



## The Advanced Certificate in Community Management of Alcohol Use Disorders: a new venture for SMMGP

### Background

We could do much better at treating problematic alcohol use. National Institute for Health and Clinical Excellence (NICE) guidance highlights the fact that alcohol dependence affects 4% (1.1 million) people aged between 16 and 65 in England, and that over 24% of the English population consume alcohol in a way that is potentially or actually harmful to their health or well-being<sup>1</sup>. However, only 6% (around 660,000) of alcohol dependent individuals receive treatment in England. Possible causes for the low uptake of treatment include limited access to specialist services in some areas, under-identification by health and social care agencies leading to missed opportunities to identify problems, inconsistency in service provision at every level of service, and underdeveloped care pathways.

There is good evidence that brief screening and interventions in primary care are effective in detecting and preventing alcohol related harm<sup>1</sup>. However, the low level of detection and treatment suggests that generalist GPs in most areas are not proactive in screening for alcohol even though many of the co-morbidities are associated with areas prioritised by the Quality Outcomes Framework.

It seems clear that the development of intermediate level competencies amongst Practitioners with a Special Interest in Alcohol (PwSI) could play an important role in the improvement of alcohol services by providing local leadership to increase screening

1 National Institute for Health and Clinical Excellence (2011) Alcohol dependence and harmful alcohol use (Clinical Guideline 115)

and diagnosis and by providing support to commissioners in the design of local services. However, while PwSI have had a large impact upon the drugs field over the past decade, this does not appear to have happened as widely in the alcohol field.

In January 2013 SMMGP conducted a training needs and gap analysis for General Practitioners with a Special Interest (GPwSI) in Alcohol<sup>2</sup>. The objectives of the training needs analysis were:

- to identify the learning and development needs of generalist GPs with regard to developing the knowledge and competency required to become a GPwSI in Alcohol;
- to identify gaps in current course provision;
- to recommend the broad content of future courses to support the development of GPwSI in Alcohol, if gaps in current course provision were identified.

### Methodology

We carried out a number of activities, some of which our members helped us with (thank you) including:

- an online questionnaire to SMMGP members
- interviews with commissioners of alcohol services
- interviews with generalist GPs with an interest in alcohol services

2 The training needs analysis and the Advanced Certificate in Community Management of Alcohol Use Disorders have both been funded by an educational grant from Lundbeck Ltd

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We hope you enjoy this edition.

Editor



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- interviews with GPwSI in Alcohol
- a focus group of generalist and GPwSIs in Alcohol
- a literature search of existing courses including analysis of journals, websites of current alcohol training providers and internet based searches
- a literature review identifying the knowledge and competencies required for GPwSI in Alcohol.

**Key findings**

Key findings include:

- ❖ Of a total sample of 273, just over a quarter (27.5%) of intermediate level clinicians in alcohol reported having no alcohol specific training and over half, 56% of generalist level clinicians reported having had no alcohol specific training (see table 1).

**Table 1**



- ❖ The intermediate level doctors interviewed appeared to be split between a minority who had had strategic support to develop their role, and the majority who had not.
- ❖ Clinical supervision and mentoring appeared to be hard to access for both generalist and intermediate level doctors.
- ❖ Whilst intermediate level GPs felt confident in delivering basic clinical support to patients there were a number of advanced clinical and medical needs identified including working with more complex patients (including those with mental health problems and concurrent health problems) and the effectiveness of medications.
- ❖ It was common for both the generalist and intermediate level GPs interviewed to feel that primary care could offer solutions to improving screening, brief interventions, diagnosis, and treatment and to improve care pathways in alcohol use disorders, whilst at the same time reporting a lack of confidence and ability to communicate this to commissioners.
- ❖ Of the intermediate and generalist level clinicians, the greatest training and development needs identified in the online survey was the ability to influence alcohol commissioners in their area regarding service provision.
- ❖ The commissioners commonly appeared to see intermediate level doctors as being a clinical rather than a strategic resource prior to the interviews. However when asked about the potential role for GPwSI, commissioners quickly identified positives such as championing and spreading good practice amongst primary care colleagues, feeding into all aspects of the commissioning process, making service provision more accessible and effective, improving care pathways, and clinical support and mentoring to generalist GPs; this suggests that if a rationale to involve PwSI in alcohol in service development is put to commissioners, they will see the potential for this role.

For a full copy of the report please follow this link <http://www.smmgp.org.uk/html/others.php#094>

**The Advanced Certificate in Community Management of Alcohol Use Disorders**

As a result of the report's recommendations, SMMGP are developing an advanced course in alcohol to begin in April 2014. The course will have two distinct sections:

**Improving health and reducing harm:** this section focuses on building advanced clinical skills and knowledge following the completion of the *RCGP Part 1 Management of Alcohol in Primary Care*, including working with patients with complex needs. This will include knowledge of evidence based psychosocial interventions used with people with alcohol use disorders.

# Editorial

For the first time we are bringing Network Newsletter to you in an online format only without a paper copy. For almost 18 years we have provided Network free of charge to anyone who has asked, and we have never used advertising. In the past we have funded the paper copy of network via educational grants but the period of austerity has meant that this has become more difficult.

We know that some people prefer online formats, which include standard web pages, downloadable PDFs and digital publication versions. However, we know that it's difficult to beat the ease-of-reading and convenience of a printed copy. We would like to provide printed copies of future Network editions, but cannot guarantee this at present. We want to continue to provide Network for free. We would also like to avoid having to fill Network with pages of advertising.

So... we would like to ask for help from our readers. If you feel that Network is useful to you now or has been in the past, please consider donating a small amount to help us continue to provide it.

Donations can easily be made via the "Donate to SMMGP" button found at the foot of every web page on our website <http://www.smmgp.org.uk>. Alternatively, please contact us for other ways to pledge support. Please also contribute to the forums or contact me directly at [smmgp@btinternet.com](mailto:smmgp@btinternet.com) to let me know of your views about us changing to an electronic format.

It's getting to that time of the year to book for the Royal College of General Practitioners Management of Drug and Alcohol Problems in Primary Care Conference which is on 14<sup>th</sup> and 15<sup>th</sup> May at Stratford-upon-Avon. The theme of this year's conference is Early Interventions - which way forward? and as usual there will be a range of speakers and networking opportunities. For more information please visit <http://www.rcgp.org.uk/courses-and-events/managing-drug-and-alcohol-problems.aspx>

Enjoy this issue!

**Kate Halliday**

Editor



**Clinical leadership:** this section focuses on building skills and knowledge in a range of areas of clinical leadership including understanding commissioning processes and influencing local care pathways and service design. This will include knowledge and skills in building a proposal for a community alcohol service for commissioners.

### Structure

The course will consist of a variety of learning activities including e-modules, assessments, service visits and reflective learning via a patient logbook. A tutor will guide participants through the course. The course will run over a one year but there will be an option to extend this to 2 years in some circumstances.

### Entry criteria

Applications will be welcome from GPs, pharmacists, specialist nurses, and key workers. Participants will be expected to have completed RCGP Part 1 in the Management of Alcohol, and to be able to demonstrate active working contact with patients with alcohol use disorders.

### Accreditation

SMMGP are seeking accreditation from the RCGP, the Royal College of Nursing, and also a partner with learning arrangement with the Centre for Pharmacy Post Graduate Education (CPPE).

### Conclusion

The aim of the *Advanced Certificate in Community Management of Alcohol Use Disorders* is to develop practitioner knowledge and skills to a level that would be considered to be appropriate for a PwSI. It is hoped that provision of this course will have the effect of increasing the level of care provided to patients, and also of increasing clinical leadership in the shaping of services in participants' localities. This may go some way to improving access to and the quality of treatment for those with alcohol use disorders.

For more information about the course please contact Sarah Pengelly sarah@morganpengelly.co.uk

**Kate Halliday, SMMGP Policy and Development Manager**

## Does prescribing heroin to heroin users work? Martyn Hull takes us through the history of heroin assisted treatment to the present day and takes a look at the evidence. Ed

# HAT

### Heroin assisted treatment



For the treatment of heroin dependence, and opiate dependence in general, opiate substitution therapy (OST) remains the mainstay of the treatment culture in the UK. Methadone remains the most widely used substitute, with good reason and with a solid evidence base for its efficacy.

Despite this, there is a recognised cohort of users for whom methadone appears to be ineffective. This recognition has led to the use of other substitutes, including buprenorphine, but also in some circumstances the use of pharmaceutical heroin, and in this article I will explore the history, evidence and rationale for this heroin assisted treatment (HAT).

### Plus ca change

Heroin was launched by Bayer in 1898, and so-called because it was deemed to be the "hero" of drugs<sup>1</sup> – "non-habit forming" and "free from the disagreeable side effects of morphine". Initially marketed

as a cough suppressant and very popular, soon worrying reports began to surface of addiction and "heroinism", and the medical bandwagon slowed such that by 1913 Bayer stopped producing it<sup>2</sup>.

In the UK, heroin has been prescribed for opiate addicts since the Rolleston Report in 1926 advised it was legitimate practice. This was the basis for what became known worldwide as the "British System".

Since this time, there has been a cycle in which GPs have successively been advised to: prescribe heroin; to stop prescribing all opiates (which were to be dealt with in approved specialist clinics only); to use methadone (but only to "cure" addicts); to use methadone – and then buprenorphine – with a harm reduction emphasis; and now with a political shifting emphasis towards *medically assisted recovery*.

Plus ca change....

### Early role in addiction treatment

By 1900 there was already a pervasive illicit drug culture in the USA, and recreational use of heroin was rapidly absorbed into this, leading to increasing illicit production. In response to this in 1914 the Harrison Act was passed in the USA, making it difficult for doctors to prescribe heroin, and the few permitted clinics that survived prescribed morphine before being phased out by the 1920s. Consequently a flourishing illicit trade evolved and drug use became synonymous with gang activity and criminality.

In the UK, in contrast, heroin prescribing

was permitted by any doctor, with the intention of assisting addicts and preventing such an illicit trade developing. There were, however, many less opiate addicts in the UK and they were not, for the most part, associated with criminality or social deviance. For example, in 1938 there were 519 known opiate addicts in the UK: 50% of the men were doctors, and many of the women had developed their addiction iatrogenically after childbirth.

This system lasted until the 1960s, when – as a result of a significant increase in the numbers of users, underpinned by a social shift in the demography of drug users (more working class, younger, less likely to engage with a medical treatment model leading to increased illicit use and criminality) regulations were brought in that meant heroin could only be prescribed in specialist clinics overseen by psychiatrists. Many patients on prescribed heroin were switched to injectable methadone, and new heroin prescriptions dropped off rapidly.

Evidence remained anecdotal until the 1990s when Swiss studies raised the issue again.

### Evidence for HAT: Switzerland

In the early 1990s, against a background of opposition from UN Drug Control Authorities, the Swiss PROVE Study and subsequent studies<sup>3 4</sup> recruited heroin users who "were not reached by other treatments". PROVE, a longitudinal prospective study, demonstrated high

<sup>3</sup> Steffen T, et al. (2001) Infectious diseases and public health: risk-taking behaviour during participation in the Swiss program for a medical prescription of narcotics (PROVE). *Subst Use Misuse* 2001;36:71

<sup>4</sup> Farrell M, Hall W. (1998) The Swiss heroin trials: testing alternative approaches. *BMJ* 1998;316:639

<sup>1</sup> Davenport-Hines R. (2003) *The Pursuit of Oblivion: A Global History of Narcotics*. Norton & Co, London.

<sup>2</sup> Carnworth T, Smith I. (2002) *Heroin Century*. Routledge, London

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retention in treatment with improvements in physical health, mental health, social situation, crime reduction and reduced illicit drug use. A subsequent Swiss double-blind randomised control trial (RCT) compared heroin versus injectable methadone and morphine, and the heroin group showed better recruitment, retention in treatment and reduced illicit drug use. Additionally, cost-benefit analysis suggested the system saved more money than it cost, and long-term data remains strong. These results were used as a basis for what became the Swiss Model.

HAT is now fully integrated into the Swiss treatment model, based in 23 clinical centres. Contrary to initial objections, the number of estimated opiate users in Switzerland has decreased since its introduction.

**Further studies**

Two RCTs were undertaken in Holland <sup>5</sup> with patients experiencing “problematic use despite enrolment in orthodox treatment”, and these demonstrated that HAT was “significantly more effective” than methadone alone, and also that – on the cessation of the trial – significant numbers suffered from “severe relapses” and had treatment restarted. They concluded that HAT is effective for chronic addicts who had failed to benefit from orthodox methadone treatment alone.

Subsequently, HAT studies were set up in Canada <sup>6</sup>, Germany<sup>7</sup> and Spain <sup>8</sup>, all of which reported similar positive outcomes in retention, reduced illicit drug use and improved physical, psychological and social health.

From 2006, the RIOTT (Randomised Injectable Opiate Treatment Trial) Study was undertaken in the UK <sup>9</sup>. RIOTT was a multicentre RCT which compared injectable heroin with injectable methadone and “optimised oral methadone” in heroin users unresponsive to standard treatment. It reported a significant reduction in illicit heroin and other drug use (confirmed by drug testing, not just self reports), and a

reduction in risky injecting practice. RIOTT is important as it compared HAT with oral methadone at adequate dose levels, with additional psychosocial support and sufficient duration, thus addressing the prior criticism that previous studies had only compared HAT with inadequate alternative treatment options.

**Problems with the evidence**

Recruitment to HAT trials is often difficult, and some have suggested that this reveals a paradox wherein HAT is oft proposed as being most suited to chaotic users, but only those who settle well with it continue with HAT: the others revert to standard treatment options or fall out of treatment. Additionally, some commentators have suggested that a subset of heroin users do not want to “respond to treatment” at all, and would never respond to tightly medically regulated HAT.

A Cochrane review in 2005 <sup>10</sup> could not come to firm conclusions due to the differences in study designs and settings, though there has been significant further research, including RIOTT, since this time.

**Social, political and scientific issues**

In the face of increasingly persuasive scientific evidence, we are yet to see a rollout of widespread access to HAT, and this can be primarily explained by social discomfort with treatment of heroin users with heroin. Opponents argue that HAT is not treatment, merely social programme prescribing (with the main aim being a reduction in acquisitive crime), and media reports and politically principled objections hold significant sway in many countries, including the UK. Here, there have not been the changes in legislation or drug treatment administration that would have seen HAT mainstreamed into treatment, despite Strang’s recommendation after RIOTT that “supervised injectable heroin should now be provided ... for carefully selected chronic heroin addicts in the UK” <sup>11</sup>. Against a backdrop of change in government and economic austerity, a commentary in the Lancet argued “the existing interference and non- evidence-based opposition from politicians ... who refuse to acknowledge the limitations of methadone maintenance and the superiority of prescribed heroin in selected populations, is arguably unethical” <sup>12</sup>.

**What now?**

It remains to be seen what happens next, though there remains little debate about the evidence base for HAT. This is amply demonstrated by the case of Denmark, who considered the evidence in other countries so conclusive that they proceeded directly with HAT rather than proposed trials to investigate it further <sup>13</sup>.

It seems that the integration (or indeed re-integration) or not of HAT into mainstream UK practice will be decided not upon evidence, but on socio-political and ethical grounds.

After the initial RIOTT study, the Department of Health awarded a three-year contract for supervised heroin treatment clinics to be run in London, Brighton and Darlington – to 2015 -and we await complete evaluation data from these sites. It has been noted by some that such clinics are very expensive to run, but in the recently published cost-effectiveness review<sup>14</sup>, it is concluded that “*injectable opioid treatments are more cost-effective than optimised oral methadone for chronic refractory heroin addiction*”, although there was an acknowledgement that injectable methadone may be more cost-effective than heroin. The cost-benefit overall is particularly marked by taking into consideration savings in criminal justice costs. The authors conclude that – “*with an estimated 93,400 people in England addicted to injectable heroin in 2010-11, of whom 5-10% will be unresponsive to conventional treatment, the total cost savings of providing injectable opiate treatment for this chronic group in England could be between £29 and £59 million per year*”.

The UK Drug Strategy 2010 supports ongoing research into this area, stating “we will continue to examine the potential role of diamorphine prescribing for the small number who may benefit and in the light of this, consider what further steps could be taken, particularly to help reduce their offending”.

Watch this space....

**Martyn Hull, Medical Director, Swanswell, Lead GPSI, Birmingham and Clinical Lead, RCGP Certificate in Drug Misuse (Part 1)**

5 Van den Brink W, et al. (2003) Medical prescription of heroin to treatment resistant heroin addicts: two randomised controlled trials. *BMJ* 2003;327:310

6 Oviedo-Joekes, E et al.(2009) Diacetylmorphine versus Methadone for the Treatment of Opioid Addiction. *N Engl J Med* 2009;361:777

7 Haasen C, et al. (2007) Heroin-assisted treatment for opioid dependence: Randomised controlled trial. *Br J Psychiatry*2007 :191:55

8 March J, et al. (2006) Controlled trial of prescribed heroin in the treatment of opioid addiction. *J Subst Abuse Treat* 2006;31:203

9 Strang J, et al. (2010) Supervised injectable heroin or injectable methadone versus optimised oral methadone as treatment for chronic heroin addicts in England after persistent failure in orthodox treatment (RIOTT): a randomised trial. *Lancet* 2003;375:1885

10 Ferri M, et al. (2005) Heroin maintenance for chronic heroin dependents. *Cochrane Database Syst Rev* 2005;2:CD003410-CD003410

11 [www.kcl.ac.uk/iop/depts/addictions/research/drugs/riott.aspx](http://www.kcl.ac.uk/iop/depts/addictions/research/drugs/riott.aspx)

12 Kerr T, et al. (2010) Science and politics of heroin prescription. *Lancet* 2010;375:1849

13 Hallam C. (2010) Heroin assisted treatment: the state of play. *International Drug Policy Consortium*

14 Byford S et al. (2013) Injectable heroin - effective treatment for opiate misusers, but is it cost-effective? *Br. J. Psychiatry* 2013;203:325-326

**What role does decision making play in problematic drinking? Matt Field outlines psychological theories that explain the development and maintenance of alcohol use disorders. Ed.**

## Drinking without thinking? The psychology of alcohol use disorders



Most people would agree that social drinkers have control over their alcohol consumption: they know why they drink, and they choose when to do so. However, as alcohol use disorders develop, drinking gets out of control. People with alcohol problems want to cut down on their drinking, or maybe stop altogether, but they find themselves unable to do so. In other words, it seems that something other than a rational decision-making process is responsible for drinking behaviour in those who have an alcohol use disorder. In this article, I will show how theoretical models that are based on brain adaptations and cognitive distortions can go some way toward explaining the development and maintenance of problem drinking.

Neurobiological models suggest that alcohol use disorders are characterised by abnormal function in at least two core brain circuits<sup>1</sup>. Firstly, brain adaptations in subcortical structures such as the amygdala and nucleus accumbens drive excessive *wanting* for alcohol, which manifests itself as strong alcohol craving and powerful responses to alcohol-related cues such as the sight and smell of alcoholic beverages. The idea is that those cues acquire powerful incentive properties as a result of their repeated pairing with the rewarding effects of alcohol; as a consequence, those cues exert a potent motivational pull on the individual, a topic that we return to below. An alternative view is that adaptations in these brain regions reflect long-lasting downwards adjustments in mood state, such that the individual becomes progressively miserable and this state can only be briefly alleviated by drinking alcohol.

The second key brain circuit includes the prefrontal cortex

and regions including orbitofrontal cortex, insula and anterior cingulate cortex. These regions are thought to be involved in planning and cognitive control, in particular maintaining long-term goals despite competing drives which arise from subcortical regions. Long-term heavy drinking is thought to lead to neuroadaptations (and possibly cell death) in these regions, resulting in diminished self-control.

When we consider these brain adaptations together, we see that alcohol use disorders (and other substance use disorders) can be characterised as increased drive to drink, combined with poor self-control. Studies with laboratory animals, combined with functional and structural brain scans of dependent individuals and longitudinal studies that track adolescents as they begin to drink alcohol, support these theoretical models. For example, in laboratory animals chronic alcohol consumption leads to strong motivational responses to alcohol-related cues, combined with neurotoxicity in regions of the prefrontal cortex. Heavy drinkers show increased activity in subcortical regions of the brain when viewing alcohol-related cues, but they show blunted activity in prefrontal regions when performing tasks that require self-control. Longitudinal studies with adolescents suggest that children with poor self-control are at increased risk of developing alcohol use disorders as adolescents, but there is also evidence that the neurotoxic effects of alcohol on the prefrontal cortex are exaggerated if alcohol is consumed in a binge pattern during adolescence.

Cognitive theories of addiction, based on models of cognitive processes and decision-making in healthy individuals make fairly similar predictions. Dual-process models suggest that behaviour is directed by both controlled and automatic processes<sup>2</sup>. Controlled processes are slow, rule-based and reflective, and correspond to what we might think of as rational decision-making and conscious thought. Automatic processes are based on associations (such as those formed during classical conditioning) and they are rapid, efficient, and can influence behaviour in the absence of conscious awareness. In general terms, human behaviour is influenced by both controlled and automatic processes, but if a given behaviour is repeatedly practiced (think of driving a car) then it becomes increasingly automatic.

In social drinkers, drinking behaviour is largely influenced by controlled processes. However, if people engage in persistent heavy drinking, then automatic processes begin to develop which can in turn begin to influence behaviour directly. For example, when the rewarding effects of alcohol are repeatedly paired with alcohol-related cues, such as the sight and smell of beer, those cues will activate automatic processes in the heavy drinker. These automatic processes might include attentional bias for alcohol cues (the glass of beer 'grabs the attention'), automatic positive associations with alcohol, and approach behaviours elicited automatically by alcohol cues. Indeed, there is evidence that automatic alcohol-related cognitions such as these are seen in problem drinkers, they are proportional to individual differences in alcohol consumption, and they may predict the risk of relapse to heavy drinking (and other substance use) after individuals are discharged from treatment.

Dual-process models also account for failures of self-control in substance use disorders. Self-control is viewed as an aspect

1 Baler RD, Volkow ND. Drug addiction: the neurobiology of disrupted self-control. *Trends in Molecular Medicine*. 2006;12(12):559-66.

2 Stacy AW, Wiers RW. Implicit cognition and addiction: A tool for explaining paradoxical behavior. *Annual Review of Clinical Psychology* 2010. p. 551-75.

of executive function, a set of flexible cognitive abilities that are linked to activity within the prefrontal cortex. Dual process models predict that the behaviour of individuals with poor executive function (which includes poor self-control) is excessively influenced by automatic (rather than controlled) processes. So, for example, an individual in whom alcohol-related cues evoke a strong automatic approach response would be particularly likely to drink alcohol when faced with those cues if they had poor executive function, compared to a different individual with equally strong automatic alcohol approach responses but relatively intact executive functions. Emerging evidence with adolescent drinkers provides some support for these interactions between automatic processes and self-control, although at present this has not been thoroughly studied in dependent populations.

When we juxtapose these neurobiological and cognitive models we see a great deal of overlap in terms of the core psychological dysfunctions which lie at the heart of alcohol use disorders. But what are the implications for treatment for alcohol and other substance use disorders? Existing pharmacological treatments aim to either substitute the addictive drug for a similar drug in a less harmful form (for example methadone, nicotine replacement therapy), they may reset a drug-induced imbalance within the brain (for example acamprosate), or they aim to blunt the positive effects of the drug if it is consumed (for example naltrexone). Recent focus has been on cognitive enhancing drugs, which

could, in principle, boost executive function and help heavy drinkers to gain control over their behaviour.

Talking therapies such as motivational interviewing and cognitive-behaviour therapy have been shown to be reasonably effective treatments for substance use disorders, but there is clearly room for improvement. Computerised interventions, based on the underlying principles of dual-process models, are currently being investigated. For example, in cue avoidance training, alcohol-dependent patients are trained to repeatedly categorise alcohol-related pictures by making an avoidance response. Multiple sessions of this intervention lead to robust changes in automatic alcohol associations, and reductions in relapse risk which persist one year later<sup>3</sup>. Other computerised interventions such as attentional bias modification, and alcohol cue-related self-control training are also being investigated. We await results from large-scale clinical trials of these therapies, and hope that they may prove to be useful adjuncts to existing pharmacological and psychosocial treatments.

**Prof. Matt Field, School of Psychology, University of Liverpool**

<sup>3</sup> Wiers RW, Eberl C, Rinck M, Becker ES, Lindenmeyer J. Retraining automatic action tendencies changes alcoholic patients' approach bias for alcohol and improves treatment outcome. *Psychological Science*. 2011;22(4):490-7.

**The last year has seen a massive change in the drug and alcohol field with the move from the National Treatment Agency to Public Health England. Rosanna O'Conner discusses the impact of the transition and the important contribution primary care can make in the new environment. Ed.**

## Substance misuse in the new public health landscape: new opportunities, new challenges



**Public Health England**

This year's healthcare reforms have brought fundamental change to the landscape of substance misuse treatment in England, with local authorities now in the driving seat on tackling drug

and alcohol problems in their areas. Clearly localism brings with it some significant risks – particularly of disinvestment by financially pressurised local councils, however there are also major opportunities – particularly around better joined-up working between healthcare partners and other agencies.

Public Health England (PHE) has taken up the reins of national leadership from the former National Treatment Agency

and continues to support local authorities with information and intelligence, expertise, evidence of what works, and benchmarking of effective performance. To this has been added the national remit for prevention of substance misuse and this is where much of the new potential lies, working with others to tackle the problems much further upstream. Alcohol and drug misuse are key priorities for PHE's Health and Wellbeing Directorate and by 'joining the dots' with other agendas including mental health and sexual health, we can achieve greater impact on all fronts.

The ambition for recovery set out in the 2010 drug strategy remains very high on the agenda of national government. This is the ambition that everyone – including those with the most long-term and entrenched addictions – is given the best chance to recover and get their lives back on track. It is an ever-increasing challenge: with the treatment population now dominated by an ageing cohort of heroin users, the going is getting tougher for treatment services as they strive to sustain and build on their current performance levels. The latest annual drug treatment statistics published in November bear this out, with rates of recovery leveling out in 2012-13 after the rising trend of recent years.

A number of things are essential if we are to continue to make progress on recovery. Firstly, maintenance of investment to ensure the right support is available for anyone who needs it; secondly, effective commissioning to ensure a full range of treatment options is available to meet identified need; thirdly, treatment services that are adaptable and responsive to changing patterns in drug use and associated new health harms; and fourthly, properly joined up working across healthcare, employment, housing and mutual aid to give drug users the package of support they need to build a sustained recovery. Primary care has an important role to play in this, both via clinical commissioning groups acting as champions for substance misuse treatment within health and wellbeing boards, and via individual clinicians working in a recovery-orientated way with their patients while continuing to protect their health and choice.



Alcohol misuse has not received the same focus as drugs and treatment consequently has some catching up to do. An estimated 1.6 million people in England have some degree of alcohol dependence, of which around 250,000 are moderately or severely dependent and may benefit from specialist treatment. While there are specialist services in many areas and more people are completing their treatment successfully, provision remains patchy across the country. More work is needed by local authorities to ensure that alcohol treatment is being delivered to meet their populations' needs in line with National Institute for Health and Care Excellence guidance.

Serious alcohol dependence requiring specialist treatment is of course only the tip of a much larger iceberg. Nine million adults in England drink at levels that pose some risk to their health. The health problems and costs associated with alcohol misuse are mounting steadily – alcohol plays a role in over a million admissions to hospital and is costing the NHS over £3.5bn every year. This is the 'elephant in the waiting room' we cannot afford to ignore.

The causes of harm from alcohol are complex but preventable. A multi-layered public health response is needed to tackle this complexity: evidence-based policy and action at population level; action targeted at those most at risk; and action targeted at those who are already experiencing problems. While some of this is the responsibility of national government, there is much that can be done at local level.

In March 2012 the government's alcohol strategy set out a comprehensive approach to addressing the problem using a range of levers including licensing of premises, measures to influence pricing and public health initiatives. It highlighted the contribution of effective specialist treatment in reducing alcohol-related hospital admissions and overall costs to the NHS. It also identified two other evidence-based approaches as likely to have a significant impact: identification and brief advice (IBA) delivered in GP surgeries and other healthcare settings, and hospital-based alcohol services including Alcohol Care Teams.

We have made clear PHE's disappointment with the announcement in July that the government will not be taking forward the introduction of minimum unit pricing of alcohol (MUP) at this time. Evidence from Sheffield University and Canada shows that MUP would make cheap and higher-strength alcohol less available, with the greatest impact being in relation to younger drinkers and heavier drinkers. We will be looking at the current and forthcoming evidence to see how best we can inform the government's decision on implementation of this measure.

A more positive recent development is the inclusion of an alcohol risk assessment in the NHS Health Check for adults aged 40 to 74. All those undergoing the Health Check will be screened for their alcohol use and given appropriate advice or a referral.

It is in the delivery of identification and brief advice (IBA) that GPs have a particularly important contribution to make in preventing alcohol harm. Most people are unaware that they are drinking over the lower-risk limits and most are unconcerned about their use of alcohol. The overwhelming majority of these people don't have a serious problem with alcohol dependence; they are just drinking too much too often. While many are aware of the link between alcohol and liver problems, there is far less awareness of the links to cancers, high blood pressure etc.

This is where IBA comes in. There is [30 years of research](#)

showing the value of giving patients brief alcohol advice and the impact that has on their drinking and health. However there is also evidence that this conversation rarely happens. A generation ago, healthcare professionals had trouble raising the issue of cigarette smoking with their patients. They didn't like commenting on someone's lifestyle and often they were smokers themselves and felt a bit hypocritical raising the issue. Today, it is alcohol that healthcare professionals are reluctant to raise – as well as fearing a bad reaction, there is also the obvious issue of limited time and the need to focus on the problem the patient has come in with.

We need to overcome this situation. Giving brief advice on lifestyle issues is a quick win that can save the patient future health problems and save the NHS unnecessary expense. There is a range of reliable screening tools to help identify patients who are drinking at risky levels. These take just one to two minutes to use. There is [evidence](#) that screening is a powerful tool in itself – just using an objective measure and informing the patient of the results can trigger change.

The reformed healthcare system presents real opportunities for continued improvements in substance misuse treatment, and for a stronger emphasis on prevention. Public Health England will be playing our part by championing the evidence base for what works, and galvanising local authorities to work with the NHS and other partners to ensure that the right information, advice, treatment and support is available for anyone who needs it.

**Rosanna O'Connor, Director of Alcohol and Drugs, Health and Wellbeing Directorate, Public Health England**

**SMMGP**  
SUBSTANCE MISUSE  
MANAGEMENT IN  
GENERAL PRACTICE

**TREATING  
SUBSTANCE MISUSE  
IN PRIMARY CARE**

**YOU KNOW IT MAKES SENSE**

**SAVE THE DATE**

**9<sup>TH</sup> PRIMARY CARE DEVELOPMENT CONFERENCE**  
**THURSDAY 23<sup>RD</sup> OCTOBER 2014**  
**MCDONALD BURLINGTON HOTEL, BIRMINGHAM**

**Naloxone schemes are beginning to establish themselves in the UK but their development is patchy. Judith Yates describes how Birmingham developed a model and argues that every area should be providing naloxone to everyone using opioids. Ed.**

## Naloxone works. Have you got yours?

I first met Catherine in my clinic in the Summer of 2012, and when I asked if she had heard about naloxone she said "Oh yes, I do need some. I've used my dose". She told me of the time when, with shaking hands and knees like jelly, she had used naloxone to save the life of her partner. A few months later, looking nervous but proud, she stood up in front of one of our early naloxone training the trainer sessions at the Drug and Alcohol Action Team, and told the story: she had met her partner from prison that day; they had both injected heroin in the toilet of the nearby supermarket, and to Catherine's horror and initial disbelief (she thought he was fooling about), he collapsed and turned blue. She remembered the naloxone at the bottom of her bag, given to her as part of her own prison pilot discharge naloxone scheme, and got it assembled in time to revive him. The ambulance took twenty minutes to arrive in the rush hour traffic, and the paramedics confirmed that she had almost certainly saved his life.

Since that first session in the summer of 2012, drug workers, support workers, clinicians and service users all over Birmingham, have been learning to teach people who use opiates how to recognise and manage opiate overdose and, after calling an ambulance, to give naloxone<sup>1</sup>. It has been startlingly difficult to change the prescribing habits of a city. Hard enough to change my own prescribing habits. Finally during the last twelve

1 Training materials adapted for use in Birmingham from: National Addiction Centre resource 'Naloxone as part of Managing Opiate Overdose' and from the 'NHS Highland Naloxone Programme'

months, this cascaded information has been reaching the people who can follow Catherine's example and save lives. By Christmas 2013, 1200 doses of take-home naloxone had been prescribed or distributed across Birmingham, and we are now hearing reports of one or two successful reversals every month, confirmed by impressed local ambulance crews.

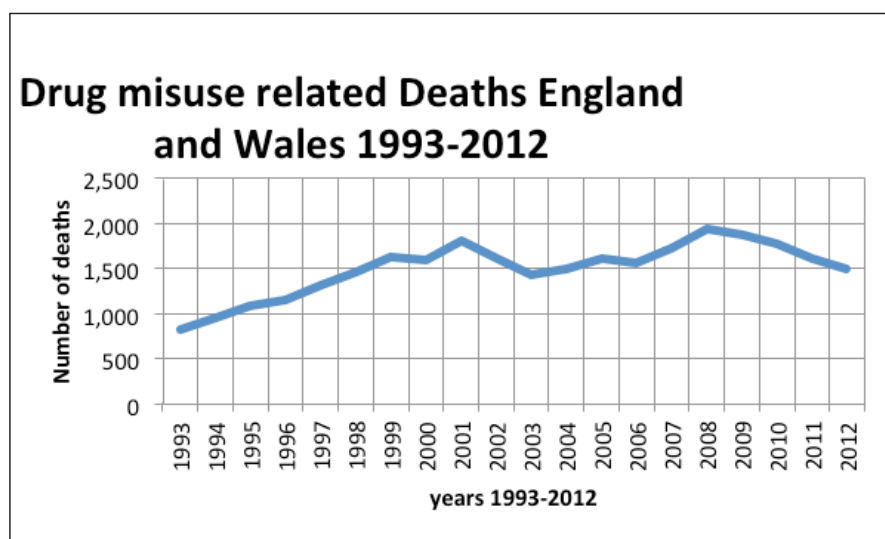
The initial training sessions were very moving, as many of us remembered people whose lives had been shortened by accidental overdose, and whose death could have been prevented if someone around them had been carrying naloxone.

is needed for each drug user, costing between £8 and £20 depending on formulation.

### Take home naloxone in the UK

In 1996 John Strang et al<sup>3</sup> suggested the potential for take-home naloxone in the UK as part of harm reduction measures, but changes to regulations were as usual frustratingly slow.

It was not until 2005 that the Medicines Act (1968) was changed, in the Medicines for Human Use (Prescribing) (Miscellaneous Amendments) Order and naloxone was added to the list of injectable medicines that can be given by anyone for the



Source: Office for National Statistics.

Drug related deaths in England and Wales have been slowly falling for the last four years, but still there were still 1496 deaths in 2012<sup>2</sup>.

### What is naloxone?

Naloxone was first developed as an antidote to opioid overdose in 1961 by Dr Jack Fishman who died aged 83 in December 2013. Since the 1970s it has been widely used in hospitals and by ambulance crews around the world. It is an opioid antagonist, which rapidly but temporarily reverses the respiratory depression caused by overdose of heroin and other opioids. It has no other effects, and has no street value or potential for abuse and almost no side effects. It will do no harm even if given to a person who has not taken an opiate overdose, but collapsed for some other reason such as stroke, seizure or heart attack. It is not expensive; only one prescription

purpose of saving life in an emergency. The list includes adrenaline, atropine, glucagon, glucose and snake-venom antiserum and now also naloxone.

Following publication of the favourable results of take-home naloxone pilot programmes in 2008, Scotland started its own National Naloxone Programme in 2010, followed by Wales in 2011<sup>4</sup>. Co-ordinated programmes were planned and successfully implemented in both countries and ways were found to encourage wider provision of take home naloxone. In Scotland this was helped by guidelines written by the Lord Advocate allowing, for example, staff to

3 Strang J, Darke S, Hall W, Farrell M, Ali R. Heroin overdose: the case for take-home naloxone. *BMJ*.1996;312:1435-1436. doi: 10.1136/bmj.312.7044.1435.

4 Strang J, Manning V, Mayet S, Best D, Titherington E, Santana L. Preventing overdose death through overdose management training and provision of take-home naloxone to opiate users in treatment: prospective cohort study of impact on knowledge, attitudes and behavior. *Addiction*.2008;103:1648-1657. doi: 10.1111/j.1360-0443.2008.02314.x.

2 Office of national Statistics : <http://www.ons.gov.uk>



hold naloxone on hostel premises without needing a prescription.

England is running to catch up. At present naloxone is still a prescription-only medication, and can therefore only be prescribed directly to a patient who has a risk of opiate overdose via FP10, or supplied via a Patient Group Direction (PGD) or Patient Specific Direction (PSD). It cannot currently be prescribed (or supplied using a PGD/PSD) to a carer, peer, or member of staff on behalf of a drug user, and cannot be given to anyone without the drug user's informed consent.

Efforts are underway to widen naloxone availability in England, but as usual regulatory change is frustratingly slow. In May 2012 the Advisory Council on the Misuse of Drugs (ACMD) published its "Consideration of naloxone" which noted the success of the Scottish and Welsh programmes and pointed out "The efficacy of naloxone is not in dispute. Naloxone is a WHO-recommended medicine, and efficacy has been proven in several published studies and pilots"<sup>5</sup>.

The ACMD made three recommendations to government in May 2012:

*Recommendation 1: Naloxone should be made more widely available, to tackle the high numbers of fatal opioid overdoses in the UK*

*Recommendation 2: Government should ease the restrictions on who can be supplied with naloxone*

Recommendation 3: Government should investigate how people supplied with naloxone can be suitably trained to administer it in an emergency and respond to overdoses

In December 2013, the MHRA (Medicines and Health care products Regulatory Authority) launched a consultation on the need for extended provision of naloxone <http://tinyurl.com/NALX-consultation>. The consultation closed on 7<sup>th</sup> February 2014. Even though the closure date has passed, please fill it in to support changes which will make it easier for naloxone to be carried by friends and carers of drug users, hostel workers and other non-healthcare workers who may

<sup>5</sup> Advisory Council on the Misuse of Drugs (ACMD). Consideration of naloxone. London: Home Office. London, England: The Stationery Office; 2012.

be in a position to save life in case of emergency<sup>6</sup>.

### The Birmingham story

In Birmingham we found barrier after barrier between 'we think that naloxone is a good idea', to actually getting it into the hands of our patients. The answer turned out to involve concerted and co-ordinated efforts on every front. Following several all-services training the trainer sessions in 2012, progress was still very slow, so we invited a Naloxone Champion from each prescribing and outreach service (there are many in Birmingham) to a brief Naloxone Steering Group update meeting at 1:30pm on the first Wednesday of each month to share problems, solutions, news of drug related deaths and of successful reversals. We have seen unprecedented partnership working across every sector, with everybody learning from each other. I had thought we would need to meet for only a month or two, but it has been clear that the monthly meetings have supported the roll out of naloxone provision across the city over the last 18 months.

Training in overdose recognition and management and the use of naloxone takes only ten to fifteen minutes, and we have found it is most effective when carried out mainly by key workers in one-to-one sessions. The key worker will then ask the prescriber to provide either a naloxone kit, or if in primary care, a FP10. Prescribers themselves have found it a struggle to provide the training during busy prescribing clinics, and though groups are effective in some settings, we have found they will not reach most people. Key workers around the city have set up schemes and compete for prizes such as chocolate eggs for those getting the most naloxone into the hands of service users.

I went to visit four of the largest hostels in Birmingham in the week before Christmas. I was told of two examples of naloxone use in the preceding few days, both carried out by hostel residents while awaiting arrival of the ambulance. In the first hostel, a resident was sharing the room of a man who stopped breathing after taking alcohol and heroin. He was

<sup>6</sup> MHRA Consultation 2013: Proposal to allow wider access to naloxone for use in emergencies

<https://www.gov.uk/government/consultations/proposal-to-allow-wider-access-to-naloxone-for-use-in-emergencies>

able to call for an ambulance and then give naloxone as he had been trained. In the second hostel, a support worker called Simon described vividly how he had been called to a resident who was lying blue on the floor, and a "saviour" resident came running down the corridor carrying his own naloxone. Simon described it as "like a miracle" to see the casualty revive from apparent death, within a minute or two, and be right as rain after a night in hospital. While I was there the saviour resident returned from his prescribing clinic appointment, dressed in his best suit and tie, clutching proudly his replacement naloxone kit in case it should be needed.

### ***The majority of overdose deaths take place in the presence of others who could prevent death if they had access to naloxone.***

It seems to have taken a long time, but provision of naloxone is now becoming normal across the city for everyone who is using heroin or prescribed opioid substitution treatment (OST). It is not possible to predict the most at risk groups, as those who die are most likely to be out of treatment at the time, or indeed never to have been in treatment, so our target is everyone who uses opiates across the city. Primary alcohol users who buy heroin only on payday like the two hostel dwellers described above, make up a large part of our accidental overdose deaths each year. Our alcohol outreach worker provides naloxone for this group, even though they are not on OST. Naloxone is now provided in primary care and secondary care and as people leave our local residential detox unit. Although we have not yet persuaded our main prison to hand out naloxone as prisoners are released, (we are working to get over the barriers to this), there are in-reach and out-reach workers who now give training and try to make sure people get a kit within a day or two of coming out.

We have over 5000 people in treatment across the city, and have so far dispensed over 1200 doses of naloxone, so the task continues.

"No-one need die from a heroin overdose"

Birmingham Drug and Alcohol Action Team *Naloxone- A Life saving Guide*

**Judith Yates, GP Specialist in Harm Reduction**

**This inspiring story describes the struggle one family had while receiving a range of treatments including opioid substitute treatment, and how getting care from their GP has transformed their experience. Ed.**

## Getting treated by my GP – a whole new lease of life

To explain why I describe GP shared care as giving myself and my family a whole new lease of life I have to explain what life was like before.

When my daughter was born, myself and my husband were both on methadone which we got from our local Specialist Addiction Unit. I was on about 30ml, my husband on around 60ml, we were stable, we had a beautiful new baby and everything was great.

When my daughter was about 6 weeks old, the blow fell. My husband was diagnosed with HIV, hepatitis B and hepatitis C all in one go. Yes, I know that's unusual, I've been told. No, nobody else I've ever met has heard of it happening before either. This wasn't much comfort, it still isn't really.

Suddenly we were catapulted from a quiet life of crèches and mother and baby music classes into an alien world of HIV clinics, hepatologists and specialist paediatricians. My daughter needed to be tested repeatedly. I'm still not sure why, seeing as I don't have HIV nor hepatitis C nor even hepatitis B. She also needed hepatitis B immunisations. I thought that would be easy, after all she had been immunised for everything else. Silly me, this particular immunisation involved us visiting a specialist paediatric clinic that is only held once a month, a 40 minute bus journey away. When I asked for our GP surgery to administer the third dose I had to personally arrange the delivery of this "non-standard" vaccine to the surgery and make a special appointment.



Meanwhile her dad had had lots of tests and it turns out he needed to start treatment for HIV and hepatitis B immediately. What no-one told us, maybe no-one knew, is that some HIV drugs interact with methadone. This meant his daily methadone dose (after considerable time, effort and stress) was increased to 180ml a day.

Over the years at various times and for a variety of reasons that I believe were good, I asked an assortment of GPs if they would consider prescribing my husband's methadone. They were mostly sympathetic, but invariably described 180 as a very large number. A few said they felt it was outside their competency and one even mentioned the Care Quality Commission. What they all said was "no". I gave up asking.

The years passed and my husband's health deteriorated. In no particular order he had, HIV, hepatitis B, hepatitis C, asthma, COPD, fits, seborrhoeic dermatitis, hyperhidrosis, memory loss, blood clots and leg ulcers. He was also taking hepatitis C treatment. I nearly forgot! He was still on 180ml of methadone a day and (maybe unsurprisingly) being treated for depression. I became a full time mother and a carer to an adult who couldn't be left alone. I was unable to remember the last time I had an unbroken night's sleep.

There was one particular month when he had 27 different appointments with 27 different hospital consultants. This didn't include appointments for blood tests (at least 3 days before seeing the doctor and at the same hospital the doctor holds their clinic) nor pharmacy visits; each hospital has their own pharmacy, you know. I became a full time personal assistant as well as a mother and carer. I forged a fragile system of childcare. I sat in hospital waiting rooms, sometimes two different ones in two different hospitals on the same day. I definitely contributed to London Regional Transport's profits that month.

Somewhere around appointment 25, or maybe appointment 26, I don't remember too clearly - I'm glad, I don't want to remember clearly, it was awful - childcare arrangements stretched, tempers frayed and broke and just to make the day complete the HIV clinic said they could no longer change the bandages for his leg ulcers. They gave me a reason. It might even have been a good reason. I honestly don't know. They told us he would need to arrange to have the bandages changed at his GP surgery. I accepted this news with what little equanimity I had remaining and carefully added a new set of appointments to the calendar.

At the first appointment with the practice nurse we answered the usual set of questions, basically variations on the theme of "Which other medications are you prescribed?" and "Where do you get them from?" – a process that, by this stage, took some considerable time. The nurse then stopped what she was doing and said that she needed to speak to the GP. For me, this was a worrying development. I was sure she was going to come back and say "This case is too complex, you need to attend a specialist clinic that is approximately fifteen miles away and only accessible using two buses, a train and a taxi." I'd heard that too often over the preceding years. Breaking

point was fast approaching. My fragile system of childcare arrangements was shattering before my eyes. Sanity had left the building. I honestly couldn't take any more.

To my complete surprise she came back and said that obviously these appointments were too much and that if we came back on Friday we could see the GP for the methadone, her for the bandages and a colleague for the International Normalised Ration (INR). I think I asked her to repeat herself, so that I could be sure I wasn't hallucinating. I hope I remembered to say thank-you.

This simple act changed everything for us. I cannot express the improvement in our quality of life adequately: everything

has changed. The GP surgery is a ten minute walk from home, sometimes my daughter and I play in the park over the road while her dad attends his appointments, sometimes we even have an appointment with a doctor or health visitor for ourselves. When my partner has needed bandages changed at the weekends the district nurses have come to our home. Repeat prescriptions are delivered directly to the pharmacy. This time when my daughter was due a hepatitis B vaccination, the surgery even phoned and reminded us! Our calendar now contains birthdays, school-trips and gymnastics classes, just like other families. We have a whole new lease of life.

**Anonymous author**

**Opiate dependency but not as we know it? Laylah Johl describes her work with people who have become dependent on poppy pods. Ed.**

## Poppy pod tea dependency

During the course of my work as a GPwSi working in a busy urban specialist clinic I came across 5 cases of addiction to poppy pods. This article summarises how these cases were managed, common themes and discussion on the nature and management of poppy pod tea addiction.



### Method of use

Poppy tea is brewed from the poppy straw (pod and the stem) or seeds of several species of poppy. The species most commonly used for this purpose is *Papaver Somniferum* which produces opium as a natural defence against predators. In the live flower opium is released when the surface of the bulb (seed pod) is scratched. The potency of poppy pods varies dramatically from one variety to another and from one crop to the next, although experienced poppy drinkers learn to titrate their own dose as they gain greater experience. On average 2-4 pods are used per dose.

There are many different preparations of poppy tea but most methods call for the poppy straw to be ground into a fine powder because most of the opium latex is located within the walls of the pod. There are a plethora of poppy seed recipes freely available on the internet with much debate on the use of hot/ cold water and indeed the use of citric or asetic acid to lower the acidity of the water to optimise morphine extraction. Alcohol has also been cited as an alternative solvent.

### Effects

The effects begin 30 minutes after ingestion and can last up to 12 hours. The effects experienced are predictably as a result of the location of mainly mu opioid receptors within the brain, spinal cord and gastrointestinal tracts. Most report euphoria and warm extremities as a result of vasodilatation. Nausea is as a result of the presence of noscapine and is more common in first time or inexperienced users. Itching can occur and is caused by release of histamine from mast cells.

Interestingly a small amount of dried poppy tea at night is an effective treatment for restless leg syndrome as a result of the presence of papaverine which acts as a smooth muscle relaxant which affects the vascular system (unfortunately withdrawal from the narcotic constituents of the tea, mainly codeine and morphine, paradoxically cause restless leg syndrome).

Frequent use results in tolerance and dependency and abrupt cessation will result in a well recognised withdrawal state. As users are addicted to all the different alkaloids found in the opium poppy (including morphine, codeine, paperverine and thebaine) withdrawal symptoms can be particularly severe and prolonged as compared to those experienced by users of just one opioid, lasting typically 4-10 days. Cravings and psychological dependence may last for longer. Treatment methods for addiction are generally the same for any opioids.

...continued overleaf



**Case 1**

A 35-year-old Asian male referred by his GP developed poppy pod addiction after being introduced by a co worker to increase productivity in the factory where he worked. He was referred by his GP and following assessment was dose titrated from 4 to 8 mg of buprenorphine over a 2 week period. His use of poppy pods, which was largely psychologically rooted, reduced from several times daily to twice weekly. After a stabilisation period of 4 weeks a controlled reduction was commenced at a rate of 2mg per month. This is ongoing and uncomplicated thus far with cessation of all poppy pod use after the 3rd month of engagement.

**Case 2**

A GP referred a 54 year-old-Asian male factory worker who had a history of chronic alcohol misuse. His use of poppy pods was related to alleviating cravings after pressures from his family had forced him to abstain from all alcohol. He had been maintained on 6mg buprenorphine in excess of a year despite being abstinent from use shortly after starting treatment. A review of his case saw a willingness to commence dose reduction of 2mg per month, which was revised several times as a result of difficulties with withdrawal symptoms. He finally opted to stop all treatment at 0.8mg buprenorphine.

**Case 3**

A GP referred a 29-year-old Asian male postal worker who started using poppy pods to complete his rounds in the face of severe social anxieties. He was titrated to 10 mg of Suboxone. He remains on this dose and is currently off work as a result of severe anxiety and is being supported by The Community Mental Health Team and his GP. This has prevented any discussions in relation to dose reductions.

**Case 4**

A GP referred a 32-year-old Asian foundry worker whose poppy pod use was linked to productivity and stamina. He had been in treatment for several years and commenced on methadone from the outset and was maintained on 40 ml. Discussions around scope for dose reduction had been protracted and complicated by stress associated with his immigration status following a failed turbulent arranged marriage and ongoing, intermittent poppy pod use to alleviate this stress.

**Case 5**

A GP referred a 30-year-old Asian factory worker who initially used poppy pods recreationally after work to relax and then continued use in order to be able to keep up productivity in the factory in which he worked. He stabilised on buprenorphine 8mg and completed a successful uncomplicated detoxification 6 weeks later.

In all cases oral fluid screening was used to confirm use and all tested positive on 2 consecutive occasions for either morphine or opiates. With the exception of the individual on methadone, all were dose titrated with buprenorphine and settled on doses ranging from 6 to 10 mg. Clear discussions around dose reductions were undertaken in the treatment journey and seemed to work particularly well with this small cohort of patients.

Of those successfully detoxed, all declined naltrexone to assist with the possibility of relapse.

**Discussion**

There are some obvious similarities in the cases presented. All have been referred via their GP highlighting once again the pivotal role that GPs have in facilitating such referral to specialist care if there is insufficient expertise and experience in house. All of the men were Asian and interestingly from Northern India. India is one of the largest opium harvesting countries in the world. There are acres of poppy fields in Northern India which produce tonnes of opium annually for export to Europe and America for pharmaceutical use. The industry is strictly regulated by the government but inevitably there is local diversion. All of these cases mentioned that their knowledge and use of poppy pods stemmed from culturally acceptable practices observed in their homeland and indeed poppy seeds still feature regularly in Arurvedic practices in India.

All cases reported buying the pods from under the counter sources at local Asian supermarkets. A carrier bag retails at £5 to £10 for 20 pods which would provide on average a week's use. In all cases the pods were crushed to a fine powder and either simply ingested neat by the teaspoonful or dissolved in a small amount of water before ingestion. This is in contrast to the majority of users in the West where preparation as a tea is the preferred method prior to ingestion.

Another emerging theme related to reasons for use, with increased productivity or stamina being cited as primary motivation for use in 3 of the 5 cases reported. In the remaining 2 cases, use was linked to psychological symptoms or mental ill health which runs true for a significant proportion of traditional opiate users.

Buprenorphine was used in 4 of the 5 cases and appeared to be well tolerated and an acceptable treatment option, allowing the patients to maintain a clear head to be able to participate fully in all family, work and social obligations and commitments. Buprenorphine also lends itself well to dose reduction with greater flexibility with 0.4 mg doses towards the completion of a detox schedule.

**Laylah Johl, GPwSI**

**How do you encourage GPs to get involved in drug and alcohol treatment? Laurie Windsor describes how he identified barriers to GP involvement in North Devon. Ed.**

## Shared care in North Devon

I have just completed a year as a higher trainee in alcohol and substance misuse in Devon. While I was there I was asked to look into why the percentage of service users prescribed within a shared care arrangement was so small in North Devon compared to other areas in the trust.

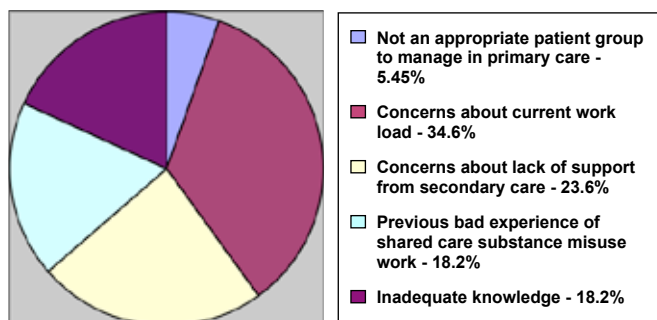
I created two separate questionnaires to help answer this question. One of these was a questionnaire with open ended questions that I would complete in a face to face interview with GPs who were already taking part in the shared care service. The second questionnaire had closed ended questions and was sent to all the GPs and practice managers working currently in North Devon.

The open ended questionnaires gave very positive feedback about the service. They essentially stated that the system worked and felt that the clients they saw were stable and took up very small amounts of their time. They suggested that funding should be increased to encourage more GPs to take part and that the system shouldn't be changed too much as it appeared to be working.

The closed ended questionnaires were sent to all of the GPs and practice managers who were working in North Devon and who weren't already involved in shared care. I gained a response rate of 36 people (approximately 33%). I have listed the questions below with graphic representation of the responses. Each of the questions included an "other" option where participants were invited to write their answer in free text. I have summarised the themes of these answers below the pie charts and indicated how many people ticked the "other" option.

### Findings

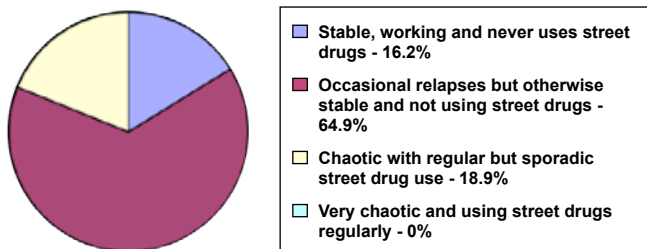
**If you aren't taking part in shared care work in substance misuse, please choose the two most important reasons from the following options.**



Ten participants ticked the "other" option and themes from this included "insufficient number of patients of the practice list to make it worthwhile for the GPs" (mentioned in two responses),

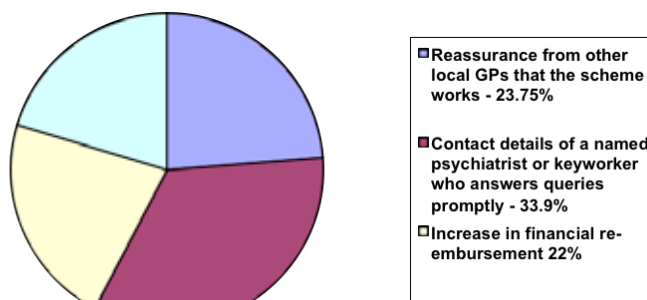
"not financially viable" (mentioned in two responses), "secondary care better placed to care for this heterogeneous group of damaged individuals" (one response)

**What do you think are the characteristics of the average patient in shared care?**



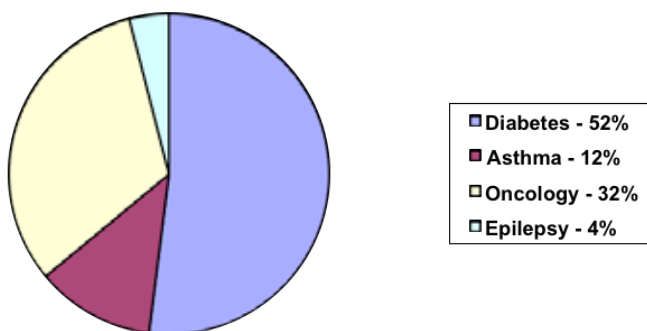
Six participants ticked the "other" option. Themes included "insufficient experience to comment", "secondary care better placed", "patient will state stable...but might spot an inexperienced trusting doctor to double supply".

**What would persuade you to take people onto the shared care scheme? Please choose the two most important factors.**



Nine participants ticked the "other" question. Themes included "drug seeking behaviour is disruptive", "work is time consuming", "wishing for increased information regarding shared care in substance misuse before deciding", "increase in finance" and "longer appointment times".

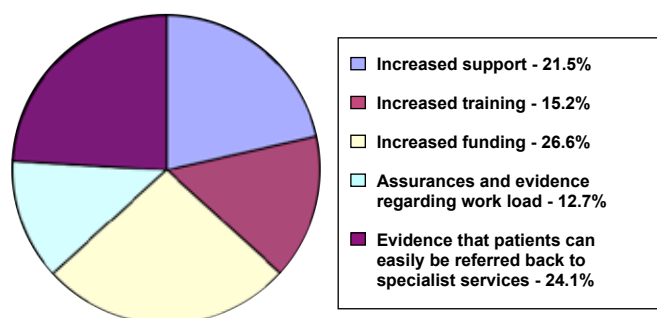
**What type of shared care work do you undertake currently?**



This led to confusion as it appears that from most of the GPs' perspectives the only "true" shared care work they undertake is in rheumatology/ gastroenterology with a class of drugs called DMARDS. Generally most medical chronic conditions are part of core work and they seek advice when they need to.

...continued overleaf

**What can the drug service do to make the shared care service more appealing for GPs? Please choose the two most important factors.**



Eight participants ticked the "other" question. Themes included "I think they need a whole team approach which we would have difficulty finding time to effectively engage with" and "increased funding".

**Please add any other comments regarding your views on shared care. Including why you would or wouldn't like to take it on and what support you would like from the drugs service.**

Participants were asked to write their answers in free text form and thirty two people choose to answer this question.

The themes were more complex here due to the greater amount of information. I have summarised the answers below:

- Previous experience has been negative - Six mentions
- Secondary care is better placed to give a better service - Three mentions
- Bad experience of shared care in general (not simply substance misuse) - Two mentions
- Work load - One mention
- Disagreed with the principle of substance misuser being managed in primary care - Two mentions
- Concern that it will attract out of area patients with substance misuse to sign up to their surgery - Two mentions
- Increased training and support - Two mentions
- Funding - One mention

**Summary and discussion**

The main barriers that the survey has identified for GPs considering starting shared care appears to be concerns about current work load and lack of support from secondary care. Previous experiences and lack of knowledge also play an important but less significant part. The most important factor that would persuade GPs to start back onto the scheme was the contact details of a psychiatrist or key worker who would answer queries promptly. This would suggest that this is either not the case or they aren't aware that this does or would happen. Other important issues for GPs were increased funding and reassurance that patients could be easily transferred back to specialist services. Less important but still significant factors

included further training and information as well as reassurance from local GPs already taking part in the scheme.

The majority of GPs feel that clients in shared care would have occasional relapses but otherwise are stable and wouldn't use street drugs. My fourth question asked what shared care GPs were currently involved in. This highlighted the fact that although GPs are used to joint working they don't perceive that they are involved in much shared care which might partly explain their reluctance to join.

The free text answers showed the most important factors in not getting involved were previous negative experience of shared care and the perceived nature of the client group. The next most frequently mentioned factors were insufficient funding and the belief that secondary care services would be better placed to deal with this group of clients' needs. Finally GPs were also concerned that out of area clients would sign up to their practice. This is linked to the overall concerns about excessive workload.

I believe that this needs analysis is useful to people outside the trust because it gives an interesting insight into GPs' views of shared care in an area with poor involvement. Some of the issues raised are local such as poor previous experiences with shared care. However many of the answers can be generalised to other areas. It could give other services some ideas regarding how to improve GP involvement in shared care or how to conduct a needs analysis of their own.

**Laurie Windsor, Higher Trainee in Psychiatry (Spr)**

**Let us know your views on a Professional Association for the Alcohol & Drugs workforce**

Dear Colleagues

Skills for Justice is conducting research on the **demand** for and **benefits** of setting up a **Professional Association** dedicated to the **Alcohol & Drugs workforce**.

We are keen to hear your views. Your **opinion** will help us to assess if **setting** up a **Professional Association could be valuable to you** (or your organisation) and the **Alcohol & Drugs sector**.

**How can I get involved?**

To access the consultation, click onto this survey link <http://surveys.sfjuk.com/ProfessionalAssociationSM/>. The survey will take approximately **15 minutes** to complete depending on your answers and how much information you wish to provide.

The survey will close on **17 February 2014**.

We would **welcome the views of those working or involved in the Alcohol & Drugs sector** such as workers and other professionals, students, volunteers, teachers, policy-makers and commissioner of services.

If you have any difficulties or would like further details about the work, please contact Sophia Verhaeghe by email on [Sophia.verhaeghe@sfjuk.com](mailto:Sophia.verhaeghe@sfjuk.com) or by phone: 0114 231 7399.

We would like to thank you for your support



**Judith Yates is Dr Fixit to a mother who would like naloxone for her son who is on methadone. Ed.**



**Dear Dr Fixit,**

*I know you can't talk to me about my son, but you must know that he comes to your surgery and is prescribed methadone for his heroin addiction. I think he is still using heroin at times, and I am terrified that I will find him dead one morning. I have heard there is an antidote to heroin overdose. Can you prescribe it for me so that I can keep it at home? Do you think if he knew that I had naloxone it might make him even more reckless, thinking that I could just revive him? I asked my son about it but he just said I was worrying too much and he knows what he's doing.*

**Answer provided by Judith Yates, GP Specialist in Harm Reduction**

You are quite right; the antidote you describe is called naloxone. Since 2005 it has been legal for naloxone to be used by anyone for the purpose of saving life in an emergency but at present I can't prescribe it to you. We have been prescribing it for people who use heroin, and they can give permission for their kit to be held by a friend or carer such as yourself. I could only give you a prescription in your son's name, if he gave his consent.

You ask whether it could encourage reckless use of heroin in the knowledge that an antidote was available. People

who have been given naloxone after an overdose initially feel very uncomfortable, as for a short time the effects of the heroin they have taken have been blocked. They do not initially appreciate that their lives have been saved, as they have no memory of the time they were unconscious. Availability of naloxone has not been shown to increase doses taken by drug users as they would not choose to undergo reversal in this uncomfortable way.

Naloxone has no pleasurable effects. It is not abused. Its only effect is to reverse opiate overdose. If it turns out the collapse is not caused by opiate overdose but by some other problem such as a stroke or a heart attack, naloxone will do no harm. Its effects can wear off within 10-20 minutes, so an ambulance should always be called before it is given.

I agree that it would be useful for families and friends of people who use drugs to have their own supply of naloxone and regulatory changes to allow this were recommended by the Advisory Committee on Misuse of Drugs in their "Consideration of 'Naloxone' in May 2012"<sup>1</sup>. These changes take time, but the next step is a consultation period, launched by the Medicines and Healthcare products Regulatory Authority (MHRA) in December 2013<sup>2</sup>. There is a section you could fill in yourself to support these changes and I would encourage you to contribute your views even if we are past the consultation period. We hope the outcome will allow changes to the healthcare regulations so that people like yourself and also outreach workers and hostel workers who might be in a position to use naloxone will be able to carry a naloxone kit without a prescription.

In the meantime perhaps you could talk again to your son. If he is an opiate user, with his permission I could prescribe naloxone in his name and it would be legal for your son to give it to you for safe-keeping. Of course we hope it would never need to be used. If your son has a drug worker, you would be very

<sup>1</sup> Advisory Council on the Misuse of Drugs (ACMD). Consideration of naloxone. London: Home Office. London, England: The Stationery Office; 2012.

<sup>2</sup> MHRA Consultation 2013: Proposal to allow wider access to naloxone for use in emergencies

<https://www.gov.uk/government/consultations/proposal-to-allow-wider-access-to-naloxone-for-use-in-emergencies>

welcome with his permission to join him at a session to learn about recognition and management of overdose and the use of naloxone. Our patients have found the short training is both interesting and informative, and as well as feeling proud to be entrusted to carry such life saving medication, many have used the opportunity to discuss experiences they have had and risks they may have taken which they will hopefully avoid in the future.

You might find it helpful to make contact with Adfam<sup>3</sup>, who support families affected by drugs and alcohol, and please come and see me again later in the year, by which time hopefully the regulations may have changed.

<sup>3</sup> Adfam: <http://www.adfam.org.uk/>



## 19th National Conference: Managing drug and alcohol problems in primary care

*Early Intervention -  
Which way forward?*

**Wednesday 14 and  
Thursday 15 May 2014**

**Holiday Inn Hotel,  
Stratford-upon-Avon**

For more information  
and to register follow  
this link

<http://www.rcgp.org.uk/courses-and-events/managing-drug-and-alcohol-problems.aspx>

## COURSES AND EVENTS



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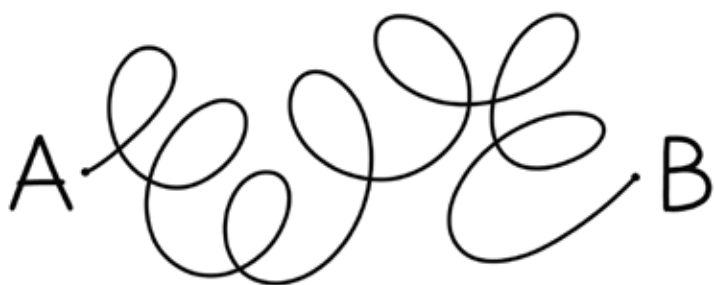
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## TREATING SUBSTANCE MISUSE IN PRIMARY CARE

**YOU KNOW IT MAKES SENSE**



SAVE THE DATE

**9<sup>TH</sup> PRIMARY CARE DEVELOPMENT CONFERENCE  
THURSDAY 23<sup>RD</sup> OCTOBER 2014  
MCDONALD BURLINGTON HOTEL, BIRMINGHAM**

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