

Getting it Right in Practice: Collaboration not Competition

Thursday 19 and Friday 20 April 2007
Hilton Birmingham Metropole

Paper Presentations

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Paper 1

Cocaine use and the cardiovascular system

Nat Wright

HMP Leeds

Email: N.Wright@leeds.ac.uk

Biography

Nat is currently the clinical director for substance misuse at HMP Leeds and a GP advisor to the Department of Health Prison Policy Unit. This entails developing drug services within the prison and working across the national prison estate to improve the quality of care offered to drug users. From 2003-2005 he was the GP advisor to the National Treatment Agency for Substance Misuse which entailed working nationally with key stakeholders to develop the primary care drugs agenda. At that time he was also the clinical director for the Leeds Integrated Community Drug Treatment Services. This involved providing clinical leadership, direction, training, mentoring, research and development support to over 50 practices in Leeds which are part of the shared care scheme for drug users. From 1996-2003 he was the lead partner at the NFA health centre for homeless people Leeds, during which time the practice became a first wave beacon practice and an NHS executive approved research practice. He is the chair of the RCGP Health Inequalities Standing Group and has published extensively on the topics of substance use, homelessness, health inequalities and primary care.

Abstract

Background

There is anecdotal evidence of cocaine use adversely affecting the cardiovascular system. However much of the evidence has traditionally been based on isolated case reports. This paper will present the results of a narrative systematic review of the literature pertaining to the link between cocaine and either arterial or venous thrombosis

Methods

Systematic review of Medline, CINAHL, Embase, Psycinfo and Cochrane databases supplemented by hand trawling of relevant journals and reference lists up to June 2004. In-vivo studies and those with clinical endpoints were included in the review.

Results

A total of 2458 abstracts led to 186 full-text papers being retrieved. 15 met the criteria for inclusion in the review. The weight of evidence would support cocaine as a pro-thrombotic agent. There is evidence of it activating thrombotic pathways. The effect of cocaine upon clinical endpoints has not been quantified though there is evidence of an association between cocaine and myocardial infarction particularly amongst young adults. Cocaine may also be a causal agent in cerebrovascular accident though studies lacked sufficient power to determine a statistically significant effect. There is a gap in the evidence pertaining to the issue of cocaine and venous thrombosis.

Conclusions

Clinicians should consider questioning for cocaine use particularly amongst young adults who present with cardiac symptoms. More epidemiological work is required to quantify the effect of cocaine upon both arterial and venous clotting mechanisms.

Paper 2

Alcohol in Primary

Jeff Fernandez

Islington PCT

Email: jeff.fernandez@islingtonpct.nhs.uk

Biography

Abstract

Alcohol, from much of the literature, looking at trends in drinking has shown that the consumption of alcohol is increasing, Often they are associated health complication,; such as cardiac problems (CHD), hypertension, and liver damage through hepatitis. While it is important to treat these physical problems it is important to practice preventive medical treatment. Therefore health education and looking at the problems associated with lifestyle, such as alcohol consumption is important for primary care to focus upon.

In the structure set-up in Islington, the nurse specialist is involved in delivering a service for people with alcohol presentations. The system in Islington is very much introducing the concept of shared-care for alcohol but instead of the medical model a more psychological approach using Motivational interviewing and some Cognitive behavioural Therapy (CBT. This service is now two years old and has been well received by GP's in Islington. A case study of one GP Practice in Islington shows what is achievable with support for this client group.

This paper is an evaluation of the nursing approach showing beneficial results in reducing drinking, or bringing it into some form of control. This was effectively achieved through basic Motivational interviewing and reflective practice. This role is to be expanded in Islington and asks the question should shared care services for alcohol be introduced? If so would they be as successful as the shared-care model for methadone? This paper argues that it would.

Paper 3

High dose Methadone: Remit for a Specialist Service or primary care?

Jeff Fernandez

Islington PCT

Email: jeff.fernandez@islingtonpct.nhs.uk

Biography

Abstract

Literature on the subject of methadone dosing in the area of substance misuse is well documented. Some have argued there is increasingly a place for high dose methadone in specialist services. This is useful in helping to achieve stability and engage clients better.

However, prescribing in primary care is uneven as this is seen a 'specialist area' but the RCGP part 1 and part 2 have achieved a more able and evenly spread prescribing GP in Britain. Also, more promotion from the RCGP for GP's to enter shared care structures in their boroughs have enabled GP's to prescribe, in this field, with greater confidence.

This paper seeks to address whether the national training programme and a shared care structure has enabled a GP to be confident in prescribing at the levels associated with specialist services. With shared care enabling a more confident GP (logically) this should be achievable.

This research looked at this through an audit of all prescribing GP's in Islington who where in shared care. The questions asked where about their training and the mean dose for their patients in shared care. This was compared to the specialist service's methadone audit. The findings will be discussed with the idea promoted that shared care is as able to prescribe at levels similar to specialist services and therefore could accommodate more complex clients as a result.

Paper 4

Wirral Shared Care: A Success

Kevin Holmes

Wirral Drug Service

Email: Kevin.Holmes@cwpsnt.nhs.uk

Biography

Kevin Holmes has worked within the drug treatment field for 15 years and is currently employed as Clinical Coordinator for the GP liaison team at Wirral Drug Service. Kevin is also an accredited facilitator for Part 1 RCGP training has also completed RCGP Part 2 and is a bank tutor.

Wirral Drug Service was recently cited as an excellent service in the national treatment/healthcare commission improvement review and was recognised as one of the top performing services in the country.

Wirral Drug Service is one of the few services in the country that has 100% GP involvement in its shared care scheme.

Abstract

Substance misusing individuals have often presented at GP surgeries. In The past the response from health professionals has been varied. Some GPs prescribed medication for drug use whilst others did not. The GPs who did prescribe for drug use often did so inappropriately due to lack of guidance and support. Those that were unwilling often avoided prescribing due to the lack of guidelines and the potential risk inherent in substitute opiate medication. There was a general lack of consistency in the treatment of drug users across the Wirral. Over the last few years Wirral Drug Service has endeavoured to address these problems by providing a consistent evidence based approach to drug treatment. Since its opening GPs have become actively involved with the service by identifying substance use problems in individuals and referring them for treatment.

Treatment outcome monitoring shows that the treatment provided at Wirral Drug Service measurably improved the health of its clients, reducing drug related harm and enabling them to lead lives that do not revolve solely around drug use. After a period of successful treatment it became clear that a substantial proportion of the clients had progressed to a stage where they no longer required the intensive involvement offered at Wirral Drug Service. It was clear that these individuals could progress further on their treatment journey by receiving their drug treatment at their GP surgery with continued support from the drug service. This led to the creation of the GP Liaison Scheme. This enabled the GP surgeries to again be actively involved in Drug Treatment and allowed the Specialist drugs unit to concentrate its efforts on individuals with more chaotic and harmful patterns of use.

Wirral Drug service was one of the first organisations in the country to offer this service and formalise a coherent plan for the treatment of drug use through the GP surgeries. Each GP surgery on the Wirral now has a Substance Misuse Practitioner attached to it. This Drugs worker jointly manages substance misuse issues in partnership with the patient and the GP. The SMP is able to fully and continually assess new or established patients with substance misuse issues and offer guidance to the GP on appropriate treatment. Drug using individuals have in the past often been viewed as demanding patients who monopolised a Doctors time. By providing a service that listens to the needs of these patients, builds a complete picture of their patterns of use and providing a consistent approach, treatment is now better planned, more effective and less demanding on the GP surgeries. .

GPs have also been provided with a set of both national and local prescribing guidelines enabling them to continue to deliver a consistent approach to presenting drug problems. It can be summarised as the following:-

- Opiate replacement therapy is the generally accepted treatment option (Methadone or Subutex™). No prescribing should take place without a full assessment and urine drug screen taking place. And all prescriptions should be initiated on an increasing titrating basis. An action plan should always be in place.
- No Benzodiazepines to be prescribed unless as an agreed reduction plan. Evidence has shown there is no therapeutic value in the long term prescribing of benzodiazepines and that benzodiazepines are involved in 75% of drug related deaths.
- No Prescribing for substance misuse to take place without discussion with the drug service. If this is not possible due to the patient presenting out of hours it is important to remember that drug use alone, does not qualify as a medical emergency.
- Clients who become unmanageable i.e. complex or non compliant at the GP surgery will have their care transferred to the Specialist Drug service.

Complex would include:

- Drug using patients under the age of 20 or who may be pregnant women or severe alcohol use with co-existing mental health problems, will probably need specialist treatment at the drug service. This is also true for individuals who are severely ill through substance misuse.

The clinics that operate at the GP surgery under the GP liaison scheme take place several times a year. Generally speaking at least six clinics operate per annum at minimum standards in each surgery. Many of the GPs on the Wirral have expressed a desire to be involved to a greater extent in the provision of drug treatment and the clinics at these surgeries operate on a monthly basis. Above all, the treatment of Patients with Substance misuse problems is negotiated with the GP and the patients' involvement. The GP Liaison Scheme has learnt to be flexible enough to accommodate all the different working practices on the Wirral. The shared care delivered through the scheme involves the clients being seen regularly at each surgery, with the SMP and GP present. Between these clinics the SMP will have continued involvement with treatment reviews, home visits and risk assessments each client and will explore substance misuse related issues in more depth than is practical during the GP clinic. The SMP ensures the relevant prescriptions are generated for each clinic, keeps detailed treatment records and takes responsibility for a great deal of the patients' ongoing care.

Training is provided to Surgeries during protected learning sessions and GPs are encouraged and supported to attend RCGP part 1 & 2 certificate in Substance Misuse. Part 1 training is facilitated by members of the GP Liaison team

The GP Liaison Scheme currently consists of 10 full time SMPs. The team has capacity for around 730 clients managed through 65 Surgeries, involving over 200 GPs. Since June 2006 the GP liaison scheme has contracts with all Surgeries in the Wirral giving 100% coverage. This has only been possible with the support from PCTs and Surgeries and individual GPs who have supported this scheme, special mention should be made to Dr Abhi Mantgani and Dr R Edwards who helped to set up the initial scheme and continued to support in persuading reluctant GPs to join scheme.

Paper 5

Collaboration Promotes Success of GP Lead Prescribing Services in Forth Valley

Leona Paget

NHS Forth Valley

Email: Leona.Paget@fvhb.scot.nhs.uk

Jean Logan

NHS Forth Valley

Email: jean.logan@fvhb.scot.nhs.uk

Biography

Leona Paget. RGN; BSc Nursing; Extended, Independent & Supplementary Nurse Prescribing. GP Prescribing Co-ordinator, GP Prescribing Service.

Qualified as a RGN at Glasgow Royal infirmary in December 1991. Her first job was as a Nurse Officer in HMP Saughton, Edinburgh in 1992; she then transferred to HMP & YOI Cornton Vale in August of that year. During Leona's time at Cornton Vale which was the only female prison in Scotland ensured that her background had a firm foundation within the drugs, alcohol and mental health arena.

In 2001, Leona then became the Substance Misuse Development worker in Clackmannanshire for the Forth Valley Substance Action Team working towards implementing the national drug and alcohol strategies at a local level. Leona was heavily involved with the voluntary sector and developing substance services throughout Forth Valley. One of these services was GP Prescribing Service (GPPS), which Leona has been the co-ordinator of since November 2005.

This service is for opiate dependent clients who wish to move towards reduction and abstinence and are prescribed for by their own GPs with intensive keyworking support from Signpost FV, input from their community pharmacists, the Area Specialist Pharmacist in Substance Misuse and the other treatment services in FV.

GPPS works closely with the short term detoxification service FV-Tox, who offers 28 day reduction on buprenorphine, lofexidine and methadone.

Leona has just recently qualified as an Extended, Independent and Supplementary Nurse Prescriber and hopes to develop GPPS in the near future to incorporate this.

Jean B. Logan, BSc(Hons), MRPharmS, MSc

Specialist Pharmacist in Substance Misuse, NHS Forth Valley.

Jean graduated from Heriot Watt University in 1980 and registered with the Royal Pharmaceutical Society of GB in 1981. After a year in hospital pharmacy, she moved to gain experience in the retail sector as Pharmacy Manager with Boots the Chemist in Stirling. In 1984 Jean was appointed Staff Pharmacist at Bellsdyke Hospital, Larbert, working within learning disabilities and mental health.

From 1987 to 1993 Jean worked part time as a community pharmacy locum before returning to the speciality of mental health. She took up a clinical post part time with NHS Forth Valley and progressed to Lead Clinical Pharmacist in 2001. During this time she also pursued her interest in forensic psychiatry when she was appointed Principal Clinical Pharmacist at the State Hospital, Carstairs in 2000. She continued the two parallel posts till October 2004 when she concentrated her efforts within NHS Forth Valley.

Jean has maintained a keen interest in substance misuse throughout her career and was delighted to take up the opportunity to work in this field, being appointed to her current post in April 2006. She has undertaken an extensive review of community pharmacy services and is actively promoting education and development, working closely with the GP Prescribing Service Co-ordinator. She also works in collaboration with all prescribing services to develop guidelines, policies and procedures as part of the clinical governance agenda.

Abstract

Limitations in the capacity of the Specialist Drug Services were highlighted by the emergence of increasingly long waiting lists and lengthy waiting times during 2004-5. The three multi-agency Substance Misuse Fora identified a lack of alternative treatment service options for local drug users seeking help. The Substance Action Team (SAT) supported the need to increase capacity by expanding the range of services and increasing accessibility, the result being the inception of GP led prescribing services. Two services have evolved: GP Prescribing Service (GPPS) a time limited exit service, which includes methadone prescription and Forth Valley Detoxification Service (FV-TOX) which utilises buprenorphine, lofexidine and methadone (mainly buprenorphine). FV-Tox employs a sessional GP. Both services employ keyworkers from the voluntary organisation, Signpost Forth Valley.

A GP Prescribing Service Co-ordinator (GPPC) and an Area Specialist Pharmacist in Substance Misuse (ASPiSM) were recruited to provide support for GPs and Community Pharmacists and liaise with the Specialist Drug Services and Signpost.

The GPPC developed a training programme, published a service manual and encourages engagement in the GPPS by offering one-to-one support. Close liaison with and referral pathways to specialist drug services for clients with more complex needs were crucial in reassuring the GPs. During the first year, 31 GPs enrolled in the service and 99 clients received methadone prescriptions, and there are currently 72 active clients and 11 of whom are now in the reducing phase.

The ASPiSM undertook a survey of community pharmacists to identify dispensing capacity and training needs. Subsequent training events and information packs have been issued to address issues raised. The ASPiSM developed the buprenorphine guidance and procedures for FV-TOX in close collaboration with the GP Specialist, Signpost Manager and the Specialist Drug Service Consultant.

Paper 6

Heroin and Crack Injection: Providing Integrated Responses and Interventions to Combined Drug Injectors

Danny Morris

Herefordshire PCT

Email: dannymorris@mac.com

Claire Robbins

Soho Rapid Access Clinic

Email: claire.robbins@nhs.net

Biography

Claire Robbins: Is a qualified nurse who has been working in the drugs field for 25 years, she has a Masters degree from Imperial College in Drug Use: Policy and Evidence Based Interventions and a Certificate in Family and Marital therapy (IFT). She has worked in both the statutory and voluntary sectors, and currently works for CNWL Substance Misuse Services at the Soho Rapid Access Clinic, who specialise in working with the homeless and vulnerably housed drug using community of Westminster.

As well as working in mainstream prescribing services, and GP surgeries Claire has provided drugs, welfare advice and support at many dance events, festivals and free parties, while working for Release as development officer for the Safer Dancing Initiative. She is an executive committee member of the U K Harm Reduction Alliance. Claire is committed to improving services offered to drug users and supporting service user led initiatives.

Danny Morris (Certificate of Qualification in Social Work (1986), Certificate in Counselling (BAC 1989), Practitioners Diploma in Neuro-Linguistic Programming (1998)) has nineteen years experience in the field of drug dependency. This has included in Detached Community Work, Outreach, HIV and Drug Treatment Services, in both the statutory and non-statutory sectors where he has been a practitioner and manager. He has also worked as a Commissioner in the Drugs/HIV field.

Danny is currently the Development Manager for an NHS Drug Treatment Service (Dash, Herefordshire PCT) providing a range of practical and therapeutic interventions for drug users with the aim of reducing all drug related harm. He is committed to the development of progressive and evidence based services that enhance all aspects of drug treatment provision.

He is an experienced freelance trainer and has, for over 14 years has been providing independent consultancy and training specialising in harm reduction approaches. Danny is an Executive Committee member for the UK Harm Reduction Alliance (Ukhra).

Abstract

Combined heroin and crack injection is increasingly being reported in many areas across the UK. The injecting practices associated with 'speedballing/snowballing' are related to a rise in extensive injecting related damage amongst this group of drug users.

UK drug treatment in primary care and related services have developed over many years largely in response to growing opiate use trends but would appear to be less well equipped to support, manage and provide appropriate responses to those injecting crack and heroin in combination. Many GPs and drug practitioners feel de-skilled in dealing with what is considered as a growing phenomenon although it has been suggested that many GP's are already working with this population without realising it.

This presentation will provide participants with up to date knowledge of combined heroin and crack injection, both practical and academic, and with references to pharmacology, user perceptions of the effects of 'speedballing/snowballing' and risks and consider how this understanding can inform the development of more effective interventions to combined users to reduce injecting and other drug related harms.

We will provide an overview of the current literature from UK and international sources and discuss indicators that may relate to the associated and increased injecting related harm, including the acquisition of HIV, HCV, HBV, bacterial infections, overdose and other areas of physical and psychological health concerns.

This presentation will explore the issues for both prescribers and recipients of substitute therapy within primary care. It will allow for the examination of the differences between the smoking and injection, both real and perceived, based on studies and extensive clinical discussions with crack and heroin injectors in central London and with those within a rural environment and consider the implications for prescribing from a primary care setting.

The presentation will conclude by looking at some of the challenges to working effectively with those injecting heroin and crack. We will make reference to models of good practice and consider how these can assist those in primary care and specialist services in meeting the evolving patterns drug injecting by developing interventions that reduce the harms associated with combined drug use.

Paper 7

Safeguarding the Children of Substance Misusing Parents within Primary Care - The Torbay Approach

Maria McTiernan

Torbay PCT

Email: Maria.Mctiernan@nhs.net

Biography

Maria McTiernan is a qualified General Nurse, Psychiatric Nurse and Health Visitor. Prior to Health Visiting she worked as a Staff Nurse on an Acute Psychiatric admission ward. Since qualifying as a Health Visitor 14 years ago she has worked within a number of different geographical areas with diverse practice populations within the Torbay area.

Maria was the second Specialist Health Visitor for Substance Misuse appointed nationally and has been in post since 2002. She has set up a service within Torbay specifically aimed at reducing the impact of Parental Substance Misuse upon children and is the strategic lead for the Hidden Harm Agenda. She currently chairs the "Children of Substance Misusing Parents Sub-group" of the Torbay Children's Safeguarding board, (who have subsequently identified these children as a priority for 2007-8). She has Co-organised two Devon Wide Hidden Harm Conferences and delivered Multi-agency training since 2002. Maria is the South West Regional Trainer for the Alcohol Concern Parenting Programme.

Abstract

'For many children living with parental substance misuse, life can be difficult, dangerous and frightening' {Kroll and Taylor 2003} {1}

This abstract is a project that has been evaluated and contains a paper waiting to be written up. The subject matter is pertinent to the conference and will be of interest to the delegates.

The paper will explore the concept of working with parents who misuse substances within the primary care setting and the dilemmas and challenges faced by professionals whilst keeping the focus on the child.

Exciting developments are happening within Devon as we are developing a pro-active approach. To date we have had two Devon-Wide Hidden Harm Conferences with an emphasis on good practice and shared protocols {2}. We have research completed by David Monk in 2003 which identified an above average incidence of substance misuse at child protection case conferences {3} There is currently Department of Health funded research in progress with Brynna Krull and Andy Taylor at the University Of Plymouth in Exeter.

Within Torbay, we are developing an early intervention approach, where all agencies ask whether a substance misusing adult is a parent. We are improving and evolving services that are universal, targeted and specialist. The Torbay Children's' Safeguarding Board have identified these children as a priority for 2007-8 and we have mainstreamed multi-agency training. This approach will be the subject of this paper and I shall discuss the impact of the service our emerging outcomes and planned future developments.

References

1. Kroll,B, Taylor,A.{2003 }" *Parental Substance Misuse and Child Welfare.*" London. Jessica Kingsley Publishers.
- 2, "*Hidden Harm –working together to help children of substance misusing parents*" {2006} Page 4,"Partnerships, tackling drugs and Crime in the Southwest". Government Office for the South West Crime and Drugs Team
- 3,"A Snapshot of Child Protection Cases in east, mid and west Devon" 2003. David Monk
- 4, Kroll,B.Taylor,A. "*Interventions with children and families where there is a problematic parental drug use; the development and evaluation of an interagency model of good practice*". Department of Health funded research in progress at the University of Plymouth.

Paper 8

Drug consumption rooms: a setting for delivering primary care in the UK?

Neil Hunt

Freelance Researcher

Email: neil@dadden.demon.co.uk

Nat Wright

HMP Leeds

Email: N.Wright@leeds.ac.uk

Biography

Neil Hunt, MSc (Social Research) is an Honorary Senior Research Associate at the European Institute for of Social Services, University of Kent, Honorary Research Fellow with the Centre for Research on Drugs and Health Behaviour, London School of hygiene and Tropical Medicine and Director of Research for the treatment agency KCA. A founding director of the UK Harm Reduction Alliance, his work has covered issues including injecting and risk, understanding drug trends, peer influence and young people, human rights and drug user involvement. He developed the 'Break the Cycle' intervention to reduce injecting that has been disseminated nationally by the Department of Health. He has completed various commissioned reviews of the evidence base for harm reduction and has recently worked as a researcher on the 'QCT-Europe' project, which examined the effectiveness of 'Quasi-Compulsory Treatments' such as DTTOs and a Department of Health funded investigation of the determinants of early-exit from treatment. Among his recent publications is the Beckley Foundation report *Cannabis and mental health: responses to the emerging evidence* and several technical reports on drug Consumption Rooms that contributed to the Joseph Rowntree Foundation's report advocating their pilot evaluation in the UK.

Nat Wright is currently the clinical director for substance misuse at HMP Leeds and a GP advisor to the Department of Health Prison Policy Unit. This entails developing drug services within the prison and working across the national prison estate to improve the quality of care offered to drug users. From 2003-2005 he was the GP advisor to the National Treatment Agency for Substance Misuse which entailed working nationally with key stakeholders to develop the primary care drugs agenda. At that time he was also the clinical director for the Leeds Integrated Community Drug Treatment Services. This involved providing clinical leadership, direction, training, mentoring, research and development support to over 50 practices in Leeds which are part of the shared care scheme for drug users. From 1996-2003 he was the lead partner at the NFA health centre for homeless people Leeds, during which time the practice became a first wave beacon practice and an NHS executive approved research practice. He is the chair of the RCGP Health Inequalities Standing Group and has published extensively on the topics of substance use, homelessness, health inequalities and primary care.

Abstract

Drug consumption rooms (DCRs) are rooms specifically set up for the supervised, hygienic consumption of pre-obtained, illicit drugs. Their objectives include both the reduction of risk/enhancement of the health and well-being of drug users and, the reduction of community nuisance associated with public drug use. Internationally, a growing body of evidence exists regarding the effectiveness of DCRs. They do not currently operate in the UK but in recent years there has been increasing debate about their potential role.

This paper will describe some key features of their operation in countries elsewhere with reference to a) the vulnerability of the drug using populations they engage, b) the opportunities they provide for different healthcare interventions and, c) indicators of the level of need that exists within the UK.

Drawing extensively on an independent review funded by the Joseph Rowntree Foundation (JRF), we will identify a range of ways in which DCRs may be understood as a potential setting for delivering primary care to some of the most marginalised drug users in the UK. These arguments will be discussed in the context of the government's response to the JRF report and 'next steps' within an evidence-based drug strategy.

Paper 9

The Illicit Diversion of Methadone and Benzodiazepines

Mark Knight

Salford DAAT

Email: mark.knight@salford.gov.uk

Mick McKernan

Salford DAAT

Email: mckernanmf@onetel.com

Biography

Mark Knight is the Research and Data Manager for Salford Drug and Alcohol Action Team. He has a background in social policy and research and has worked in the drugs field for around 10 years with organisations including Trafford Substance Misuse Services and Lifeline. He recently completed an MSc (by research) on the diversion of prescription medications and has an article on diversion and its implications in the latest edition of 'Network', the SMMGP newsletter.

Mick McKernan is GP Lead at Salford Drug and Alcohol Action Team. He has an interest in research and in education/training and has published work on diabetes in the past. He is also in charge of clinical care services for youths with alcohol and drug problems in Salford

Abstract

The drugs most commonly prescribed to problematic drug users, namely methadone linctus and benzodiazepines, are also those most likely to be diverted by them. This presentation will employ findings from qualitative interviews with polydrug users to explore illicit diversion and patterns of drug use involving these prescription medications. It will also seek to provide an understanding of local market dynamics and the reasons that interviewees offered for the use of these drugs.

Methadone was apparently used functionally with regular users endeavouring to ensure they had a supply for the start of the day. Heroin droughts would appear to be very rare but a preponderance of weak heroin was associated with a need to hold onto and use methadone in place of heroin or to compensate for its weakness. In contrast, the main appeal of benzodiazepines was their intoxicating effect and versatility in combination with other drugs.

It would appear that use of diverted methadone is limited to heroin using circles and the role of methadone as a safety net for such people is central to understanding the market for it. The rotational nature of methadone trade may also make it difficult to distinguish buyers from sellers. In contrast, the market for benzodiazepines would not appear to be associated with the same 'rotation' of drug debts and supply and demand extends beyond heroin using circles. However, essentially we found that the markets for both drugs involved small networks of individuals who tend not to attract police attention.

Paper 10

Substance Misuse in Pregnancy - How reliable is routine enquiry in detecting women who are substance abusers and the role of Urine Toxicology

Olubunmi Oniya

Royal Alexandra Hospital, Paisley

Email: bunmi_oniya@yahoo.co.uk

Biography

Abstract

For the first time ever a separate a chapter was included in the last confidential enquiry on substance misuse in pregnancy. 31 women were known to have died due to directly or consequent to their substance misuse. Apart from known and or registered substance misuses, the diagnosis is often heavily reliant on direct enquiry during antenatal booking and this is the recommended mode of detection. Because substance misuse is illegal and associated with a lot of social stigma coupled with the fear of child protection issues and the real possibility of children being taken away, some substance abusers will deny substance misuse during routine enquiry. Noting that a patient is visibly intoxicated at antenatal visit often only prompts new diagnosis.

While Urine Toxicology is a sure method of detecting the presence of illegal substances it is often only offered to known users to detect the presence of continued use or undeclared substances? It is not usually employed as routine for women not known to be using illicit drugs. It is further limited by the fact that probably only substances that have been used only during a specified amount of time will likely be detected.

The Paisley area in Renfrewshire has a big population of women in childbearing age known to be substance abusers. We audited the women known to be users in Royal Alexandra Hospital Paisley who had been pregnant or had had confinements during the year 2004 and 2005. they represented 33.5% of all referrals for Special Needs In Pregnancy. (SNIPS)

We then studied the correlation between what substances was declared during routine enquiry and what was found in the urine samples of those who had urine Toxicology performed. A total number of 59 patients were audited

RESULTS

AMPHETAMINES (Speed & Ecstasy)

Only 1(1.7%) woman was positive for amphetamines although 8(13.6%) patients had admitted to regular use.

BENZODIAZEPINES

33(56%) patients were positive for Benzodiazepines although only 18(30.5% had admitted to regular use. An Additional 16(27.1%) patients who had denied use of Benzodiazepines during routine enquiry were actually found to have positive Toxicology.

METHADONE

Only 31(52.4%) out of 41(69.5%) women known to be on Methadone tested positive. All Toxicology positive patients were known to have been using Methadone and had admitted to use during routine enquiry. Urine Toxicology did not detect any additional patients

OPIATES (Heroin)

32(54.2%) patients had admitted Opiate misuse. 29(49.1%) tested positive. 7 (11.9%) additional patients who were not known Opiate users had positive toxicology.

COCAINE

Only 4(6.8%) women were Positive for cocaine. 5 (8.5%) women had admitted to regular Cocaine use. Only 1(1.7%) patient who admitted use was found to be positive and 3(5.1%) additional women who had not volunteered cocaine misuse were found to have positive toxicology.

CONCLUSION

This study shows that although most women by far are honest about disclosing which substances are being abused, substance abuse in pregnancy may be underreported during routine enquiry. In known substance abusers other undeclared drugs may continue to be used in addition to those already known.

For those on Detoxification programmes illicit use may continue in addition to Methadone.

Amphetamines are unlikely to be detected on routine toxicology even in known users.

More women were likely to deny Benzodiazepine (16 patients 27.1%) and Opiate (7 patients 11.9%) use. Some women who are on Benzodiazepines as prescribed medication solicit additional illegal sources.

Most patients on Methadone are usually already known to the healthcare system although many patients on Methadone (10 patients 17%) still tested negative showing the limitation of Urine toxicology depending on the interval between last use and time of testing.

It is possible to obtain Methadone illegally as some patients on prescribed Methadone will sell their medication to procure opiates although the incidence of this has significantly reduced with the introduction of making patients drink their Methadone in the presence of the dispensing Pharmacist.

Cocaine is expensive and likely to be smoked in crack form. Although not as commonly used as other illicit substances it is probably the least likely to be declared as use is often recreational just as is the use of Amphetamines. 3 additional patients (5.1%) Tested positive for cocaine.

Although routine enquiry will continue to be the mainstay of detecting substance abusers in pregnancy and most women are by far honest about declaring which substances are being abused, a good proportion of women will still seek to conceal their substance misuse.

The use of routine urine toxicology will aid in recognising more patients and help in monitoring compliance in patients on detoxification programmes. Routine Toxicology raises the issue of consent and confidentiality but this may be advisable in patients already known to be misusers as toxicology will detect other substances being used and not declared.

Paper 11

Training A&E Staff to Treat Drug Users for Both Pain & Withdrawal

Sandra O'Neill

AdAstra Treatment Centre

Email: sandraoneill@adastracentre.org.uk

Biography

Following more than a decade in mainstream management consulting, Sandra O'Neill, MSc Psych, changed career paths and moved into the field of addictions. Frustrated by the vagaries of treatment frameworks in the United States, she moved to the United Kingdom in 2001. After running the Training Unit at Mainliners and then creating her own training company, Networx Training, with a colleague, she subsequently entered into drug treatment counselling in private practice, preferring the level of independence that it provided and removing many of the limitations she had encountered in her past work. Ms. O'Neill is a counsellor and a Director of AdAstra Treatment Centre, Ltd., a private substance dependency treatment clinic in Central London.

Abstract

Background: A hospital Accident and Emergency department requested a basic training programme for staff to attend whilst on rotation through that department.

Emergency Medical Services often fail to treat drug users presenting with abscesses, DVT, etc., appropriately, underestimating the value of early intervention in minimising harm and the opportunity to act as a conduit into drug treatment.

Approach: Develop a training course which would inform A&E staff about the basics of treating drug users for both pain and withdrawal and which would also focus on a paradigm shift allowing the A&E staff to look at the individual as a person in need rather than as a drug user with a self-inflicted injury. The course needed to address basic drugs awareness, basic assessment skills, treatment guidelines already in effect protecting the hospital staff, opiate equianalgesia, tolerance vs. addiction and the roles of empathy and congruence in gaining the trust of the user in order to ensure that effective care can be provided.

Course Topics:

- Understanding Drugs & Drug Users
- Recognising Signs & Symptoms of Drug Use in Clients Presenting for Acute/Urgent Care
- Basic Assessment & Onward Referrals to Appropriate Drug Treatment Services, Needle Exchange, etc.
- Understanding the Roles of Empathy & Congruence When Treating Drug Users
- Managing Pain & Withdrawal in Drug Users

Conclusions: There appear to be two major reasons that drug users either fail to seek emergency medical care or self-exclude; 1) that A&E staff often see these injuries as 'self-inflicted' and thus fail to treat the user with appropriate pain relief and opiates for withdrawal; and 2) that drug users are reluctant to wait hours and risk withdrawal whilst in care. When appropriately educated, A&E staff can both treat the user for the immediate crisis and serve as a gateway into harm reduction. Often, a crisis admission to hospital can effectively be used as a motivator to enter into substance misuse treatment.

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The Role of Private Therapy in Substance Misuse Services

Elaine Beard

AdAstra Treatment Centre

Email: drbeard@adastracentre.org.uk

Biography

Dr Beard first encountered the problems of substance misuse whilst working as a General Practitioner. Moved to action by the suffering she encountered with these individuals, she began to specialise in addiction, focusing on the psychological and psychosocial underlying causes of substance dependency. Dr Beard was deeply moved by her experience treating drug users; she found the work both challenging and rewarding, and moved full-time into the field of substance misuse. With a degree in psychology and years of experience in drug treatment, both within the NHS and private practice, Dr Beard has dedicated her life to the pursuit of best practice within the field of addiction. Dr Beard is Clinical Director of AdAstra Treatment Centre, Ltd., a small private substance dependency clinic in Central London.

Abstract

Addressing attitudes to the use of private medicine in substance misuse treatment compared with those of other branches of medicine in the Statutory and Voluntary Sectors.

- Negative Perceptions of Private Treatment
 - Doctors motivated by profit; patient's by greed
 - Doctor/Patient complicity in overmedication
 - Legal Drug Dealing by unethical, unqualified doctors causing diversion
- The Realities of Ethical Private Treatment
 - Fills gaps in NHS provision
 - More suited to the employed patient
 - No waiting lists, rapid intake
 - Clear need for high moral and ethical ethos
 - Draws workers and volunteers who are motivated by altruism, not pay grade
 - Reduces drain on NHS resources
 - Addresses occasional issues requiring confidential care
- Principles of Ethical Private Treatment
 - Thorough Assessment
 - Titration
 - Care Plans
 - Liaison with the General Practitioner
 - Taking the time to effect change
 - Patient-Centred Treatment
 - Empathy, Congruence and Unconditional Positive Regard
 - Staff trained in multiple theoretical models of counselling
- Steps Towards Best Practice
 - Attending to Individual Patient Needs and Goals
 - Extended Hours and Flexible Appointment Times
 - Supervision: The Policy Review Board
 - Ongoing Education and Training
 - Up to Date Research into the Evidence Base
 - Continual Review of Statistical Data

- A Vision of Ethical Private Treatment
 - Appropriate Assessment and Titration
 - Stabilisation
 - Short-, medium-, and long-term care plans
 - Strong Therapeutic Alliances between Workers and Patients
 - Addressing the underlying issues to prevent long-term relapse