work with drug users. This is particularly common in the newer shared care schemes. However, one thing to note is the variety and inconsistency of payment schemes across the UK. This may reflect local negotiations and appropriate responses to local need, but it may also indicate the need for some sort national consistent policy guidance on this. The variety of payment can be partly explained by local circumstances and expectations, or what rationale people apply to payments.

The rationale behind payment is twofold. The first acknowledges *increased workload* and the second acknowledges *an extended role and/or extended clinical responsibility*. With regard to workload, an average patient can be expected to attend 5 times per year, a scripted patient can be expected to attend many times more (+/-30/year) for substance misuse consultations. These consultations often and ideally can involve a more extended role as in line with recommendations in the Clinical Guidelines, but they may in certain cases where there is less developed practice amount to signing a script. The extended role may go hand in hand with professional development such as training, clinical audit or implementation of local or national guidelines. The action of prescribing engages the GP in full clinical responsibility, which cannot be delegated to a drugs worker or a supervising specialist.

In the past prescribing for drug users has been argued by the General Practitioners Committee (GPC) to be outside of general medical services, the core contractual obligations for GPs. It has often been poorly or indeed not covered in the general medical training curriculum. The GPC and Royal College of General Practitioners (RCGP) now support the development of *particular expertise* in the management of substance misusers by GPs, providing there is support, training, resources and 'appropriate additional remuneration for this work'. They also support a more *generalist* level of involvement in line with the levels described in the Clinical Guidelines.

Levels of reimbursement vary widely as do the formulas for activating payment. We thought it would be useful to give an overview of types of payment from some of the schemes we are aware of. In terms of payment amount, we are aware of a range between £25 per patient per year (Sefton scheme 1) to £300 per patient per year (Suffolk). Of all the schemes we are aware of, the average is between £100 and £200 per patient per year, sometimes paid in quarterly instalments.

Within individual schemes there are often different levels of reimbursement depending on the level of input the GP is expected to provide. For example in Sefton at the £25 level, patients are managed fully by the drug worker with the GP signing scripts and being available when required. There is also a £75 level and a £100 level requiring much greater GP involvement. All Sefton schemes pay an additional £500 per annum to practices treating more than ten drug users. Norfolk pays GPs varying on the perceived complexity of the case with a GP receiving £135 per annum for dealing with a stable patient and £200 for more complex cases. In Brent new patients, or those coming back into treatment after a break, receive a quarterly payment of £75 to reflect greater GP input, whilst on-going stable patients receive £60 per quarter. However the most common schemes involve a simple flat rate yearly or quarterly payment.

Many schemes attach **conditions to reimbursement**. In Glasgow GPs have to attend the drug team's training scheme before being eligible. In the Brent and Harrow scheme GPs have to attend initial and on-going GP led training, conduct a clinical audit, agree to an annual review visit and sign up to local good practice guidelines. Many other schemes put a limit on the number of patients that a GP can treat (e.g. Sefton 15 per GP principal), sometimes increasing if partners also take on the work (e.g. Brent & Harrow, 20 increasing to 30). Some schemes have no lower limit in order to encourage uptake of the work by new GPs who may only be confident with one or two patients. On the other hand in order to create maximum capacity the Manchester scheme only pays GPs (£100 per patient pa) who treat at least 12 drug users.

Several schemes use the concept of 'treatment slots'. This means that funding is related to filled treatment slots rather than individual patients. This means that if a patient leaves treatment and another takes their place then just one payment is made. The scheme in Berkshire uses this concept linked to a four-way contract between the drug user, the drug worker, the GP and the Pharmacist (See article on page 5). Both GP and Pharmacist get paid £90 per treatment slot per year.

As can be seen there are many different schemes that have developed out of local circumstances and negotiations. They support a range of involvement from script signing to more extended roles, requiring differing quality standards. Sometimes payments directly reflect these criteria, sometimes they seem more arbitrary. The differing schemes mentioned above all report good progress. This indicates that it may be best to develop and negotiate reimbursement schemes locally than to import one directly from elsewhere. However there is a case for a more consistent national approach. There has been some work towards a consistent pan-London payment scheme. This was prompted by the realisation that GPs one street away from each other but in different boroughs were receiving vastly differing payments for the same work. The pan London idea, whilst a useful information sharing exercise, has not yet materialised. This disparity may be more of a London concern due to the proximity of borough boundaries than a national one. However, some of the difficulties highlighted by this variation in quality and consistency of payment would suggest that bodies such as the GPC and RCGP need to enter into national negotiations with the Department of Health if we are to gain agreed national standards for payments.

What does seem evident is that with increasing numbers of districts reimbursing GPs and the increased funding for drug treatment, it is likely to become increasingly difficult for areas not reimbursing GPs to sustain their position. Local disparities are likely to become more evident. However, we need to remember that whilst GP payment has a functional and political rationale, *it cannot override the need for broader resource and quality measures*. These would include good training, well developed and co-ordinated shared care, local clinical guidelines and audit, with GP receiving support and able to access to good specialist services.

Should GPs be paid? Should we try and negotiate a national payment? Have you a good scheme in your area? Ed.

The Berkshire 4 Way Agreement on Shared Care for Opiate Dependent Patients

The 4 Way Agreement (4WA) is a system for organising the shared care and treatment of substance misusers prescribed methadone 1mg in 1ml mixture. It brings together in partnership, the GP, pharmacist, drug team key-worker and the patient. The Department of Health (DH) has recognised the difficulties in persuading GPs and pharmacies to take on the additional roles and responsibilities needed to ensure a safe and quality service for treatment of opiate dependent patients. The 4WA is one way in which this is being achieved. It is a system that is still evolving, but the evidence appears to suggest that it is successful at attracting and containing people (including GPs & pharmacists) into treatment through this shared care model.

The process starts with the CDT. In line with the DH guidelines, GPs are strongly advised not to prescribe until a multi-disciplinary assessment is completed by the specialist team. The CDT draw up a 4 way agreement (see example) which names the client's chosen GP and pharmacy and the key-worker ensures the client understands the agreement which specifically includes reference to a code of conduct. The process and wording of all 4WAs is consistent for all clients and helps to prepare clients for working successfully with their GP, pharmacist and key-worker. This has benefits for all involved and improves the quality of care, not just for the patient but also for the GP and pharmacist. The CDT then sends identical copies of the 4WA to the GP and pharmacy and a recommended treatment plan is discussed with the GP. The co-ordinator is responsible for tracking patients, ensuring the GP and pharmacist know and understand their roles and responsibilities and trouble-shooting issues as they arise. It is at the discretion of the GP whether or not to continue to prescribe to a client, and any abuses or difficulties with compliance with this contract will result in a review of the situation.

THE FOUR-WAY AGREEMENT

I, the patient named below, understand and agree to the following conditions of treatment:

1. (a) I will be prescribed ? ml (1mg in 1ml) oral methadone mixture for daily collection.
Special instructions: Supervised consumption.
- (b) I will collect my prescription in person from the pharmacy named below, at the time arranged between myself and the pharmacist.
- (c) My GP will be notified in the event of non-attendance for appointments.
2. I will keep all my appointments with my GP named below unless by prior agreement.
3. I will see my key-worker from Neutral Zone/Cascade on a regular basis and keep all my appointments unless by prior arrangement.
4. The following have the right to discuss my case and may wish to see me together if this is felt appropriate:
5. If I am not in a fit state, my GP and the pharmacist have the right to refuse to see me.
6. I will not be a nuisance or abusive or violent to the practice, unit or pharmacy staff.
7. I will not take any drugs other than those prescribed to me and I will provide a urine sample for analysis when requested.
8. I am responsible for any drugs which I am prescribed and if I should lose them or take them other than as directed they will not be replaced.
9. I will abide by any other conditions which my GP may wish to make.
10. I understand that I can only obtain prescriptions from the GP named in this contract unless alternative arrangements are made to cover holidays.
11. I understand that I have chosen the pharmacy named in this contract from which to collect my prescriptions. This means I cannot have my prescriptions dispensed by any other pharmacy without re-negotiating my Four-Way Agreement with Neutral Zone/Cascade, my GP and another pharmacy.
12. (a) I understand that I must collect my prescription on the specified day. If I fail to collect a dose on the specified day, I will not be able to collect that dose on a later day.
- (b) I understand that if I fail to collect my dose for three days or more, my treatment will be reassessed.
- (c) I understand if I am unable to collect my prescription, I must inform the pharmacist and then, if the pharmacist agrees, I will send to the pharmacy a named representative, known to the pharmacist with a letter signed and dated by me.

SMMGP comment on respect for patients and tone/wording of agreements – This type of 4 way scheme based on excellent support, clear agreement and shared protocol as a very useful model for local adaptation. We acknowledge that the 4WA is looking to further develop its initial wording which was developed based on the needs and concerns of local practitioners that the scheme seeks to support. It is important that the tone or language of agreements should be supportive to patients whilst acknowledging that mutual respect by staff and patient and clear agreements are fundamental. In Berkshire this is organised through a *mutual respect code of conduct* whereby the GP, drug misuse service and pharmacists agree 'To treat people as individuals and accord them respect' and 'To empower people to make informed choices'. Agreements should also clarify the role and responsibility of GPs, Pharmacists and Keyworker to the patient. In Berkshire, roles and responsibilities are described as part of the 4WA and patients are provided with a copy of this information. A harm minimisation approach requires some flexibility for patients who 'fail' tight agreements. The 4WA provides support for all partners in the 4WA to ensure agreement so that decision processes can be flexible and appropriate to the individual patient. This supports drug use been seen as a chronic relapsing condition with a practitioner's role as supporting the patient through change, which is often incremental.

Some 4WA Facts: Over 400 clients/patients have been started on 4WAs since January 1999, across the 4 PCG in the west of Berkshire. These involve 150 (59%) of GPs and 47 (73%) of pharmacies (DH target = 20% of GPs). Since May 2000, the scheme has been further rolled out across the 4 PCGs in east Berkshire with over 120 patients so far, bringing the overall Berkshire total (8 PCGs) to over 45% of GPs and 63% of pharmacies involved. DH performance indicators, can be measured using data collected by the co-ordinator via the pharmacies and so reducing the paperwork for GPs. Pharmacies and GPs 4WA remuneration is for each treatment 'slot', activated by starting a 4 way agreement. GP and pharmacy receive £90 per 12 month patient slot organised and calculated by the co-ordinator. Pharmacies provide up to 13 weeks of supervised consumption during this slot.

The 4Way Agreement has helped to identify issues occurring as a result of treating methadone patients in primary care and provides a foundation and framework for solving such problems. Difficulties that have been resolved and monitored by 4WA include urine testing arrangements, tracking of patients, monitoring of outcomes, providing an evidence base for the treatment, reducing the paperwork for surgeries, remuneration for GPs and pharmacies. Due to the increasing success of the scheme, new difficulties are arising. For example some current issues identified and being investigated include:

- **Pharmacies difficulty in coping with increased workload. Often these pharmacies also operate the needle exchange scheme and are having to limit the number of 4WA patients seen. Some have decided to withdraw from the needle exchange scheme.**
- **GPs are concerned about those patients who repeatedly 'break' their agreement and whether further guidance is needed.**
- **Clients need a GP to prescribe. As some do not have a GP, problems have been identified with the allocation process.**

The ethos of the 4WA scheme has meant that it is possible to look at such issues with all professionals working together and, importantly, promotes greater understanding and so avoids a 'blame' culture. Many GPs and pharmacists since have commented that there has been a big improvement in the response, attitude and behaviour of patients.

Contact Marion Walker, Dr Sue Rendel or Andy Semmens at Neutral Zone, 159 Oxford Road, Reading, RG1 7UY

Monitoring of Drug Misuse Treatment in General Practice

National Drug Misuse Monitoring System (NDTMS) Replaces Regional Drug Misuse Database

It is important to monitor the current drug trends in any area and monitor people in and out of treatment to enhance knowledge and understanding of the problem and help to inform decision-making, improving the suitability, range and quality of services available. The National Drug Treatment Monitoring System (NDTMS, Donmall, Hickman & Glavas, 2000ⁱ) is a national initiative from the Department of Health (DH) to monitor problem drug use within the community. The DH requires every Regional Health Authority to operate this system. The DH Guidelines "Drug Misuse and Dependence – Guidelines on Clinical Management" (p.24),ⁱⁱ recommend that GPs should report patients that they treat for drug misuse to NDTMS.

Previous methods of data collection on drug misuse included the Drug Misuse Database (DMD) and the Addicts Index. The Drug Misuse Database collected episodic data and therefore recorded new episodes of treatment, rather than information about all individuals in treatment. The Addicts Index ceased operation in 1997. The National Drug Treatment Monitoring System (NDTMS) collects data about all drug users who are in structured treatment with any service including GPs. An initial data set is collected when treatment commences, and patients are reviewed annually when information regarding treatment provided (e.g. prescribing) and outcome measures are collected. In brief, the additional features of this data set over and above previous systems include prevalence/numbers in treatment, new information on first treatment and age of first injecting: better information about treatment retention and drop out rates and information on waiting lists. In addition, analysis of numbers in treatment by area of residence and area of treatment will be available by PCG, Local Authority, Health Authority and Drug Action Team. The main feature of this system over previous monitoring is that ongoing treatment is monitored. Unlike in the old system, which used to collect information for new treatment demands only, NDTMS will follow-up clients' progress in structured ongoing treatment (i.e. drop-ins, Needle Exchanges etc are not included)

What data are collected? There are two data collection forms for GPs. The first, which is for initial contact, gathers information about the patient, the current episode of treatment, previous treatment and the drugs used (illicit and prescribed). The second form is for annual review and is completed at 31st March of each year until treatment is completed. No full names or addresses are required, however, the collection of attributor data (initials, date of birth and gender) minimises double counting and enables tracking clients within and across services. The NHS number is also collected and is used to trigger the annual review.

What are the data used for?

- **Monitoring the Government's drug strategy, *Tackling Drugs to Build a Better Britain*ⁱⁱⁱ:** the data will be used to assess achievement of government set targets
- **Clinical management:** the data will also provide valuable information on local patterns and trends in presenting drug use to both providers and commissioners of drug services
- **Epidemiology:** data summaries will be sent (in anonymised format) from each region to the Department of Health every twelve months. DH provides annual statistical bulletins giving a comparative national picture of drug treatment.

What about confidentiality? It is good practice to explain to patients why data are collected and with whom they will be shared. NB No data that could be used to identify the patient are available to central government, nor to any body, organisation or individual outside of the centres where the NDTMS are based. All data are published in aggregate format.

For information on NDTMS, forms or copies of reports and statistical bulletins, please contact local data centre:			
Merseyside and Cheshire	0151 231 4319	Manchester, Lancashire & S Cumbria	0161 772 3790
Anglia & Oxford	01865 226734	Northern & Yorkshire (inc. N Cumbria)	0113 295 1337
Thames	020 846 6562	South West	0117 958 4383
or	0207 594 0771	(South West number may change, other data centres will help)	
Trent	0116 225 6360	West Midlands	0121 580 4331
Wales	02920 826206		

Petra Meier Drug Misuse Research Unit, University of Manchester

Rachel Birtles Public Health Sector, Liverpool John Moores University

ⁱ Donmall, Hickman & Glavas (2000). Strategic Review of Drug Misuse Databases, London: Department of Health

ⁱⁱ Drug Misuse and Dependence – Guidelines on Clinical Management (1999) Department of Health; Scottish Office Department of Health; Welsh Office; Department of Health and Social Services, Northern Ireland

ⁱⁱⁱ Tackling Drugs to Build a Better Britain (1998): The Government's 10-Year Strategy for Tackling Drug Misuse. The Stationery Office

News Update

License for pegylated interferon granted for treatment of hepatitis C - Pegylated interferon is more powerful and effective interferon that is metabolised differently and so stays in the body for longer. Trials show that using it in combination therapy can improve the cure rates of hepatitis C to about 60% and may be as high as 80% in genotypes 2 and 3. Possible restriction on this new treatment is its cost of about £11,000 / year / patient.

The UK Harm Reduction Alliance - held their first conference titled 'Drug policy - getting harm reduction back on the agenda' in Blackpool in May. It was well attended, exciting and provoked much healthy debate. If you would like to join UKHRA visit their web site at www.ukhra.org to learn more about the organisation and download an application form.

SMMGP Recent Paper and Article Review

1. Alcohol – 3 Useful articles in BJGP March 2001 Vol. 51 No 464

a) Patients with alcohol problems – simple questioning is the key to effective identification and management. Paul Wallace, P172 –173. Very useful editorial pointing out that alcohol misuse causes a massive burden of health and social problems. There is good evidence that eliciting a good history of alcohol intake, followed by simple intervention, can result in important reductions in consumption, although GPs are not too good at detecting or intervening. It also points out that we should stop using CAGE and use AUDIT.

b) Screening properties of questionnaires and laboratory tests for the detection of alcohol abuse or dependence in a general practice population. Aertgeerts, B, et al P206 –217. Study comparing different screening tools for alcohol, noting that AUDIT is superior to CAGE and that screening blood tests are no use for detecting alcohol abuse in a primary care setting.

c) General practitioners' and practice nurses' knowledge of how much patients should and do drink. Webster-Harrison P, P 218-220. Postal survey showing how poor we are at knowing about sensible limits and how many units of alcohol there are in common drinks.

2. Opiates – American Journal of Public Health Vol. 91; No 5

The impact of harm-reduction-based methadone treatment on mortality amongst heroin users. Langedam M, et al P 775-780. The results indicated that harm-reduction-based methadone treatment, in which the use of illicit drugs is tolerated, is strongly related to decreased mortality from natural causes and from overdose. Provision of methadone in itself, together with social-medical care, appears more important than the actual methadone dosage.

3. Shared Care - 2 articles in Journal of Substance Use Vol. 6 No 1 2001

a) The primary care treatment of drug users: is shared care the best approach? Ryrie I, Ford C. P 3 – 6. This paper examines the historical peculiarities of British drug policy to help understand the challenges of contemporary care. It is proposed that specialist led models of 'shared care' may militate against GP involvement and presents primary care facilitation as one alternative.

b) General practitioner satisfaction with 'shared care' working - Kenyon, R et al P 36 – 39. All 50 participating GPs were surveyed by anonymous postal questionnaires. Most reported satisfaction with the service. It was thought that the success of the scheme can be attributed to fast assessments, clear protocols, good communications and access to a consultant-led specialist unit for backup. The developing schemes which are in line with the usual NHS structures is likely to be attractive to GPs and may encourage their participation.

Ed's note: *Have you read any papers or articles that have impressed you or changed your practice? Send in a short précis.*



Dr Fixit on Opiate Detoxification

Aims and process - Opiate detox is a process whereby an opioid dependent individual is taken off a drug incrementally so as to eliminate physical dependence, ideally with minimum discomfort from withdrawal symptoms. This involves ceasing the use of illicit opiates, transferring to a prescribed drug, and reducing the dose in a controlled manner towards a drug free state. This can be undertaken rapidly or slowly as an in-patient or outpatient.

Drugs used in community detoxification - These include **methadone***, **buprenorphine***, **lofexidine****, **dihydrocodeine***** and **self-reduction using heroin**.

* Licensed for the treatment of drug dependence. ** Licensed for the management of symptoms of opiate withdrawal. *** Not licensed for drug dependence. Products not specifically licensed for drug dependence may still be used as recommended in the Clinical Guidelines. Dihydrocodeine is described as for the 'experienced practitioner' p.38 C.G. Buprenorphine is recommended to be initiated by a specialist practitioner p. 39 C.G. Buprenorphine can now be prescribed in daily instalments which may change its official remit in primary care.

Additional therapies to help detox process - Motivational interviewing, behavioural supportive counselling, acupuncture particularly auricular, shiatsu and herbal teas. Good *aftercare* is essential.

Withdrawal symptoms - Teaching people what they are likely to experience can help reduce anxiety and can

alleviate the intensity of symptoms. Raised anxiety levels contribute to the physiological process in opiate withdrawal:

Weakness, yawning, sneezing, sweating, tremor, goose bumps, high temperature but feeling cold, insomnia, irritability, aggression, muscle spasm/jerking, diarrhoea, nausea, vomiting, appetite loss, deep aches 'painful bones'

Symptoms in untreated self-reduction - Untreated heroin detox peaks at 36-72 hours and subsides in around 5 days. An untreated methadone detox peaks at 4-6 days and subsides in 10-12 days.

Abstinence, relapse, aims and expectations

- *Newly detoxified patients are very vulnerable*
- Detoxification may not be effective in achieving lasting abstinence but it is a useful tool in helping clients understand the nature of their addiction.
- Detoxification alone cannot be expected to directly lead to long-term abstinence and radical alteration in other outcome measures such as employment, criminality, interpersonal relationships and general physical and psychological well-being.
- It is best considered as a precursor to, or on-going element of treatment.

People who don't 'get better'

- Success can be acknowledged as patient contact with services, and experience of working towards change and understanding of their drug use.

- Frustration at the 'failure' of opiate users who don't 'recover' and become drug free following efforts to help them is common.
- Better to balance expectations than to put pressure on clients to 'do better'.
- Opiate dependence can be a long-term problem - it is also a chronic relapsing condition.
- Demoralising the patient by constantly admonishing their failures is unlikely to help recognise where the patient is, help set appropriate goals or offer appropriate help.

Methadone reduction programme

- As with all detox, clarify treatment aims, expectations, concerns and aftercare/support needs with client at the outset.
- If detoxifying from heroin, use the conversion chart to decide on the starting dose of methadone (never more than 40mls - titrate up from less). Titrate the dose of methadone against observable signs of withdrawal e.g. perspiration, tachycardia and dilated pupils, until stabilised. Give these more weight than symptoms.
- If already on methadone continue to reduce as below.
- A stepped reduction is the best approach.
- A more rapid reduction is possible in the earlier stages rather than the later stages.
- Reduction of 2-5 mgs of methadone every 1-2 weeks is possible but a spread over several months, or even a year may be necessary.
- The reduction regime should always be done in conjunction with the patient and with monitoring of how they are managing the reduction. Flexibility should be considered at all times.
- The last 5-15mgs are always the most difficult. It may be necessary to use other drugs to help with the withdrawal symptoms in the short term, such as lofexidine or Lomotil.
- Psychological support for the drug-user can be helpful and may be required during detox.

Dihydrocodeine reduction programme

- May be useful in people who are smoking small amounts of heroin.
- Useful for people wanting to stop using drugs in a short period.
- Can be used in young people to avoid methadone, or with clients who have not used or are unwilling to use methadone. Useful in communities where methadone has not been introduced.
- Start at about 10 x 30mgs and adopt a stepped reduction over 2-3 weeks.

Buprenorphine (Subutex) reduction programme

- Binds to morphine receptors and acts as a partial agonist.
- Has an effective duration of at least 24 hours and is available in 0.4mgs, 2mgs and 8mgs tablets
- Less risk in overdose, lower risk of respiratory depression.
- Can be used for detoxification (and maintenance) - stabilise and then reduce dose over 3-4 weeks.
- It is not picked up on routine urine screening (Screening however is possible).

Lofexidine (Britlofex) reduction programme Tablets 0.2mgs

- Lofexidine is a ganglion blocker acting at the level of the spinal cord. Opiate withdrawal is caused mainly by the release of large amounts of adrenaline into the blood stream when opiates are abruptly stopped.
- Lofexidine blocks this release. The physical symptoms of withdrawal are therefore lessened, although it has no effect on psychological craving.
- Useful when opiate habit is small (1/4 gm or less of heroin) and short-lived or to complete a methadone detoxification for the last 15mls.
- The dose regime can be between 7 and 14 days.
- Titrate up to 3 tablets QDS quickly and monitor blood pressure.
- The worst withdrawal symptoms will be experienced in the first five days.

Rapid detox - Rapid Induction into Opiate Antagonist Treatment using sedation rather than anaesthetic seems to be the preferred and safer option. This is done using the opiate antagonists naloxone/naltrexone and varied sedatives. Treatment is usually provided by private clinics in the UK. Naturally it has a higher completion rate than traditional methods, but a similar abstinence rate after completion.

NB Tolerance to opiates drops quite quickly, so the client needs to be warned about this so they do not overdose, if they relapse. After care after all detoxification programmes is essential.

Ed. Sometimes we can forget the value of detox. We would like to know of your experience of conducting opiate detox.

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