

Encouraging general practitioners to treat drug users: an analysis of the policy of 'shared care'.

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General Practitioners (GPs) have both been encouraged to take on more of the treatment for patients with drug addiction problems^{1 2} and have succeeded in doing so³. 'Shared care' arrangements have been part of this process. Yet it is not necessarily self evident that GPs and primary care are the best way to deliver services for drug addiction problems, or that 'shared care' is most appropriate. So where did the policy of 'shared care' come from, what were the agendas behind the concept, and what even does it mean?

One way of investigating this problem is to analyse the various policy documents with a view to determining the origins of the policy, to consider the purposes it was intended to serve, to determine its relationship with other related policies and to determine the problems envisaged and the proposed solutions. To research this area I have analysed the following documents:

- Tackling drugs together: a strategy for England 1995-1998⁴
- The Task Force to Review Services for Drug Misusers⁵
- Tackling drugs to build a better Britain⁶
- Guidelines on Clinical Management 1999⁷
- Guidelines on Clinical Management 2007⁸
- The models of care document⁹

The results are discussed under the headings of *reasons to encourage GP involvement* and *definitions of shared care arrangements*.

Reasons to encourage GP provision and shared care

There are several different agendas in the policy documents, some explicitly stated, others implied. There is an assumption in 'Tackling drugs together'⁴, without providing reasons or evidence, that GPs and primary care are both best placed to take over more addiction work and need encouragement to do so. Advantages of doing so are more explicitly discussed in 'The Task Force to Review Services for Drug Misusers'⁵. These include a view that drug users will see GPs as their first contact and prefer the anonymity of GP services compared to specialist services. The evidence for this is not clear, though a survey (no longer easily accessible) is quoted as stating that users regard GP services as less stigmatising. A further agenda apparent in the Task Force document is that greater GP involvement would allow specialist services to get more people into treatment and deal more effectively with problematic users. This concept is communicated slightly differently in the 1999 Clinical Guidelines⁷ where shared care is seen as a means of reducing referrals for patients with simple problems but encouraging 'selective' referrals to specialist services; shared care is also envisaged as a means of 'enhancing' GP skills with implication of diffusion down from expert, secondary care services. Barriers and problems with GP provision are discussed in many of the documents and include lack of skills as well as adverse attitudes^{5,7}.

Definitions of shared care

Descriptions of shared care arrangements are vague in 'Tackling drugs together'⁴, as in other documents. The Task Force document⁵ describes two possible shared care systems, though it is unclear why they were chosen, and the document goes on to argue that there are a number of possible systems for the involvement of GPs in drug treatment. The description of shared care reach their most expansive level in the 1999 Clinical Guidelines⁷ in which it is described as 'a model that can be applied to any close co-operative work between agencies or services'. Shared care is closely allied to 'multi-disciplinary approaches across different agencies' not only within the drugs field but even 'beyond'.

The confusion about the definition of shared care is illustrated by the 2007 Clinical Guidelines. Shared care and the role of primary and GP care is much less explicitly discussed in this document. Despite the 1999 Clinical Guidelines' very expansive definitions of shared care, and indeed explicit statement that 'there is no single' ideal model of shared care' the 2007 Clinical Guidelines state that 'the single' shared care model described in the 1999 Clinical Guidelines has developed into a range of different models (p 13).

Discussion

A number of agendas appear to be behind the development of greater involvement in drug treatment by GPs. These include views that GP services are less stigmatising and more easily and 'naturally' accessible. The evidence for this appears scanty. Another agenda concerns preventing overload for secondary care. This is not made very explicit but is present in the documents I reviewed, and shared care is seen as the means by which it is believed this will be accomplished. This is a hierarchical concept, with specialist care at the top. The concept is introduced in the Task Force Review, expanded considerably by the 1999 Clinical Guidelines and then apparently retracted in the 2007 Clinical Guidelines.

Conclusion

Different agendas are apparent in policies to encourage GPs to become involved in drug treatment services. These include views that GP services are less stigmatising and more easily and 'naturally' accessible (without much supporting evidence) and will prevent the overload of secondary care. The evidence for shared care, its definition and its effectiveness appears poorly articulated. The objections and barriers to greater GP involvement have not been addressed in any significant way except through the belief that shared care may provide support and education by 'diffusion' down from secondary care.

In order to deliver the best services for patients, it would be useful if future policy were to address in more detail a number of issues, including which group is best placed to deliver drug treatment services in which situation. It is also important that policy documents do not simply reflect what the current practice is, but seek to actively ask questions about what best practice is.

References

- ¹ Groves, P., et al. (1996) The identification and management of substance misuse problems by general practitioners. *Journal of Mental Health*, 1996. 5(2): p. 183-193.
- ² Strang, J., C. Hunt, and C. Gerada (2007) What difference does training make? A randomised trial with waiting-list control of general practitioners seeking advanced training in drug abuse. *Addiction*, 2007. 102: p. 761-770.
- ³ Strang, J., et al.(2005) The prescribing of methadone and other opioids to addicts: national survey of GPs in England and Wales. *The British Journal of General Practice*, 2005. 55: p. 441-451.
- ⁴ United Kingdom Anti Drugs Coordinating Unit (1995) *Tackling drugs together: a strategy for England 1995-1998*. 1995: London:HMSO.
- ⁵ Department of Health (1996) *The Task Force to Review Services for Drug Misusers: Report of an Independent Review of Drug treatment Services in England*, Department of Health.
- ⁶ United Kingdom Anti Drugs Coordination Unit (1998) *Tackling drugs to build a better Britain. The Government's 10-year strategy for tackling drug misuse*, T.S. Office, Editor.
- ⁷ Department of Health, Drug Misuse and Dependence (1999) *Guidelines on Clinical Management*. HMSO: London.
- ⁸ Department of Health (2007) *Drug Misuse and Dependence - Guidelines on Clinical Management*. London.
- ⁹ Department of Health (2002) *Models of care for treatment of adult drug misusers*. National Treatment Agency for Substance Misuse: London.