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Treating stimulant misuse - what pharmacology has to offer

Fabrizio Schifano

In the second part of the 1990s, a global trend of escalating stimulant (cocaine and methamphetamine) use was observed across a number of EU countries, including the UK. To cope with this increasingly widespread clinical issue, the evidence-based pharmacotherapeutic approach has become an important factor but this still proves to be a challenge. A few clinical and neurobiological issues of stimulant misuse will be described, and this will be followed by some comments related to the different pharmacological approaches that have been recently proposed.

Clinical and pharmacological issues related to stimulant misuse

After a cocaine binge (which is characterised by increase in both NA and DA turnover), the beginning of the withdrawal phase is observed. This is schematically divided into three different sub-phases: crash (characterised by decrease in NA levels); withdrawal (characterised by decrease in both 5-HT and DA levels); and extinction (with a possible rebalance of the neurotransmitter pathways). Crash lasts for a period of 9 hours to 4 days; it is characterised by dysphoria and by different levels of craving. The withdrawal phase lasts for approximately 1–10 weeks; in the later period of this phase the craving, anxiety and dysphoria levels may be very high and relapse risk is considerable.

Methamphetamine shows both direct sympathomimetic effects secondary to disruption of vesicular storage of monoamines and inhibition of their breakdown by MAOIs and indirect actions through inhibition of central presynaptic reuptake of catecholamines. Similar to cocaine, the clinical picture (‘tweaking’) is characterised by a ‘binge and crash’ cycle.

Pharmacotherapeutic options

Following a significant stimulant binge, most frequent acute psychopathological consequences include violent and bizarre behaviour, anxiety, confusion, sleep disorders, tactile hallucinations, paranoid-type disorders, and aggressive behaviour. These high levels of aggression may
require significant levels of both physical and chemical restraint. Benzodiazepines (often required in very high doses) should be the first-line medication with antipsychotics used only where additional tranquillisation is required. To decrease illicit stimulant misuse levels, the use of amphetamine substitution has been proposed, but this has been criticised because of both the risk of amphetamine binging and difficulty in reaching acceptable levels of clinical stabilisation. However, Mooney et al. (2009) in a double-blind, placebo-controlled study showed that sustained release (SR) methamphetamine was associated with consistently low rates of cocaine-positive urine samples and craving reduction.

Since stimulant withdrawal symptoms include anxiety, strong craving, tiredness and depression, the use of antidepressants has been proposed to address the cocaine/stimulant cravings. Within this group, dispiramine has been suggested to operate a post-synaptic down regulation of the NA system. However, this has not been accompanied by satisfactory retention in treatment. Antidepressants, per se, do not possess any specific anti-craving effects, and their efficacy in reducing depression might be confined to those stimulant users who are depressed. The persistence of depressive symptoms beyond 2–4 weeks after stopping stimulant use may suggest that there is an underlying depressive illness and this should be treated.

Another proposed strategy to cope with the stimulant cravings is to operate a post-synaptic down regulation of the DA system. Amantadine, levodopa, bromocriptine, lisuride, selegiline, pergolide, mazindol have all been proposed, but the use of these medications (which often increase the pre-synaptic level of DA release) may further predate an ‘impoverished’ DA system. Carbamazepine use is still controversial and baclofen (which modulates the GABA-B receptors) has not shown promising results in humans. On the other hand, Reis et al. (2008) in 25% of his sample administered with an open label trial of topiramate described a significant reduction in craving intensity and duration. Promising results have been reported in concurrent alcohol/cocaine users with the use of disulfiram, which inhibits the central DA metabolism. As such, it may exert a direct effect on cocaine use rather than through reducing concurrent alcohol use. Finally, a range of immunotherapies, including vaccines, monoclonal antibodies and catalytic antibodies, have been shown to reduce drug seeking. In human clinical trials, cocaine vaccines have been shown to induce antibody titers while producing few side effects.

Conclusions
There are currently no widely accepted evidence-based pharmacotherapy regimes for the treatment of stimulant misuse. From the examination of this brief overview, some drugs may however seem promising, such as the D2/D3 partial agonists, disulfiram and therapeutic vaccines.

On the other hand, recent pharmacological evidence emphasises the importance of the endocannabinoid system in modulating the reinforcing effect of cannabis, opioids and stimulants as well. More than a single treatment approach that is valid for all, it is then conceivable that most promising results can be achieved by a combination of both pharmacological and psychosocial treatment approaches.
Pharmacology of benzodiazepines
Anne Lingford-Hughes and Nicky Kalk

Benzodiazepine receptor pharmacology
Benzodiazepines bind to a specific binding site on the gamma-aminobutyric acid-A (GABA-A) receptor. The GABA-A receptor is a ligand-gated chloride channel, which is widely distributed throughout the central nervous system. GABA is the major inhibitory neurotransmitter and as such, limits the excitability of neurons through hyperpolarisation produced by chloride influx. Benzodiazepines are safe in overdose because, unlike barbiturates which also bind to the GABA-A receptor, they are unable to open the GABA-chloride channel directly. In addition to agonists such as diazepam, there are inverse agonists which have the opposite effects to agonists, e.g. increase anxiety, are pro-convulsant, promnestic (improving learning and memory). There are also partial agonists or inverse agonists, which results therefore in a wide range of possible activity at the GABA-A receptor. The effects of agonists and inverse agonists are blocked by the antagonist, flumazenil. In addition, other important modulators of GABA-A receptor activity are neurosteroids, e.g. allopregnanolone, anaesthetic steroids and alcohol (Nutt & Malizia, 2001).

The GABA-A receptor consists of five protein subunits, each of which has several isoforms, is commonly made from 2 alpha, 2 beta and a gamma subunit. There are 6 alpha, 3 beta and 3 gamma isoforms and receptor nomenclature is determined by the alpha subtype, e.g. alpha1. Despite this plethora of subunits and potential combinations, there only appear to be nine commonly expressed GABA-A receptor subtypes, with possibly another 15 or so also expressed. The benzodiazepine binding site is formed at the interface between the alpha- and gamma-subunits. Benzodiazepines cause an allosteric structural change such that the GABA-A complex is more sensitive to the effects of GABA resulting in an increased frequency of chloride channel opening. Receptors can be located within the synapse where they mediate phasic inhibition, though increasingly the importance of extra-synaptic receptors mediating tonic inhibition are being realised (Belelli et al. 2009). Subunit composition determines the pharmacological and electrophysiological properties of the benzodiazepine receptor. Recently the GABA-A receptor pharmacology has undergone a renaissance due to characterisation of particular subtypes with distinct roles. This has been possible due to development of, for example, ‘knock-out’ mice where activity of one subunit or receptor is minimised and also compounds with activity only at a particular subtype. This means that more selective medications targeting particular subtypes, e.g. an anxiolytic with minimal sedation are a possibility.

The various benzodiazepine receptors are distributed in different brain regions, e.g. alpha1 is widely distributed and is a ubiquitous receptor subtype, whereas alpha4 is only present in the cerebellum, and alpha5 has a limited distribution outside the hippocampus. The roles of each of these subtypes are still being characterised but activities of each of the subtypes include: alpha1 - sedation (zolpidem is a relatively alpha1 selective drug), amnesia and seizures; alpha2 and 3 – anxiolytic; alpha5 – learning and memory; and alcohol-lowering (Rudolph et al. 1999). However, there are receptors which are insensitive to benzodiazepines, e.g. alpha4 and 6 subtypes and the alpha4 may increase at times to reduce benzodiazepine function (Wafford et al., 2005).

Benzodiazepine dependence
Intrinsic to any descriptions of drug liking and dependence is the dopaminergic mesolimbic pathway. However, evidence for this pathway playing a key role with benzodiazepines is lacking. Indeed reductions have been reported rather than increased dopamine levels which are seen with other substances of abuse (Licata & Rowlett, 2008). Benzodiazepines appear to be only weakly reinforcing compared with other substances of abuse. In man, acute lorazepam administration failed to alter D2 receptor availability using 11C-raclopride PET (Hietala et al., 1999). It is hypothesised that benzodiazepine addiction is primarily fuelled by negative reinforcement to overcome effects of withdrawal, rather than by the positive, or hedonic, reinforcing effects of the drug.

Chronic use of benzodiazepines is associated with dependence or tolerance and abrupt cessation can lead to withdrawal syndrome (Griffiths & Weerts, 1997). Benzodiazepine tolerance is well-recognised in the clinic and experimentally, but only develops to some, e.g. sedation, motor coordination, but not to all effects of benzodiazepines (Licata & Rowlett, 2008). For instance, clinical trials have shown that tolerance to the anxiolytic effect of benzodiazepines does not occur, even after several months of treatment (Griffiths & Weerts, 1997).

The mechanism underlying tolerance to regular benzodiazepine exposure is still unclear since changes in receptor numbers have been hard to robustly demonstrate (Nutt, 1992). There is evidence of a shift in GABA-A receptor composition with altered gene expression, particularly down-regulation of the δ1, δ5, and γ2 subunit mRNAs reported as well increases in the benzodiazepine-insensitive, α4 subunit (Licata & Rowlett, 2008).

‘A set point shift’ has been speculated – a propensity for the GABA-A receptor to become more sensitive to the actions of inverse agonists or antagonists and less sensitive to the actions of agonists (Nutt et al., 2001). Increased glutamatergic sensitivity may also play a role in tolerance to benzodiazepines (Licata & Rowlett, 2008). Such changes in the GABA-glutamate balance likely underlie the withdrawal syndrome. However, most preclinical models do not reflect intermittent high dose benzodiazepine use often seen by patients in addiction services who also take opioids and possibly stimulants, so it is not clear what happens to the benzodiazepine receptor under these conditions in patients.

The benzodiazepine receptor in addiction to other substances
Despite having limited reinforcing effects on their own, benzodiazepines have shown greater reinforcing effects in those who abuse other substances, particularly opioids (Griffiths & Weerts, 1997). Evidence for this pathway playing a key role with benzodiazepines is lacking. Indeed reductions have been reported rather than increased dopamine levels which are seen with other substances of abuse (Licata & Rowlett, 2008). Benzodiazepines appear to be only weakly reinforcing compared with other substances of abuse. In man, acute lorazepam administration failed to alter D2 receptor availability using 11C-raclopride PET (Hietala et al., 1999). It is hypothesised that benzodiazepine addiction is primarily fuelled by negative reinforcement to overcome effects of withdrawal, rather than by the positive, or hedonic, reinforcing effects of the drug.

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1997). Comorbid benzodiazepine dependence can be seen even when a patient has taken them as prescribed with a long-standing prescription, or in those who use their benzodiazepines in doses above those prescribed, often buying them illicitly. They may be used for a variety of reasons such as aiding the ‘come down’ from stimulants, reducing opioid or alcohol withdrawal or increasing the effects of methadone as well as to help with emotional ‘distress’.

Many of the acute effects of alcohol involve increasing GABA-ergic activity through the benzodiazepine receptor and an inverse agonist at the alpha5 subtype can reverse the memory impairing effects of alcohol (Nutt et al., 2007). In alcohol dependence, a reduction in receptor levels, predominantly in the frontal cortex and reduced sensitivity to sleep-inducing effects of benzodiazepines (Lingford-Hughes et al., 2005) has been shown. The interaction between opioid and benzodiazepines of relevance to abuse is not clear but chronic administration of morphine is associated with increased benzodiazepine receptor binding levels that normalise with withdrawal and reduction in cortical GABA release (Simonato, 1996). If the same is true in humans, i.e. opioids reduce GABA-A function, this could explain withdrawal symptomatology such as insomnia and anxiety and the use of benzodiazepines by opioid addicts.

References


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Legal highs and recreational drugs: the Psychonaut web mapping project

Paolo Deluca, Fabrizio Schifano, Zoe Davey, Ornella Corazza

The recreational drug market in novel compounds and combinations, including legal highs, research chemicals, and online pharmaceuticals, continues to grow both in the UK and across Europe.

IN THE UK the most recent recommendations of the ACMID highlight the importance of this issue. The expansion of this market can be attributed to developments in the manufacture, distribution, and communication of new substances of abuse, and new methods of administration. The rapid rate of diffusion of these new drugs is a challenge for health professionals, health agencies, treatment services and addiction specialists as there is often very little, if any, evidence-based literature about the substance available.

The Psychonaut Web Mapping Project is funded by the European Commission with the aims of developing a web monitoring system to identify and categorise novel recreational compounds, and new drug trends based on information on the Internet, supplementing existing information emerging from national and European early warning systems. Exploratory qualitative online searches in eight languages have led to the development of a database of over 350 novel psychoactive compounds and combinations, and over 25 more detailed technical folders, including pharmacological and toxicological information, details of psychoactive effects and negative side effects, slang terms and synonyms for particular compounds, and routes of administration. This methodology has allowed for emerging trends in substance misuse to be detected and their diffusion to be monitored.

Spice

The early identification of the herbal smoking blends widely referred to as ‘Spice’ is one example. ‘Spice’ refers to a large range of products including Spice Gold, Spice Diamond and Spice Silver, sold as legal substitutes for cannabis since at least 2004. At the end of 2008 analyses of Spice identified potent synthetic cannabinoids, such as JWH-018 and HU-210, in the products that were not listed as ingredients on the packaging. Spice products or their active constituents have already been controlled in Austria, Estonia, Germany, Finland, France, Chile, Poland, Russia, South Korea, Sweden, Switzerland, Argentina and Luxembourg and are due to be controlled in the UK by the end of 2009. However, the evolution of the market means that new blends and different synthetic cannabinoids are already being explored as possible replacements.

Mephedrone

The Web Mapping project has also monitored the growth in popularity of the stimulant research chemical Mephedrone (4-methylmethcathinone; 4-MMC; MMCAT), which is widely available to purchase online as ‘plant feeder’ or ‘not for human consumption’. Psychiatrists in the UK have already warned of the dangers of Mephedrone. Mephedrone is associated with a number of negative side effects, including hallucinations, vasoconstriction, and possible psychosis, and has already been linked to fatalities in the UK and Europe. As yet there have been no published clinical or animal studies into the pharmacological or toxicological effects of Mephedrone, despite it being a highly addictive and an increasingly popular legal substitute for cocaine and ecstasy.

We are at the project’s dissemination stage and have started granting health professionals and addiction specialists access to the Psychonaut Web Mapping database and technical folders. The intended outcomes are to evaluate how useful the database and technical folders are from clinical and research perspectives, and to establish the web monitoring system as a sustainable resource for drug information. We will rely on contributions from registered members in the form of:

• Missing or updated information about existing entries
• Information about substances not included in the database
• Requests for information about unknown compounds
• Alerts about the prevalence of specific compound(s)

By establishing this two-way flow of information, we are hoping to develop a system that will remain current, be regularly updated, and continue as a unique source of information in an area in which there are
Cocaethylene
A brief look

Martyn Egerton

It is the story of many discoveries that what starts out as a good idea comes back as a significant burden for future generations. The enthusiasm for “coca wine” in the mid 19th century as a tonic for a variety of conditions now seems bizarre: albeit that the cocaine dose was quite small and the wine was probably a lot less potent than today’s vintages.

COCAINE use is widespread, despite valiant efforts to reduce supply to the UK and alcohol consumption has remained high. It was not until the last decades of the 20th century that the transesterified metabolite cocaethylene was identified. The compound is formed when cocaine is mixed with ethanol and a methyl group on the cocaine molecule is exchanged for an ethyl group.

Metabolism

The production of cocaethylene normally takes place in the liver through carboxylesterase activity but some synthesis occurs in other tissues by the action of ester synthetases. There remains uncertainty as to whether it is necessary to consume the alcohol before cocaine in order to achieve a significant production of cocaethylene. The reaction to form cocaethylene may be dependant on the amount of alcohol consumed, especially where the amount of alcohol is low. Traces of cocaethylene have also been detected as an impurity in samples of seized cocaine material.

Cocaethylene pharmacological actions and excretion

Cocaethylene is pharmacologically active. It binds to the same dopamine receptor as cocaine and has a similar pharmacological effect; albeit the potency may not be as great as cocaine. It blocks dopamine transport but is less potent in blocking serotonin transport. Metabolism follows the same pathway as cocaine with the formation of benzoylecgonine as the main metabolite while norcocacethylene and ecgonine methyl ester are also formed in smaller amounts.

There is evidence that there is tubular reabsorption of cocaethylene and this, combined with the potential to reform cocaethylene from benzoylecgonine in the presence of alcohol, may explain the prolonged euphoric effects when cocaine and alcohol are combined and the longer half life of cocaethylene (two to three times that of cocaine). In most studies the concentration of cocaethylene observed after ingestion of cocaine and alcohol is about 20% of the peak cocaine concentration.

It is no surprise that co-consumption of cocaine and alcohol takes place and the altered effects that result when the two drugs are consumed together have become part of the drug taking culture. The two drugs are frequently found in patients treated in Emergency Departments for drug-related admissions although it remains unclear whether cocaethylene plays a significant role in most patients compared with the effects of the two drugs individually. When cocaine and alcohol are consumed together there is a sustained increase in cardiovascular rate and pressure. There is evidence that combined use of cocaine and ethanol increases the risk of cardiovascular events and sudden death, although the role played by cocaethylene in this is uncertain.

It may be that the prolonged effect when alcohol and cocaine are taken together and the reduced serotonergic effects of cocaethylene lead to an increased desire to repeated consumption.

The placenta does not provide any protection for the foetus from cocaethylene. Both cocaine and cocaethylene readily cross the placenta. The reported dynamics of transfer to the foetus vary in reports; some suggest that the

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8 www.psychonautproject.eu
Cocaethylene
A brief look

placenta provides a degree of protection, however, of particular concern in one study was that in over 30% of meconium samples where benzoylecgonine was present, cocaethylene was also found.

It should be noted that animal models for understanding the production and metabolism of cocaethylene have not always been found to be consistent with experiments on human tissue and should be interpreted with caution.

Relevance to clinical practice
Most screening tests for cocaine are based upon the detection of benzoylecgonine and so they will not distinguish between cocaine and cocaethylene. The assays specifically for cocaethylene are based upon chromatography with mass spectrometry and therefore are not offered as routine investigations. Measurement of cocaethylene is unlikely to add further to the information provided by measuring alcohol and cocaine individually. Cocaethylene measurement in hair could theoretically provide evidence of alcohol use concurrent with cocaine.

Cocaethylene therapy has been considered in the management of cocaine addiction. Infusions of cocaethylene have shown a reduction in effects of coadministered cocaine which may indicate that an alternative structural analogue with lower pharmacological activity could be used as a starting point for development of a cocaine substitute.

Further reading

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“...and those who came to mock remained to pray”

RIOTT, the Randomised Injectable Opioid Treatment Trial, was established by Professor John Strang of the National Addiction Centre to investigate the use of injectable methadone and diamorphine in difficult-to-treat heroin addicts. This cutting edge research programme commenced in London in 2005, with a second trial centre opening the following year in Darlington. We cautiously accepted an invitation to oversee a third trial site in Brighton.

And so, in September 2007, Brighton RIOTT opened its doors.

The Brighton scene
Brighton has around 120,000 people in the 15-44 year age range. Much of this population is transient, attracted by the city’s bohemian reputation. The prevalence of drug use is consequently high, with an estimated 2,300 injecting drug users in the city. Annual mortality in this group has been estimated at 2%, double that of either London or Liverpool\(^1\). The city is on record as having the highest per capita rate of drug-related death in England and Wales for six out of the last eight years. These facts indicate the need to be open-minded about new approaches to drug treatment in this locality.

The clinic
The Brighton site was effectively self-contained, sharing premises only with a counselling service. In contrast to this, the other centres were co-located with their Substance Misuse Service’s main programmes. Our clinic was to be housed in a nineteenth century dispensary and modifications were required.

We chose to have an airlock-style entrance, with a member of staff granting access through the inner door to the reception area. Leading off from this was a drug storage room, the injection room, a WIC and a clinical examination room, which in turn connected to a counselling room. The total floor area was approximately 100m\(^2\), including a staff office above.

The clinical team
The clinical staff consisted of a band 7 team leader and five band 6 nurses. These are senior nursing grades, reflecting the experience and capability of the team, which included a mix of general and psychiatric nurses from varied backgrounds. We also had the assistance of an Associate Specialist for one or two sessions per week.

The patients
Our patient group had a similar composition to those at the other centres, reporting, on average, a 14-year history of intravenous drug use and injecting heroin on most days prior to assessment. Crack cocaine use was reported by 60% and problematic benzodiazepine or alcohol use in 30%. They had a mean of five previous treatment episodes and 60% had served time in prison.

All on the trial were already in treatment and receiving optimal doses of methadone. Patients were randomised to one of three treatment arms: oral methadone, injectable methadone or injectable diamorphine. Both injectable modes of treatment were supported with oral methadone. This was required in all cases with injectable diamorphine to “hold” the patient overnight and it was used in some cases with injectable methadone to reduce the volume that needed to be injected.

The programme
All patients attended the clinic once or twice a day, at any time between 10am and 12pm and 2pm and 4pm. Patients receiving diamorphine attended once during each session. Patients receiving injectable treatment could opt for an equivalent dose of oral methadone, instead of injecting on any particular day. All take-out doses were strictly oral methadone; no injectable medication was taken off the premises.

All injections were supervised by nursing staff, who gave instruction and feedback on injecting...
technique, hygiene and infection control. Injecting sites were selected with preference to the least harmful, according to the hierarchy: arms, hands, feet, legs. Groin or other deep vein injecting and neck injecting were not permitted on safety grounds. Areas with existing local infection, vascular impairment or other contraindications were similarly prohibited. Staff observation of injections also similarly prohibited. Staff

Patients were allowed three attempts to inject intravenously. If they were unsuccessful after this, they were offered the alternatives of injecting intramuscularly or, if there was more than a small amount of blood in the syringe, an equivalent dose of oral methadone.

Safety
Safety was our paramount concern from when our patients started treatment. On the first visit, or on any injectable dose increase, patients were carefully assessed by the nursing staff. Vital signs were recorded, breathalyser readings taken and observations of level of sedation or withdrawal, such as pupil size, speech and gait, were made – before, and at intervals after – the dose. Establishing a “correct” dose was a matter of clinical judgement and could be a cause for disagreement between patients and clinical staff.

Despite due caution in a closely supervised setting, there were some occasions when patients were over-intoxicated after injecting diamorphine, although at no time was it necessary to administer naloxone or transfer to the A&E Dept. Our clinical impression was that for the most part over-intoxication was generally due to undisclosed illicit benzodiazepine use prior to the clinic visit. On these occasions, patients were asked to remain in the clinic and monitored closely until they were able to leave safely.

Patients’ alcohol use was also a challenge on a number of occasions. New patients were breathalysered on each visit until the nurses were confident that their alcohol use was not problematic. Several patients chose to address their alcohol use and we were able to provide alcohol detoxification concurrently on site.

The methadone burn
The injectable methadone group presented its own problem: the “Methadone Burn”. This resulted from “missed” injections, causing an immediate burning sensation at the site. A blister would form within hours and an ulcer within a day or two, often taking several months to heal. Intramuscular injection of methadone was painful for many patients and often poorly tolerated. After two years, only three out of 11 patients remained on injectable methadone, most having moved to oral methadone.

Diamorphine patients
Almost all of our diamorphine patients chose, after six months to a year in treatment, to come in just once a day – always in the morning – relinquishing the second injection that was available. Most also chose to reduce their dose from the amount that they had received earlier in treatment. Some have taken it further. For example, one diamorphine patient is now on a very low dose of buprenorphine while another receives no medication from us; he is drug-free and waiting for a place in rehab. Inevitably some did not fare so well. For example, two patients showed very little improvement and were returned to treatment with the main community-based programme, thus making RIOTT places available for others.

Psychosocial support
In addition to medication, patients received an extensive, and intensive, psycho-social package of care. Each patient had an individualised care plan developed with his or her assigned key worker. Goals were set, often in small, attainable steps. All patients were offered referral to the counselling service. Many took this up. They were also given help to access literacy, IT and life skills training. Full assistance was given with housing issues, benefits, work-related problems and every kind of domestic crisis. Patients across all treatment arms responded well and this underlines the significance of the care and support they received. The therapeutic influence of clinical staff characteristics is well described in the literature Ball and Ross2.

Conclusions
Overall, the experience for all of us in Brighton has been immensely rewarding. On occasions we hit a steep learning curve, but we were deeply gratified to see that our patient group – intractable, treatment-resistant addicts, the “hardcore” of drug users – responded so tremendously well. They flowered artistically; put on weight; rebuilt their relationships; became dog and cat owners; moved into better housing; bought new clothes. They took steps back into society.

Gains were greatest, however, in the diamorphine group. We reviewed our patients’ improvement after two years in treatment, using a clinical global impression scale. For each treatment arm, we rated the following proportion of patients as “much improved” or “very much improved”: diamorphine 75%, injectable methadone 45% and oral methadone 30%.

There were two key lessons: that treatment with diamorphine is effective and produces a rapid response in an “untreatable” population; but equally that patients also respond in the long term to an intensive, holistic care.

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Dr Hugh Williams, Consultant Addiction Psychiatrist, Brighton Substance Misuse Service.

Adam Baxter, RGN, MPH, Community Charge Nurse.
There is ongoing disgruntlement among SCAN members and other professionals working in NHS addiction services about the perceived irresponsible re-tendering and subsequent decommissioning of services, often driven solely by short-term and financial considerations, at significant cost to quality of patient care.

OUR experience in Solihull is contrary to this and the recently commissioned service model is a partnership between a statutory and non-statutory addiction service. The Solihull Integrated Addiction Services (SIAS) was launched in May 2009, after a year and half’s work on integrating two agencies – ‘The Bridge’ (an NHS addiction service) and ‘Welcome’ (a non-statutory addiction service). Here we share our thoughts on this unique partnership.

The addiction psychiatrist’s perspective
SG: Despite initial scepticism about such a partnership and an integrated model of service delivery, seeing how well it has translated into good quality patient care, I must admit, has been an eye-opener. Of course, the amount of effort that had to be put in was immense (and is ongoing), but it all seems worthwhile now. As the lead clinician for SIAS, I appreciated the opportunity to actively contribute towards service re-design and worked closely with the commissioner and the non-statutory service provider. Being a full-time clinician, I am most pleased about the impact it has had on quality of patient care: a single point of contact for all referrals, joined up care pathways, more efficient care co-ordination and above all a genuinely seamless service.

My greatest challenge has been in trying to alter my own false yet deeply ingrained view about the superiority and exclusivity of NHS services. In the process, I have learned that as in all successful partnerships, it does take considerable understanding, effort and commitment.

The NHS team manager’s perspective
SB: Work on our integration project started over 18 months ago. What started off as a sizeable stick was gradually overtaken by the very sweet carrot of watching our clients and our teams reap genuine benefits from our new joined up working.

After 12 months, the unthinkable happened and we finally got the go-ahead to share our client information and give each other access to IT systems. I learned that if you push long and hard enough with sound arguments and get the key stakeholders on board, you can achieve successes you never dreamt were possible.

We are still two separate organisations but we function as one and we know how to make the best use of our different skills and the very different settings we operate in. I have the backing of a huge organisation if ever we need medical, legal or HR expertise. JM has the freedom to make innovative measures happen very quickly when we need to make the most of new opportunities. Her team is very flexible and responds quickly when we need to change the way we work.

Eighteen months ago there was quite a lot of competition between our two agencies, now we get the best of both worlds by working together in a co-operative manner, and it shows in the quality of service we offer to our patients.

We still have distinct specialist skills but we have joint targets and a partnership board which oversees the working of both agencies.

Early reflections on a statutory and non-statutory addiction
Sanju George, Sylvie Boulay, Joanne Mackinnon, Chris Clarke
We are now working against the clock to design a new joint reception (funded by a 150k bid we won from the NTA) to house our single point of contact made up of members of both teams. Our new reception will contain the ‘holy grail’ – a shared filing room to hold the single files for our joint clients: even more than sharing a building or having one website, I see this as the absolute proof of our partnership.

The non-statutory provider’s perspective

JM: When I started working at ‘Welcome’ three years ago, I remember being hugely impressed by what looked on the surface like a “one stop shop” for drug users. All the services available existed on one site. I had come from an area where if you had a drug problem, you would go to the CDT, if you had a housing problem you would have to go to the other side of town to try and sort that out, and then somewhere else again if you wanted to receive counselling and so on. But here, two teams had come together in one building and between them they were providing all these things. On the surface it looked fantastic.

After about six months of being in post I realised that although we were offering all these good services, the teams were not really working together and some of them maybe did not feel the need to. This was a deep-rooted and a historical thing: I felt quite disappointed. The systems in place did not help: separate assessment tools, duplication of services, separate databases, separate care plans for the same clients, etc. On some occasions, I felt as though there was a barbed wire separating the two services. This was not always the case because there has always been good partnership work between The Bridge and Welcome, but it was largely down to individuals.

What SIAS has achieved is willing teams, who now respect and understand each other and the different work cultures of their different organisations. We are now genuinely working together in partnership. We are not 100% there yet, but we have come a really long way in the last 18 months. I no longer feel disappointed but really enthusiastic. Although it was the commissioning strategy that initiated the work, it is the sheer hard work of the teams that has made SIAS happen. We launched a seamless service on 15th May 2009 and continue to work hard in partnership to provide a quality service in Solihull.

The commissioner’s perspective

CC: As most commissioners in this field would say, there are too many influences that have to be listened to. Targets, budget limits, standards, guidelines, initiatives, theories, national and local opinions and policy etc. etc… I’m constantly left with no shortage of advice and instruction as to what the drug treatment system should and should not be doing. Of course I don’t resent these voices – many stakeholders have a right and duty to share their perspectives and influence what we do in this important area of health and social policy – but there is a danger of overload when too many messages are competing for priority!

So I try to hang on to a basic principle to help me see the wood for the trees and, for me, it should all start with the service user: what does he or she need to stand the best chance of a successful recovery from addiction? From this point of view, and listening to service users themselves, as well as the experience of workers and insights of researchers, three messages came over loud and clear.

Firstly, people with addiction problems can suffer a wide range of connected social, emotional and medical problems and so need a wide range of facilities available if they are to be helped to recover. It’s no good being excellent in treating one aspect of the problem if another factor is constantly bringing the user back to square one.

Secondly, the problems are connected, so the help needs to be connected and co-ordinated too. Thirdly, the help needs to easily engage the user without unnecessary and annoying delays or repetitions. It’s no good having great services if users are put off by de-motivating assessment and referral processes.

So this, of course, is where the SIAS ambitions came from. Could we find a way to bring together all the services users might need into one partnership organisation without losing the variety of treatments and services represented by the two main parties – NHS medical care and voluntary sector intervention? Could we take out the duplicated or overlapping assessment, care management and treatment facilities that only wasted time and resources and seemed to leave clients confused and workers mistrustful of each other? Could users be met by a co-ordinated response to their individual needs that was welcoming, comprehensive, understandable and forward looking?

Addiction services should always be in the business of change, of course, but the cultures, styles and ways of working of the different partners were never going to be easy to put together. Courage, compromise and self-examination were needed in abundance but I’ve been delighted that the answer to all those questions seems to be – yes. SIAS has made a step change in all these areas. Users and their carers see the difference and workers realise the benefits of close co-operation in their working lives as well as the benefits to users. We are just now awaiting the outcome of a user-led audit of the SIAS approach but have every reason to expect a strong endorsement of the great strides made as well as pointers to the next stages. Targets, standards, budgets and initiatives won’t go away but with the SIAS partnership we can at least offer a high quality truly joined-up route to successful recovery to every addict in the area. And that’s what really matters.
SCENARIO

A 30-year-old man with a 15-year history of alcohol and poly-substance abuse – now discontinued – presents to his GP for treatment of panic disorder. He also has difficulty with social anxiety and finds it almost impossible to sit in the waiting room. Following assessment, the GP prescribes clonazepam 0.5mg t.d.s. to allow him to attend appointments as well as starting mirtazapine on an increasing dose regime for his panic disorder.

Due to his long history of substance misuse, he has become cross-tolerant to benzodiazepines and is then prescribed diazepam 10mg q.d.s. to stabilise his addiction and prepare for detoxification once his panic attacks come under control. Once he has reached 60mg of mirtazapine a day, there appears to be some improvement but overall the response to mirtazapine is inadequate and there are still problems with break-through panic. A referral to specialist addiction services is made.

A new regime is recommended which includes a medication change to fluoxetine 40mg a day as well as engaging with CBT. After an initial exacerbation in symptoms, he reports a gradual improvement in his social anxiety and ongoing panic symptoms with no reported full panic attacks. However he does not welcome the advice to gradually reduce diazepam and says he may seek a separate private prescription if they are reduced.

What should be the long term treatment plan?

CLINICAL CONUNDRUM

Clinical Conundrum

GENERAL ADULT PSYCHIATRIST’S RESPONSE

Dr Laurence Church, Consultant in General Adult Psychiatry, Surrey and Borders Partnership NHS Foundation Trust.

This case highlights several common clinical problems: the prevalence of untreated anxiety disorders in addictions settings, the difficulties of managing anxiety disorders in primary care, and the potential iatrogenic risks associated with persistent benzodiazepine prescriptions.

Occurrence of a further separate anxiety disorder in a patient where one has been identified is common and in this case, panic disorder and social anxiety are mentioned. Examination for agoraphobia, generalised anxiety disorder (GAD) or PTSD would be recommended, as would exclusion of a depressive episode. NICE recommends use of Cognitive Behavioural Therapy (CBT), selective serotonin reuptake inhibitor (SSRI) with license for treating panic disorder (alternatively imipramine or clomipramine may be considered) and/or self help through bibliotherapy. In this case the use of mirtazapine was not an ideal first-line choice and was then used at doses above BNF limits, which does not appear justifiable as it was the first medication tried.

Benzodiazepines are generally not recommended; clonazepam was a very potent selection and would be likely to encourage dependence when prescribed without time limit, given the past addictions history this becomes even more relevant. The switch to diazepam is appropriate but even then there are difficulties in establishing a shared goal of withdrawing the drug.

The provision of CBT and switching antidepressant to fluoxetine brings about some improvement. The patient may also benefit from other drug treatments, aimed at reducing symptoms of generalised anxiety disorder, e.g. buspirone, which will not assist in the withdrawal from benzodiazepines but may be a safer alternative in this patient; pregabalin, now licensed in the UK for GAD; or beta-blockers that will reduce the physical manifestations of anxiety symptoms. There is little evidence to support the use of antipsychotics, which are sometimes used in extreme cases.

If the current treatment is effective then the final stage will be to gradually withdraw the diazepam, monitoring for relapse in his anxiety disorder as you go.

CLINICAL PSYCHOLOGIST’S RESPONSE

Dr Paul Davis, Consultant Clinical Psychologist, Camden and Islington NHS Foundation Trust.

It was probably not the wisest of decisions to start this man on a benzodiazepine for his anxiety disorder nor to stabilise his addiction with one, but this is where he is now at: seemingly dependent on diazepam and, despite some reduction of symptoms, probably no further in learning how to cope with anxiety and panic attacks than he was before this treatment started. The issue now is how to reduce the diazepam (presumably this is the specialist addiction service’s goal) and treat the anxiety disorders. CBT was suggested presumably for treating the social anxiety and panic, not the dependence, as recommended by the NICE (2008) Guidelines.

Most clinical psychologists would agree that for a CBT programme to be successful, safety behaviours maintaining the anxiety (and particularly the use of alcohol and anxioiytics) need to be removed. It’s also generally agreed as crucial that a reduction programme should be completed before the CBT is concluded. This is partly to promote self-efficacy; it is the client who is controlling panic, not the drug.

So for this patient, successful treatment requires him to negotiate two difficult phases of the long term plan. Firstly, he has to reduce the diazepam which is likely to entail coping with rebound and withdrawal symptoms.

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and in cases where recovery is possible, or when there are possible exacerbations or recurrences of the disorder that the drug was treating.

Unfortunately he hasn’t as yet signed up to a diazepam reduction, so the starting point would be referral to someone (could be the same psychologist) competent in extended Motivational Interviewing2 to help him explore his ambivalence/hostility. This would entail using the full gambit of techniques for encouraging change talk and might venture into cognitive therapy approaches for reappraising both the withdrawal symptoms and how his drug use is maintaining his anxieties.

Assuming he agrees to a diazepam reduction, CBT for the mental health problems can be started. NICE (2008) boldly states that there is no evidence that psychological interventions for common mental health problems do not work with people who are also substance misusers. This should come with at least three health warnings.

Firstly, it’s a double negative and those like me who look up the studies used by NICE for anxiety and depression guidelines quickly spot that substance misuse is often an exclusion criterion. Secondly, treating the substance misuse problem is likely to make the underlying mental health problems worse (a complication that non-addiction psychologists are unused to). As a consequence of this, the third warning is that motivation to complete both the CBT and the reduction regime is likely to fluctuate.

The chances are that he will benefit from CBT, but delivered by someone capable of switching hats between CBT protocols and MI. Not an easy task but essential for him to stay engaged and receive enough of the CBT programme to benefit.

And if after seeing the psychologist for MI he still doesn’t agree to reduce? He needs firstly to have the long term consequences of benzodiazepines explained and the reasons why any (NHS) medical practitioner will be reluctant to continue prescribing to him. Secondly, the full range of other options need to be discussed.

This should include discussion of 12-step and residential programmes, an open invitation to his GP to re-refer him for review with the offer of a range of therapies for the patient’s problems, and a reiteration to the GP and the patient that a diazepam reduction is indicated as the only medically safe option, despite being at high risk of relapse to alcohol misuse.

References

ADDICTION PSYCHIATRIST’S RESPONSE

Dr Duncan Raitstrick, Consultant Addiction Psychiatrist, Leeds Addiction Unit

My first thought here is that a good outcome has already been reached and I would wonder whether any further benefit would come from ‘specialist treatment’. At the same time I would be concerned that the history given by the GP seems rather too good to be true and that there will be some reason for the referral which is not yet clear. My working hypothesis, which I will need to test out at our first appointment, is that...

1. he remains dependent on psychoactive substances – probably in a non-specific kind of way;
2. he has some kind of anxiety disorder which has emerged out of 15 years when he lacked the opportunity to learn social skills and became socially isolated;
3. he is not ready to change his current prescribed substance use. I am expecting he will have already had a whole range of psychosocial interventions, albeit poorly delivered.

I am expecting that this person is going to need long-term care and I am also expecting that building a therapeutic alliance, rather than specific or pharmacotherapies, will be all important. I am already convinced that the long-term care should come from a single agency and the key question for my assessment will be whether that agency is primary care or the specialist service.

Assuming my working hypothesis is more or less confirmed, then I am seeing this as essentially a medical management intervention which will be low intensity and long duration, meaning monthly appointments for a year and then review. My goals are:

a) to establish a strong therapeutic alliance;
b) graded introduction to social activities – I shall use motivational dialogue to foster these goals.

c) he is not ready to change his current prescribed substance use. I am expecting he will have already had a whole range of psychosocial interventions, albeit poorly delivered.

I am not unduly concerned about the prescribing regimen and so at the end of my first session I will agree that his diazepam will remain unchanged until such time as he is ready to reduce, however, I will want to structure the collections daily Monday to Friday, and I will be directive in suggesting that fluoxetine have the long term consequences of benzodiazepines explained and the reasons why any (NHS) medical practitioner will be reluctant to continue prescribing to him. Secondly, the full range of other options need to be discussed.

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References
Earlier this year I left the drug treatment field after 16 years, just under half of them with the National Treatment Agency for Substance Misuse (NTA), to join a Strategic Health Authority as programme lead for World Class Commissioning (WCC). I write this not as an idle boast (though yes, it is possible to escape this line of work), but as an introduction to this article in which I hope to examine the new commissioning rhetoric from the perspective of the drug treatment sector.

We are now in the second year of the WCC assurance process. This is the means by which PCTs demonstrate how robustly their practice adheres to a set of competencies which in turn will ensure better commissioning and provision of services by the NHS. This short article will suggest firstly that this is an opportunity for provider agencies to demonstrate real, meaningful clinical leadership for the field; and secondly that a number of developments in this sector leave it well placed to contribute to WCC to the benefit of the whole treatment system.

**Good commissioning**

During my time as a regional manager in the NTA there were a number of issues whose ubiquity was matched only by the passion with which they were expressed. These included “When will the NTA take on alcohol treatment services?” (still don’t know); “It’s all about crime, isn’t it” (no, it’s all about better treatment services); and “what is Paul Hayes really like?” (ask him yourself). Perhaps the most persistent pleas came from providers regarding the poor quality of commissioning across the country.

As I’ve written once before in these pages, I have not, and never will, embrace stereotypes of commissioners as “faceless bureaucrats with only targets on their mind, and could never contemplate responding to actual patient need when there are NTA and Department of Health directives to be followed” (SCANbites 12 p.7). There are some who are, and a larger number who are not (as evidenced in the joint HCC/NTA inspection in 2006/7). The WCC competencies offer a means of defining what good commissioning actually involves, and how PCTs can develop the skills necessary both to practise it (and equally importantly to demonstrate that they do so).

Those who have had the perhaps misfortune to hear me speak over the years will have heard me state my belief that commissioning is a language that is spoken by few, and understood by even fewer. Whereas in terms of provision we have an ever increasing evidence base, which can inform NICE and other clinical and good practice guidelines, for commissioners, particularly in substance misuse, the ‘how to’ manuals are in short supply. The WCC programme, designed to deliver a “more strategic and long-term approach to commissioning services, with a clear focus on delivering improved health outcomes” perhaps sheds some light on the commissioner’s world.

Specific details can be found on the Department of Health website, where two things are immediately apparent. Firstly, this offers a long overdue definition of what constitutes commissioning. One may not agree with it, but there it is. Secondly, there is now a clear responsibility for PCTs to demonstrate how closely they adhere to this definition, and a process for doing so, rather than simply through performance against national or locally set targets. PCTs in summary are expected to achieve the following:

1. locally lead the NHS
2. work with community partners
3. engage with public and patients
4. collaborate with clinicians
5. manage knowledge and assess needs
6. prioritise investment
7. stimulate the market
8. promote improvement and innovation
9. secure procurement skills
10. manage the local health system
11. make sound financial investments

**Strategic commissioning**

Some of this may appear to be standard management-speak, but there are some running themes with which even the most ardent cynic would struggle to mount an argument – that treatment should be designed to be safe, cost-effective, and the best possible experience for the patient. Probably the key document with which to become familiar and if possible influence is the PCT Strategic Commissioning Plan (SCP). This was submitted to SHAs last year and the PCT scored on the basis of the evidence submitted. In essence, this first year aimed to assess ‘strategic fit’ – whether the aims of the PCT in question align appropriately with the desired nationally stated outcomes.

**World class commissioning: what it means for addiction services**

**Hugo Luck**

**Hugo Luck, Programme Lead for World Class Commissioning, NHS South East Coast.**
How to be a trainer

Dr Jenny Bearn, Addictions Faculty Lead on the Education Training and Standards Committee, Royal College of Psychiatrists

Over the last five years there has been a seismic shift in the training of doctors to become consultant psychiatrists. The main drivers have been Modernising Medical Careers (which has clearly defined the route to becoming a consultant) and PMETB, a statutory body responsible for all aspects of education and assessment in post-graduate medical education.

What was training like before PMETB?
Training was essentially an apprenticeship. The trainer acted as a role model without defined responsibilities. The trainees’ clinical skills were inferred and rarely observed directly. Training completion depended on staged summative tests and there was no formal assessment in the “natural” clinical environment to provide formative, developmental experiences.

PMETB have ratified a new curriculum, exam reforms, and the rolling out of the programme of work-place based assessments (WPBAs) to test and develop clinical skills within the hurly-burly of day-to-day clinical practice. The Royal College of Psychiatrists’ Education Training and Standards Committee with input from individual faculties, including addictions, have spearheaded this work.

Philosophy of training
The underlying philosophy of training is that each trainee is actively responsible for their own training and development, in collaboration with their trainers and educational supervisors. Trainees now have explicit responsibilities and duties to satisfy training needs. PMETB (2008) has set standards for trainers, the first of which dictates level of supervision. This should be “appropriate to the competence and experience of the trainee” and no trainee should be expected to work beyond their...
How to be a trainer

current ability. Regular WPBAs provide the benchmarks for assessment of the trainee’s progress and ability to take on more clinical responsibility, whilst giving constructive feedback. There should be regular reviews of their development, including addressing any concerns. The trainer also has the responsibility to promote a learning culture integrated with clinical care. The clinical supervisor should have 0.25 PAs allocated for training purposes.

How do these generic responsibilities translate into good trainer practice? First is the recognition that the trainer/trainee relationship is a partnership and that the training adventure is a collaborative one. The trainee has to get off to a secure, informed start so a solid induction process is critical.

At the earliest opportunity, the trainer and the trainee should sit down together and review the duties of the post, which should have an approved job plan that clearly supports the training function. The trainer should immediately assess the trainee’s experience and level of supervision that they need. The trainee should be made aware of the chain of responsibility at all times, and have the relevant phone numbers and knowledge of senior staff availability whenever they need advice. In my first supervision I always outlaw the phrase “I’m sorry to bother you but...”.

The content

There should be a minimum of a one hour dedicated face-to-face meeting timetabled per week. The time should focus on the trainee’s individual needs, support and career advice, and not clinical work. At the outset it is a good idea to organise a timetable for WPBAs, otherwise it can become a scramble to get the requisite number completed, which also goes against the spirit of their developmental function.

All trainers have a responsibility to be ‘fit for purpose’ by engaging in ongoing mandatory and non-mandatory training and development, and to be familiar with the new curriculum.

The curriculum defines the skills, which can be measured using WPBAs. During the 3 year core training (CT1-3) trainees should achieve competence in a range of generic clinical skills, including history taking, risk assessment, record-keeping and communication skills, team working, and engaging in clinical governance (the Gold Guide).

Although they may not do a specific addictions post, they should achieve competence in a range of specific addiction psychiatric skills. These include taking a drug and alcohol history and examination, knowledge of substance use disorders and complications, co-morbid psychiatric disorders, and substance use disorder specific risk assessment. Clinical management skills include understanding risks of opiate replacement therapy, the side effects of addiction medications, managing withdrawal states, and knowledge of treatments for addiction.

![](https://www.londondeanery.ac.uk)

The curriculum for specialist trainees (ST4-6s) builds on competence achieved after core training to mastery at the ST6 stage when the trainee is ready to be a consultant. This is achieved through emphasis on assessments in specialist settings (e.g. criminal justice, inpatients) and in specialist groups, (e.g. pregnant women, gamblers). Specialist management skills should also be acquired in e.g. polydrug dependence, dual diagnosis and addictive prescribing.

Managerial and team working skills are developed by progressively taking on a more supervisory leadership role within the management team, and supervising clinical governance projects. Leadership skills are honed through knowledge and understanding of addiction service provision and policy, including local commissioning processes, the role of the National Treatment Agency, and participation in service development and design projects.

Achieving competence

The acquisition of competence and mastery through the six-year training programme is continually assessed by a WPBA programme (about one a month), which includes structured observed assessments of routine clinical encounters (such as clinical assessments and care planning), case-based discussions, case presentations, journal club, and multi-source feedback.

An additional WPBA, the direct observation of non-clinical skills (DOCS) is being introduced to specialist training to provide a way of assessing activities such as chairing multidisciplinary meetings, guiding C Ts, organising educational events, and writing reports.

The new training system has many advantages. There is a far greater emphasis on formative, interim assessments with inbuilt opportunities for development and correcting problems, rather than summative, final assessments with a Pass/Fail outcome. Finally, the defined curriculum highlights the expertise and specific competencies demanded of an addiction psychiatrist, at a time when their role, responsibilities and expertise are being challenged.

Further reading


Competency based curriculum for specialist training in psychiatry –

- specialist module in addictions (substance misuse) psychiatry. (June 2008)
- Core module (Jan 2009)

A Guide to Postgraduate Training in Psychiatry – essential information for all trainees and trainers. Royal College of Psychiatrists, June 2009

Professional Development Framework for Supervisors to the London Deanery. www.londondeanery.ac.uk
In light of the recent sacking of Professor David Nutt as chairman of the Advisory Council on the Misuse of Drugs by Home Secretary, Alan Johnson, the subject of evidence informing policy has never been more topical.

RESPONDING to Drug Misuse reports to be a book offering “a unique insight into the current shape of the drugs treatment system in England.” Its editor is the Programme Coordinator for the Department of Health’s Drug Misuse Research Initiative and the list of contributors reads like a Who’s Who of the UK’s drug experts, including previous and current senior colleagues of mine and members of an interview panel for a consultant post I had recently applied for. To say I was a little daunted to review the book was an understatement. Having said that, the book’s content promised to be extremely pertinent for a doctor about to embark on his career in addictions.

Susanne MacGregor sets out her stall well in the preface by referring to findings from research linked to the government’s 1998 ten-year drugs strategy. She offers to put these in the context of current policy, practice and service development, whilst making implications for the new drug strategy, Protecting Families and Communities. Her overriding message is that problematic drug use is a complex condition with no easy solutions.

Themes for the book include the link of drug policy with crime, service users’ perceptions and their suggestions for improvement, and the impact of drug misuse on children, families and communities. The first three chapters start with how drug services responded to government strategy, focusing on crime and coercion, and point out the link with and social harms.

The main body of the book is made up of nine chapters with topics familiar to those working in addictions. These range from national variability in treatment practice and care coordination, to prescribing injectable opiates and GP shared care. The contributors reflect on government strategy, predominantly since 1995, and then give recent research findings in their specialist interests. Most conclude by indicating the need for further research and predict how policy and practice will change in the near future. Of note, the chapter on prescribing injectable opiates makes reference to the recent RIOTT study. Other well-known research projects that are described include the COSMIC study, looking at co-morbidity in treatment populations, and the effectiveness and cost effectiveness of CBT for opiate misusers in methadone maintenance treatment. It is helpful to have all these important findings in one publication.

I was particularly interested in the chapters towards the end of the book, focusing on ethnic minority groups, children and young people with drug misusing carers and effective interventions in families where there is parental drug misuse. These are topics that are being debated more and more within addictions and the 2008 drug strategy introduces them as important factors. There are currently 200,000 service users in treatment and half of them are reported to have children. The chapters refer to limited research in these areas and most support tends to be voluntary, with unclear funding. These chapters support the notion of inter-agency working but highlight difficulties, including sharing information and varying thresholds for intervention between services.

This book is excellent at covering a wide range of interesting and relevant issues in drug treatment. The chapters are well written, although there is a degree of repetition when the authors review government strategy for each of their specialist areas. Because of the diverse nature of the research funded within this initiative, the flow of the book is fragmented but I would assume that most readers will dip in and out of the book, depending on the area they are interested in. Each chapter stands alone as a well-rounded discussion paper. On appearance, the book appears to be text heavy and I can’t help feeling it would have benefited from having more tables and graphs, with a layout that is easier on the eye. The contributors raise interesting points in considering the relevance of findings for policy and practice.

The book is a must-read for all addiction clinicians, drug treatment managers, commissioners and policy makers. It neatly delivers its objectives and shows that services have come a long way in treating problem drug users. Responding to Drug Misuse highlights how much more needs to be done, in terms of research and possible changes in service configuration, policy and practice. Susanne MacGregor ends the book by pointing out that research evidence demonstrates the need for much greater attention to prevention, which would require a shift in cultural understanding. She states that “as long as the question of drugs misuse is approached in a sensational and hysterical manner, a reasoned and intelligent debate seems impossible”. Judging by the recent actions of the Home Secretary, I fear we have a big mountain to climb!

Review by Dr Jonathan Dewhurst


Dr Jonathan Dewhurst, SCAN trainee and specialist registrar, Central and North West London NHS Foundation Trust
Two new SCAN addiction psychiatry trainees

SCAN welcomes Dr Vignesh Sakhthivel from Mersey Care NHS Trust and Dr Jonathan Dewhurst from Central and North West London Foundation Trust who were successful in the recent recruitment to this special interest post with SCAN. They are already working with the SCAN team on a number of projects and will be integral in the development of the next trainee and new consultant conference programme.

Members revamp faculty conference

Dr Alison Batterby, Academic Secretary, Faculty of Addictions, Royal College of Psychiatrists

Earlier this year, the faculty carried out a survey to ask what members wanted from their conference. The faculty is listening, and the next conference in Bristol aims to deliver on this agenda on 29-30 April 2010.

It was felt that it was time to “stop whinging” and look at how we move forward by forecasting the future and preparing for it. So our theme will be “the future of addiction psychiatry: pursuit of excellence”.

Who better to open our conference than Alastair Campbell, with his excellent communication and strategic skills?

David Nutt, a distinguished academic who you may have heard of in the press recently, will look with Foresight to 2025. Fabrizio Schifano demystifies the “psychiatrists’ psychedelics” and John Strang discusses what more than methadone and buprenorphine specialists could should be prescribing.

The ‘recovery agenda’ is here and affords us some great opportunities but also some challenges. Geraldine Strathdee looks at recovery from a specialist practice: on the edge complementing our number of workshop-based sessions.

We wanted our conference to be based on clinical practice and research. Mark Prunty’s workshop discusses what more than methadone and buprenorphine specialists could should be prescribing.

We have not shied away from the upcoming challenges or from inviting speakers with differing views. Hopefully, this will provoke lively discussions throughout the conference.

Please come and share views with members of the Executive Committee. It’s your conference!

From the Royal College of Psychiatrists, Faculty of Addictions Psychiatry

Poster prize for trainees in addictions psychiatry

There is a £300 prize to be won for psychiatric trainees who present at the Annual Faculty Residential Meeting on 29 and 30 April 2010.

The Faculty wishes to encourage interest in research in addictions from any psychiatric trainee. The closing date is 28 February.

More information from Dela Goka, dgoka@rcpsych.ac.uk, 020 7235 2351 ext 145

Medical student essay prize in addictions psychiatry

The £200 Medical Student Essay Prize is for 4th and 5th year medical students in the UK & Ireland. The closing date is 28 February.

More information from Candace Gillies-Wright (Faculty Manager), egillies-wright@rcpsych.ac.uk, 020 7235 2351 Ext 234

Bursaries for faculty residential meeting

Bursaries of £250 are available to enable Specialist Registrars, Senior House Officers, Pre Membership Psychiatrists, Trainees, Affiliates and Staff Grades working in the field of addictions psychiatry to attend the Faculty residential meeting in April.

More information from Candace Gillies-Wright; details above.

Both prizes will be awarded at the Annual Faculty Residential Meeting.