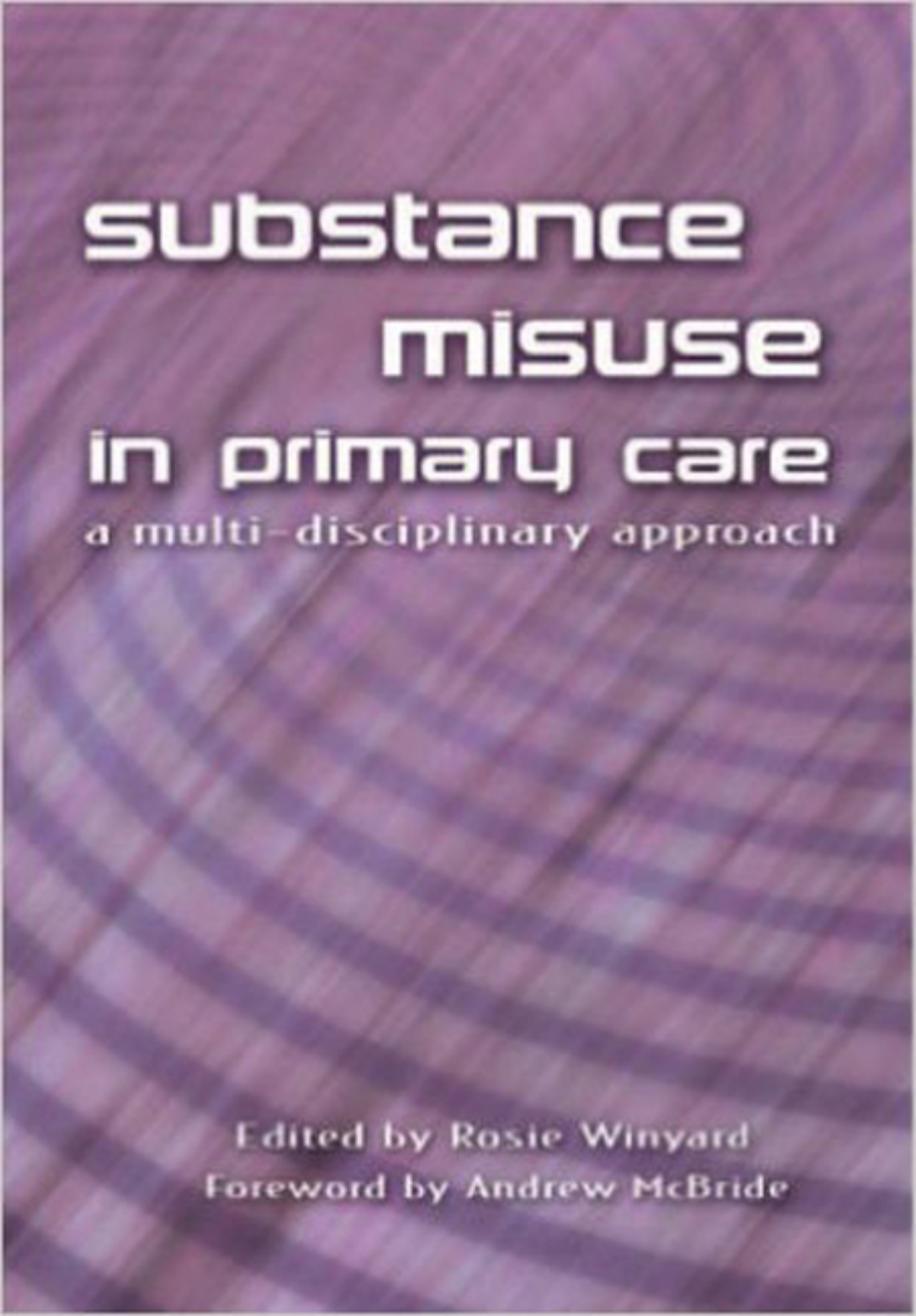
substance misuse in primary care
a multi-disciplinary approach
Edited by Rosie Winyard
Foreword by Andrew McBride

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Foreword

It is with great pleasure that I 'fast-foreword' you to this multi-disciplinary book about primary care services for people with substance related problems.

Health responses to drugs have been somewhat overshadowed in recent years by criminal justice priorities, but no doubt the political pendulum will swing back towards health when fashions change. Such changing, complex, overlapping and sometimes frankly contradictory government agendas, have led, nonetheless, to a great expansion of diverse services for drug users during the last 20 years. Unfortunately, this has not been matched by services for people with alcohol problems.

In my view, the single most positive step in the evolution of accessible and unstigmatised services for drug users seeking help has been the development of primary care and pharmacy based help.

I would draw a parallel with the delivery of services for another long-term problem, diabetes. When I was training, most people with diabetes were dealt with by 'specialists' in hospital outpatient clinics – not very user friendly, inefficient and expensive. Now diabetes is managed in primary care (unless the complexity and severity of the disorder demands additional input). Practice nurses and some GPs have developed particular interests whilst others are skilled enough to undertake the day-to-day tasks. I would not seek to push any of the possible parallels too far, but, like diabetes, substance related problems tend to last for years rather than weeks and impact beyond the individual into the family. The only agency in existing UK systems which has lifelong opportunities for monitoring and gently encouraging people into healthier lives is primary care. The pressure in most other health, welfare and criminal justice areas is to move towards shorter, more intensive and, heaven help us, 'cleverer' options.

Even in places where primary care involvement in the treatment of drug users is most developed, we are still some way from drug misuse treatment being 'normalised' in quite this way, but progress has been relentless and positive so far. The institutionalisation of drug use and alcohol related problems as 'other' in the latest GPs' contract may yet halt or even reverse these positive changes.

There can be little doubt that primary care is best placed to deal with the physical and mental health needs of most people with problematic substance use. In addition to their high prevalence and chronicity, primary care is where problems usually present and where people are most likely to stay. The evidence also supports this approach.

> Rapid entry into treatment and the duration of treatment ... may be more important than the intensity of treatment ... providers should

> consider structuring their programmes to emphasise continuity rather than intensity of care.[1]

The majority of people who drink too much or use too many drugs simply do not want or need 'specialist' help most of the time. Specialists can be defined by their client group, expertise or qualifications, exclusive methods of practice, or a specific organisational structure. Let us examine these possibilities one by one: psychoactive drug use is endemic; 'expertise' is of limited demonstrable advantage; effective interventions available to the majority of professionals and existing organisational systems are probably more a hindrance than a benefit to most service users. Further, there is no unitary explanatory theory for the pleasures of using substances, no single understanding of all the problems associated with substance use, and limited knowledge about the pathways to happier, healthier ways of living with intoxicating substances.

The good news for generalists and specialists alike is that the art of working with people is both the challenge and the pleasure of this type of work, and, generally speaking, the simpler the intervention the better the evidence of efficacy. To be aware of what we know and can do, and equally aware of what we do not know and cannot or should not do, must always be our aspiration. Working with people and their substance related problems requires wisdom, humility, patience and pragmatism; as well as knowledge and skill. In my experience these virtues are valued in primary care perhaps more than in some other professional areas.

This book will be of great value for all those interested in this important area of endeavour, and will contribute positively to attitudes, understanding and knowledge. And I say all of this from the perspective of a specialist. So, forward, onward and upward into the book itself ...

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February 2005

Reference

1 Moos RH and Moos BS (2003) Long-term influence of duration and intensity of treatment on previously untreated individuals with alcohol use disorders. *Addiction*. **98**(3): 325–37.

Andrew McBride FRCPsych has been a Consultant Psychiatrist with the Specialist Community Addictions Service in Oxford since 2002. Previously, he was Clinical Director of the Community Addictions Unit, Cardiff and Vale. He has co-edited the introductory text book *Working with Substance Misusers: a guide to theory and practice* for Routledge (2002) and the forthcoming *Injecting Illicit Drugs* for Blackwells (2005).

Preface

This book takes the patient with a substance misuse problem on a journey to meet their treatment needs. Along the way they come into contact with many skilled healthcare professionals and user advocates, all currently or recently working in primary care.

You are invited to 'listen in' to consultations and reflect on your own practice in order to develop new knowledge and share in the skills of these practitioners. The chapters in this edited volume are not designed to be 'stand alone' but rather link together and cross reference to provide a more comprehensive picture of treatment services.

Some of the contributors have never written for publication before, while others have published extensively. All chose to give their time to write because of their commitment to improve the treatment experience of people with substance misuse problems. In addition they wanted to share their perspective of developing primary care services.

Together they provide an example of a multi-disciplinary partnership – the theme of this book – and a very powerful force for change. I would particularly like to thank all the people who enabled this book to become a reality. These include Andrew McBride, Sue Pritchard, Maggie Pettifer and Jamie Etherington. In addition I acknowledge the help and support from staff at Luther Street including Dr Sally Reynolds, Liz Short, Natalie Goodman and all others who provided inspiration, knowledge and advice. I would also like to thank my two sons, Timothy and Matthew, for keeping me in touch with the challenges of growing up as teenagers in the 21st century.

This book is dedicated to all the patients and staff at Luther Street Medical Centre for the Homeless in Oxford, past and present, from whom I have learned so much. They are an inspirational team who together work out a shared vision for the practice to adopt a multi-disciplinary partnership approach to substance misuse treatments.

Rosie Winyard
February 2005

About the editor

Rosie Winyard RGN, HV, MSc is an addiction team leader/nurse practitioner at the Luther Street Medical Centre for the Homeless, Oxford City PCT. She is also a visiting lecturer at the Department of Healthcare at Oxford Brookes University. She holds a Postgraduate Diploma in Addictive Behaviour from St George's Hospital Medical School, London, and was formerly clinical nurse specialist with the Specialist Community Addictions Service, Oxford. Rosie has also worked as a Health Visitor in primary care services for over 10 years in Oxford and Leeds.

Luther Street Medical Centre is a specialist primary care practice for homeless people that was established in 1985 in a portakabin next to the Night Shelter in Oxford. This moved to a new building in 1998 that is currently being further extended to accommodate the increasing range of services and growing staff team. The centre is based on a partnership between a charitable Trust – the Oxford Homeless Medical Fund – and Oxford City Primary Care Trust. Addiction nurses are directly employed by the PCT to work in the practice and together with GPs, specialist nurses and social support staff, work together to meet the health needs of homeless people in Oxford as part of the 'Shared Care' scheme. Currently 100 people are receiving substitute prescribing for either maintenance or detoxification but overall there are over 500 registered patients, not all of whom have substance misuse problems.

The practice is the base for visiting psychiatrists, complimentary therapists, hepatologists and podiatrists. It is still located in the centre of the city next to the Night Shelter and nearby hospitals.

Luther Street Medical Centre is a treatment centre for all primary care including drugs, alcohol misuse, mental and physical health problems. It epitomises an inclusive, open-access treatment approach with the fundamental aim of destigmatising issues of vulnerability and homelessness. The centre is managed by a Leadership Team including a GP, practice manager, addiction team leader and nurse team leader, who work closely with the Head of Primary Care in implementing the requirements of a Primary Care Trust – Medical Services (PCT–MS) contract.

The editor's values remain her own, including that non-problematic drug use is acceptable. Nurse-led treatment is an opportunity to develop a wider range of high-quality addiction services according to protocols for care developed with medical colleagues and pharmacists, and regularly monitored and reviewed with PCT and DAAT commissioners. Patients have the right to participate as equal partners in both designing, implementing and evaluating their treatments. These should include opportunities for both abstinence and maintenance with different

substitute medications. 'Designer Treatment' can achieve its optimum potential if all the partners are given equal opportunities to contribute to its development in the areas of local primary care delivery and also on the wider policy making stage. The future workforce for both addiction nurses and drugs workers is dependent on the manner in which this is integrated today into RCN, RCGP, NTA and NHS policy making.

List of contributors

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Marguerite Williams is the child protection co-ordinator with Luton Teaching PCT.

Rowan Williams has promoted and developed drug user involvement since 2001. She is seconded to Oxfordshire DAAT from the Substance Misuse Arrest Referral Team Criminal Justice Services (SMART CJS), a voluntary sector organisation providing arrest referral across the Thames Valley. Rowan has assisted in the development of OUT, an independent user-led charity, delivering peer education and user involvement in the south-east.

List of abbreviations

A&E	Accidentxixixixixi and Emergency
AA	Alcoholics Anonymous
ACPC	Area Child Protection Committee
ADHD	Attention Deficit Hyperactivity Disorder
AUDIT	Alcohol use disorders identification test
BACP	British Association for Counselling and Psychotherapy
BAI	Beck anxiety inventory
BDI	Beck depression inventory
BME	Black and minority ethnic communities
BMI	Body mass index
CaFCaSS	Child and Family Court Advisory and Support Services
CAT	Cognitive analytic therapy
CBT	Cognitive behavioural therapy
CHD	Coronary heart disease
CMHT	Community Mental Health Team
D(A)AT	Drug (and Alcohol) Action Team
DANOS	Drug and Alcohol National Occupational Standards
DAST	Drug abuse screening test
DEA	Drug Enforcement Agency
DIP	Drug interventions programme
DoH	Department of Health
DTTO	Drug Treatment and Testing Order
DVT	Deep vein thrombosis
EMIS	Electronic Medical Information System
ETO	Enhancing treatment outcomes
FAE	Foetal alcohol effects
FAS	Foetal alcohol syndrome
FAST	Fast alcohol screening test
GCP	Graded care profile
GMC	General Medical Council
GMS	General medical services
GP	General practitioner
GPSI	General practitioner with a special interest
GUM	Genito-urinary medicine
HADS	Hospital anxiety and depression scale
HEA	Health Education Authority
HIV	Human immunodeficiency virus
ICAS	Independent Complaints Advocacy Service

iu	international units
IUGR	Intrauterine growth retardation
JCVI	Joint Committee for Vaccines and Immunisations
LAT	Local Authority Trust
LES	Locally enhanced service
LFT	Liver function test
LGDF	Local Government Drug Forum
LHB	Local Health Board
LSCB	Local Safeguarding Children's Board
MET	Motivational enhancement therapy
NA	Narcotics Anonymous
NES	Nationally enhanced service
NFA	No fixed abode
NHS	National Health Service
NMC	Nursing and Midwifery Council, formerly the UKCC
NTA	National Treatment Agency
NTORS	National Treatment Outcome Research Study
OUT	Oxfordshire User Team
PALS	Patient Advisory and Liaison Services
PCO	Primary care organisation
PCR	Polymerase chain reaction
PCT	Primary Care Trust
PHCT	Primary Health Care Team
PMS	Personal medical services
RCGP	Royal College of General Practitioners
RCN	Royal College of Nursing
RMN	Registered mental nurse
RNA	Ribonucleic acid
RRP	Reciprocal role procedures
SCMG	Shared care monitoring group
SCODA	Standing Conference on Drug Abuse
SFT	Solution focused therapy
SMMGP	Substance Misuse Management in General Practice
ST	Systemic therapy
STI	Sexually transmitted infection
TSF	Twelve step facilitation
UKCC	United Kingdom Central Council, now the NMC

CHAPTER 1

The policy context for substance misuse services in primary care

Duncan Williams

What's happening to primary care?

On 1 April 2004 GPs signed up to a new national contract to provide primary care within the National Health Service (NHS) via the organisation of practice teams rather than the historical individualised and hierarchical mechanisms of personal medical lists.[1] The new contract challenges the team to provide a quality health agenda and offers incentives and opportunities to develop innovative approaches to care. This chapter discusses ideas relevant to current primary care which can be adapted within your practice to facilitate your professional development in the field of substance misuse. This will enable us to maximise more quality options for our patients. You are strongly recommended to follow the learning approach found in the Royal College of General Practitioners (RCGP) certificate in Substance Misuse course and develop your own portfolio of experience, critical reading skills and reflective learning technique.

The following is a checklist of primary care principles.

- It exists in the real world.
- It is local.
- It is accessible and realistic.
- It is long term.
- It takes a 'full-length feature film look' at people's lives in the context of their health.
- 'Snapshots', although useful, belong more in rescue medicine than planned holistic management of chronic health problems which is the strength of primary care.
- It needs to be patient centred but often it isn't.

Stop here

- In your practice, are you confident you apply these principles to your patients with substance misuse problems?

Continued

- Could you pick up one of your existing cases and quickly establish:
  – the initial treatment goals
  – the motivational factors for behavioural change
  – the actions to be taken if review reveals unmet need or variance from direction of progress?

Contracts in context

The new *General Medical Services (GMS) Contract* (2003) is the mechanism by which the government contracts for primary care services from general medical

Box 1.1 Changes in substance misuse work after the new GMS contract

Pre-2003/4	**Post-2003/4**
GPs have individual lists of patients	Patients are registered with a practice, the individual list system is abandoned
GPs cannot opt out of any aspect of patient care without providing onward referral	GPs can opt out of any care defined in the contract as non-core work (substance misuse is defined as non-core)
Substance misuse services are not directly commissioned by primary care trusts, health authorities, etc.	Substance misuse services must be commissioned by the primary care trust (PCT) (England) or local health board (LHB) (Wales)
No particular payments available to GPs providing substance misuse services	Practices are paid for providing enhanced services – substance misuse work (done properly) is an enhanced service
No clear mechanisms to support innovative substance misuse posts in primary care but outside practices	PCTs and LHBs can provide salaried posts to provide primary care substance misuse services
GPs responsible for primary care of registered patients 24 hours a day, seven days a week, 365 days a year	LHBs and PCTs responsible for out-of-hours provision of all primary care
Inflexible staff pay reimbursement schemes make innovative appointments difficult and cumbersome	Global sum payment system to practices would seem to offer opportunities for innovative staff appointments

practitioners, on behalf of the nation. This provides the framework for organisation of all primary care, both directly within practices and indirectly, including non-directly employed staff included in their practical working arrangements.

Historically since the inception of the NHS, general practitioners (GPs) and their employed staff have contracted with the government of the day to provide GMS via a national contract. Fundholding in the 1990s gave budgets directly to practices to manage the interface between primary and secondary care for non-acute healthcare, although GPs continued to be paid contractually via the GMS contract. Fundholding was abolished in 1997, during the first term of the Labour government. A new contract was offered to practices who wished to have a variance on the nationally agreed GMS contract and a number of pilot schemes were established in 1998, these personal medical services (PMS) contracts now form 40% of the contractual arrangements between GPs and the NHS.[2] Personal medical services contracts allow practices in areas of particular need to be paid for organising care along different lines to the standard GMS contract. This enables the practices to take into account any particular local needs, e.g. practices offering services to the homeless, the elderly, nurse-led services, etc.

The new contract introduced in April 2004 relates to the GMS contract. Pilot PMS schemes ended in March 2004 and PMS is now a permanent alternative to new GMS. Personal medical services contracts have not changed as a result of these new contracts but there are variations including 'PCT-MS', 'PMS plus' and 'Specialist PMS'. These innovative schemes will allow providers to specialise in areas of care at a primary level (i.e. accessible and long term) without the provider being expected to deliver the totality of essential primary care. The important changes of the new GMS contract in the context of substance misuse work compared to the previous one are shown in Box 1.1.

Box 1.2 illustrates the changes to patient handling that occurred as a result of the new GMS contract.

Box 1.2 Example of change in patient handling

On 31 March 2004, JB attended his GP surgery looking for help with his heroin addiction. The receptionist said 'Our list is full. We don't want your sort here. Come back tomorrow'.

On 1 April 2004, JB went to his primary care practice and read the notice about the new nurse-led substance misuse assessment and prescribing service. He asked the receptionist if he could enrol and was given a cup of tea and asked to return next week.

Stop here

- Did you attend all those practice development meetings last year?
- Did you plan for this enormous shift in attitude?

The access agenda

> Substance misuse patients without access to services die on waiting lists – an untenable disgrace![3]

Governments and NHS policy makers of all political hues trumpet rapid access to services as a key target for the NHS.[4] (Indeed few professionals would disagree with this aspiration.) However the increase in funding and staff needed to deliver rapid access has not been forthcoming, e.g. 24-hour waiting times to be seen by a GP. Much recent effort has been focused on improving systems of access and flexibility.

Many practices have undergone extensive restructuring and retraining programmes with the express purpose of providing rapid access for patients to the appropriate team member best able to meet their needs.[5] The GP is perhaps best placed to provide investigative and diagnostic skills. The practice nurse could lead on disease management skills, treatment compliance and patient motivating skills, and disease or chronic condition monitoring. The health visitor could lead on primary prevention and child and adolescent mental health.

- What is your practice doing about access?
- Are you involved in the processes of change? (If not why not?)
- Do you have untapped potential?
- Is your team aware of it? Do you need to speak with the practice manager today?

Innovation and service development

Primary care is the melting pot for innovation and organisational experimentation. It is made up of individuals in small teams, with regular contact and interaction between members, many of whom have intimate and long-term knowledge of the families and circumstances of our patients. Team meetings are a feature of good primary care arrangements and these lend themselves to discussion and planned change, critical case analysis, near misses and hot topic discussions. All these are familiar concepts to the committed primary care enthusiast.

Box 1.3 illustrates a system failure.

Box 1.3

JB attended his GP two years ago to ask for treatment for his heroin addiction and was told he'd be referred to the local hospital trust – on 1 April he is still on the waiting list.

The development of local services for substance misusers depends upon individuals prepared to challenge the status quo in their own practice environment and to embrace change as an opportunity to provide something new that currently doesn't exist.

Some ethical issues for continuing debate

How do we view substance misuse activity as a society?

- Is it an illness?
- Is it a behaviour type?
- Is it socially determined?
- Is it culturally determined?
- Does its solution lie within health, education, social policy, or criminal justice?

Are our national treatment guidelines informing policy makers or is it all a bit *ad hoc*? The reader will find when reviewing simpler publications such as *The Orange Guidelines* and reflecting on existing national and local policy that conflict is rife between what we know works in treatment and what is available to our patients.[6] Professional ethics, General Medical Council (GMC) and Royal College of Nurses (RCN) good practice seem to exist as small oases in the desert of substance misuse services. At a whim patients are denied choices, options, treatments and the right to get it wrong.

Stop here

Do you know someone to whom these things have happened, or who has caused these things to happen? It's about time our 'caring' professions really started to care.

Ethical treatment dilemmas

What are we dealing with here? Is this process of risk management in the context of behavioural change? Is the harm minimisation agenda just a smokescreen for continuing the medicalisation of a problem which could arguably be better served by viewing addictive behaviour as dedicated behaviour? Should we be seeking to normalise dedicated drug use and understand its roots in non-pharmacological or neurobiological ways?[7]

What are the areas for development of practice-based treatments and do we have clear national agreement on defining Substance Misuse Enhanced Services in primary care? At the time of writing the RCGP has a clear view on the quality agenda, but local primary care organisations (PCOs) and LHBs seem to be accepting widely differing quality outcomes.

How should services be funded?

The policy context must include reference to the political as well as the health agenda. Is this a matter for health or criminal justice? There is a current drive towards moving funding streams to the criminal justice system via the community safety partnerships. We must be vigilant at this time and press policy makers and commissioners of substance misuse services to measure carefully whether defining