network

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Cannabis: how spending five minutes in primary care can make a difference

Cannabis remains a tricky issue for primary care. While most people who use it won't be too troubled by it, about 10 % of users become dependent, with early onset users being at greater risk. 85% of UK cannabis smokers concurrently use the substance with tobacco, and among those with pre-existing severe mental illness its impact can be devastating. At a time of changing regulation and an increasing acceptance and evidence base for its use as a medicine across diverse conditions, GPs could be left thinking that it's all a bit confusing and wondering what their stance should be in clinical practice. Hopefully in the next 1000 words or so I will share a useful thought or 2 for busy GPs who want to make the most of 5 minutes with someone who uses cannabis. I'll skip the basics about engaging, enquiring and framing your opening questions since the words 'eggs' and 'sucking' come to mind.

Cannabis in the UK today

Before I cover the intervention side of things I want to clarify that cannabis is not a single product anymore and it varies in price, effect and risk profile. Work done by the Global Drug Survey (GDS) has shown that high potency herbal cannabis (skunk), which retails for £10/ gram and currently dominates the UK market is associated with higher rates of paranoia, memory loss, dependence and help seeking behaviour than resin (hashish which is usually sticky black or hard brown) and normal weed (which has seeds in it and smells less). The latter 2 preparations are much lower in THC (tetrahydrocannabinol – the stuff that gets you high) — around 2-4% as compared to 10-15% for skunk. Resin and normal weed also have higher levels of CBD (cannabidiol) – about 2-4% as compared to almost none in skunk. CBD does not get you high but has a calming effect and tends to balance the THC content. You should also be aware of emergence of butane hash oil (a waxy, honey like extract that can be > 80% THC) and the increasingly evidenced problems associated with the use of synthetic cannabis products (herbal incense preparations). Recent research by GDS[1] suggests that the risk of seeking emergency medical treatment is 30 times higher with synthetic cannabis than high potency herbal cannabis with extreme agitation, paranoid and seizures being amongst the most prominent and distressing feature of acute presentations.

1 Winstock, A et al. (2015) Risk of emergency medical treatment following consumption of cannabis or synthetic cannabinoids in a large global sample Journal of Psychopharmacology, 03/17/2015

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We hope you enjoy this edition.

Editor

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The practical bits

There are 3 things you might want to focus on in a 5-minute appointment and these link as stepped interventions to supporting positive behavioural change and reducing use and associated harm. They are:

1. addressing tobacco use
2. offering harm reduction advice
3. helping people cut down and quit (if that is what they want to do).
4. I often start by quantifying use, asking about weekly spend and joints/ grams used. The average is 3-4 joints per gram — any less they should be told to roll smaller joints! A person smoking half-a-gram a day is spending over £1500 per year. I see patients who regularly smoke 3 or more grams per day (yep that's getting on for £10,000 per year).

> "almost one-in-four cite significant concerns over the impact of their cannabis use on their lung health and cancer risk"

Tobacco

Work done by the Global Drug Survey (Freeman and Winstock submitted) suggests the majority of smokers do have concerns over the impact of cannabis on their health, with worries about memory, mental health, motivation, work/ study and relationships topping the list. But almost one-in-four cite significant concerns over the impact of their cannabis use on their lung health and cancer risk. These are nice medical things to start with and are usually associated with concurrent tobacco use/ dependence.

What to do

Ask if they mix cannabis with tobacco: 'do you roll your spliffs with tobacco?' Do they smoke cigarettes as well? How long have they smoked for? Do they cough, wheeze or get short of breath? Do they have a family history of cancer? Especially in older groups the use of a lung age spirometer can be a powerful nudge to getting people to reconsider the impact of the 'harmless' weed on their health and wellbeing. Offer some simple harm reduction advice: roll smaller spliffs, try nicotine replacement therapy (NRT), offer referral to a smokers clinic, have they heard of a vaporizer? This heats cannabis to a temperature at which THC gets released as a vapour, but below which cannabis combusts — combustion leads to the formation and release of tar and carcinogens.

Harm reduction

For most people the harms associated with cannabis are strongly related to dose and duration of use. We've already covered smoking in the previous section so all I will add here is that it can be worth reminding users that most of the THC absorbed in the first few seconds after inhalation in the upper airways so there is no need to inhale deeply and keep smoke in your lungs. For more harm reduction advice please see the GDS High-Way Code www.globaldrugsurvey.com/brands/high-way-code.

What to do

Basically less is more. Using less avoids the development of tolerance, saves money, reduces risk and allows people to still enjoy getting high. If you can encourage behaviour change that does not diminish pleasure you are more likely to see your advice adopted. A good source of harm reduction information is the GDS Highway Code, the world's first harm reduction guide voted for by people who use drugs (the people who are most trusted by other people who use drugs). It not only ranks different harm reduction strategies by the proportion of users who normally adopt it and how important they perceive each one to be in reducing risk of harm, it also uniquely rates different strategies on the impact they have on drug related pleasure. The headline conclusion is that safer drug use appears to be more enjoyable drug use. It has been downloaded over 50,000 times. The cannabis drugs meter (www.drugsmeter.com) can be another useful anonymous free resource for people to get some personalised assessment and feedback on their cannabis use. It also allows them to compare their use to 100,000 other cannabis users and to figure out for themselves if they are using too much. It's also a source of harm reduction and cutting down information.

> "If you can encourage behaviour change that does not diminish pleasure you are more likely to see your advice adopted"

Cutting down and managing withdrawal

Work done by the GDS suggests that about 1-in-3 users would like to use less and between 5-10% might want some help in doing so. Cutting down starts with the strategies we have covered in the first two parts of this article. Withdrawal from cannabis can cause issues for 60-70% of daily dependent users. The most common symptoms include insomnia, weird dreams, low mood, craving, and irritability and restlessness. In those with premorbid aggressive personality traits withdrawal can be associated with a marked increase in aggression and hostility. Risk assessment if partners or

Editorial

We have packed this edition full of the latest developments in the field and hope this keeps your knowledge up-to-date. John Jolly gives an alarming precis of the state of the sector on page 6 and calls us to action. This comes at a time of funding cuts to the drug and alcohol field and it was with concern and sadness that we heard of the demise of DrugScope, a great campaigning charity. While we are pleased to be a sponsor of DrugScope Daily and to see its survival it is ever more important that we all campaign to keep effective drug policy and practice high on national and local agendas.

We are pleased to be accepting our second intake for the Advanced Certificate in Community Management of Alcohol Use Disorders, aimed at Practitioner with Special Interest level. To find out more, including access to our free e-learning module visit our e-learning site.

We hope you enjoy this issue!

Kate Halliday Editor

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children are nearby should be conducted. Withdrawal symptoms peak at day 2 and 3 and for most are over by day 7-10 although sleep and mood disturbance can take 3-4 weeks to settle.

Work by the Global Drug Survey has indicated that withdrawal is worse among women, heavier users, those who smoke cannabis with tobacco and those who stop in an unplanned fashion. Cutting down use over a few weeks before commencing a quit attempt and delaying the onset of the first joint of the day and reducing tobacco use means that withdrawal is likely to be less severe. Most cannabis users cheer up when they stop smoking so don't initiate antidepressants until they have been cannabis free for at least 3-4 weeks. NRT, psycho-education, family support and good sleep hygiene with an emphasis on reducing afternoon caffeine consumption are key. A few days (4-7) night sedation is fine and can be quite helpful (zopiclone 7.5mg or diazepam 10mg). Simple analgesics can also be useful for accompanying symptoms of headaches, chills, sweats and muscular aches that can be seen in a minority.

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Many health care professionals have operated for years from the position of 'one thing at a time', helping patients identify the most important thing they want to change and concentrating on that problem first before addressing another problem. Gordon Morse argues that we may be doing our patients a disservice as evidence shows that making changes on multiple problem areas is possible, and describes a pilot project looking at the issues. Ed

Smoking and drug and alcohol use: can we do more?

Smoking and tobacco use remains a leading cause of premature death and illness in the UK. It increases the risk of developing heart disease, cancers, chronic obstructive pulmonary disease (COPD), asthma and other diseases, and of dying early. And in addition, there are the considerable financial costs of smoking to the NHS estimated to be £2.7 billion a year.

Helping people to stop smoking is everyone's business. By addressing tobacco addiction and referring to treatment, those working in primary care can add considerable value especially for those who have multiple addictions. However, for many clinicians there remains the question of which behaviour to address first: smoking before alcohol and drugs; or drugs first then alcohol then smoking? Treating addiction with this 'one thing at a time' approach may involve multiple appointments, which in turn means more journeys within the healthcare system and ultimately less value for the patient themselves as well as for the NHS.

There is a developing field of evidence that links smoking cessation with better treatment outcomes for polysubstance and alcohol only users[1 2 3] and that when people present with polysubstance use which includes smoking, treatment for smoking should not be considered less important than treatment for comorbid addictions. In addition to the developing evidence, pilots of services that support the specific needs of people with multiple addictions are currently being evaluated.

One such pilot is managed by Turning Point (TP) with support from Public Health England (PHE) and the South London and Maudsley NHS Trust (SLaM). Set up in August 2014, the pilot is running at nine Turning Point services across the country. These services include community substance misuse services in Wiltshire and Westminster, an in-patient detoxification centre in Manchester (Smithfield), residential rehabs in the North West and HMP New Hall (a women's prison in West Yorkshire). There were seven key elements to the pilot:

1. Benchmarking of service user smoking data
2. Assessing workforce attitudes and behaviour
3. Staff training and development
4. Smoking policy review
5. The assessment and goal planning of interventions
6. Data recording and outcomes
7. Pilot outcomes and evaluation.

This article will briefly explore the four areas of: assessing workforce and behaviour; staff training and development; data recording and outcomes; and pilot outcomes and evaluation.

Using electronic client records, TP extracted data from April 2014 to February 2015 to establish how many service users in the nine pilot areas had: undergone structured treatment assessments; were currently smoking; had previously smoked; and had never smoked. A manager in each pilot site led a team meeting, with a quiz on tobacco smoking in substance misuse services being followed by a discussion. There was also a debate structured around a SLaM questionnaire which included issues such as how

1 Murray D et al. (2015) Brain perfusion in polysubstance users: Relationship to substance and tobacco use, cognition, and self-regulation. Drug and Alcohol Dependence Available online 26 February 2015 http://www.sciencedirect.com/science/article/pii/S0376871615001064#

2 Walitzer KS, et al. (2015) Tobacco Smoking Among Male and Female Alcohol Treatment-seekers: Clinical Complexities, Treatment Length of Stay, and Goal Achievement January 2015, Vol. 50, No. 2 , Pages 166-173 (doi:10.3109/10826084.2014.962050) http://informahealthcare.com/doi/abs/10.3109/10826084.2014.962050

3 Ouellet-Plamondon, C. (2013) Treatment of Comorbid Tobacco Addiction in Substance Use and Psychiatric Disorders. Current Addiction Reports March 2014, Volume 1, Issue 1, pp 61-68 Date: 20 Nov 2013 http://link.springer.com/article/10.1007/s40429-013-0001-8

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often staff discussed tobacco smoking with clients, when and where to bring up the subject, and examples of brief interventions that can help with smoking.

> *"More patients in treatment for alcohol or drug misuse will die from smoking-related diseases than from substance misuse causes"*

Assessing workforce and behaviour

The feedback from most staff identified that many held a false belief that heroin and alcohol use were more often associated with death in substance misuse (SM) services than tobacco smoking. The opposite is in fact the case. More patients in treatment for alcohol or drug misuse will die from smoking-related diseases than from substance misuse causes. Staff were also interested in when they should address the issue of tobacco use among service users in treatment for drug or alcohol dependency. This question was also addressed in the staff survey and Turning Point are considering this in relation to its best practice guidance. Team discussions highlighted the need to progress practice to the point that discussions with clients about tobacco smoking would be the norm.

A total of 248 staff also completed an anonymous survey (via Survey Monkey) to determine attitudes and behaviours about smoking. The majority of the responses (56%) were from front line staff in senior, recovery and support worker roles.

The results indicated that:

- Nearly two thirds (65%) were willing to help TP develop and test stop smoking interventions
- Confidence levels were high among staff to support service users who would like to give up smoking
  - more than four in five (83%) rated their confidence levels as five or above on a scale of one to ten
  - Almost a quarter (23%) rated themselves as 10 out of 10 in terms of confidence to engage in smoking cessation work
- Respondents felt it more important to address tobacco use in clients using cannabis (7.4%) than for alcohol or heroin using clients (both 6.4%).

When staff were asked about their smoking habits:

- Nearly three quarters (74%) had ever smoked
- More than two in five (41%) had smoked daily in the previous year
- Almost half (45%) had never smoked
- Nearly two thirds (64%) who did smoke said they would like to stop
- Almost a third (30%) were interested in speaking to someone about reducing the harm of their own smoking behaviour.

However, it is important to note that just over a quarter of staff (n=66) did not answer this question, so the number of staff who smoke could be higher.

Don Lavoie, PHE alcohol programme manager said, "Staff working in substance misuse services are about twice as likely to smoke as the general population. The desire by two thirds of them to stop is a good indication of a need for substance misuse services to put on stop smoking services for their own staff."

The findings from both the quiz about tobacco smoking and substance misuse and the anonymous staff survey suggest three things:

1. Most staff are open to including brief advice on smoking cessation and signposting into treatment as part of their interventions
2. Most staff already feel confident that they have the skills to support smokers to stop
3. There is a high level of staff receptiveness to the idea of cessation.

Staff training and development

Staff training and development has been a crucial part of the pilot. All nine sites evidenced that staff were being trained in delivering Very Brief Advice (VBA) and a more intensive training which provides practitioners with the evidence based interventions that are effective in supporting smokers to stop. The National Centre for Smoking Cessation Training (NCSCT) provides e-learning in VBA to all frontline workers in the pilot sites, which is complemented by local stop smoking service input at some sites. These services are also offering the more intensive training for identified staff, enabling them to provide effective stop smoking interventions.

Data reporting and outcomes

Another advance brought about through the pilot project is the standard inclusion of tobacco questions in the initial client assessment document. In addition to asking whether they smoke, clients are asked whether they would like support to cut down or give up smoking. They are also asked about use of e-cigarettes. It is important to emphasise the TP pilot is still in progress, with an end date of 15th October 2015. New data will be gathered in August to evaluate:

- The impact of the trial on tobacco use
- The effect of the project on access to interventions
- The uptake of these interventions.

It is expected that learning from this outcome data will be used to support GPs and primary healthcare professionals in making referrals that are more effective for treating tobacco use as part of the overall treatment for addiction.

> *"Staff working in substance misuse services are about twice as likely to smoke as the general population"*

Pilot outcomes and evaluation

This has already been a learning process and we have an opportunity to build on progress so far. The cessation pilot has made us think about wider organisational policy and wellbeing for staff alongside service users. The clear message is that everyone working within treatment systems needs to be asking the question about tobacco use to reinforce behaviour change. As a model of a treatment pathway, the TP pilot has highlighted that there is an opportunity to share resources and access training for staff across the system. GPs should be encouraged to access the free NCSCT training available for them and their staff, to ensure that referral and treatment practices demonstrated by staff follow best practice models.

Something that we already know from speaking to clients is that the more difficult to engage groups fall out of any programme (for example health, social care or educational); a more integrated public health model of service delivery will create less attrition and better outcomes from treatment.

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There is good evidence to support the treatment of smoking alongside other addictions and further research to establish the most effective methods will be useful. We want to encourage staff in drug and alcohol services to access training and develop the confidence to address smoking, deliver interventions to support their clients to stop smoking where this will provide better opportunities for engagement and support people to stay with the stop smoking programme for longer.

All such services should follow the appropriate National Institute for Health and Care Excellence guidance and refer to the Local stop smoking services: service and delivery guidance 2014 for information on the effective commissioning, delivery and monitoring of services. All delivery staff should be assessed as competent to provide services to the NCSCT standard by completing the online training that is available and ideally supplementing this through mentoring from a trained advisor.

Gordon Morse, Medical Director, Turning Point

Useful links

For national training resources visit http://www.ncsct.co.uk/

Including a resource for mental health practitioners http://www.ncsct.co.uk/publication_Smoking_cessation_and_Mental_Health_briefing.php

and a short training course on providing very brief advice http://www.ncsct.co.uk/publication_very-brief-advice.php

For support in stopping smoking visit http://www.nhs.uk/smokefree

For information about smoking and stopping visit http://www.nhs.uk/livewell/smoking/Pages/stopsmokingnewhome.aspx

Andre Geel discusses the growth of problem gambling and identifies ways in which primary care can help to identify this issue. Ed

Problem gambling and primary care: whose problem?

Gambling is a relatively new concept within the addictions field and also a relatively novel one to assess and treat in primary care. Although GPs have probably been providing comfort to patients with this problem for as long as the general physician has been around, it is unlikely that they have been able to provide appropriate evidence-based treatment for the addiction. That treatment is relatively new, CBT (cognitive behavioural therapy) having only recently been adapted to treat this behavioural addiction. It has only been in the last 15 years or so that standardised and coherent treatment packages using CBT have been specifically designed for problem gambling. It has only been in the last 7 years that the NHS has recognised this disorder with the establishment of the National Problem Gambling Clinic.

In terms of incidence it has only been more obviously and accurately recorded in recent years, most notably via the British Gambling Prevalence Survey (BGPS) first conducted in 1999. Gambling had achieved a higher public profile and degree of acceptance with the introduction of the National Lottery in 1994.

The Gambling Act (2006) followed this and enshrined into law much of the behaviour expected by and of the gambling industry.

The BGPS of 2010 estimated that there were approximately 596,000 "problem gamblers" in the UK and an additional 3.5 million 'at risk" of becoming problem gamblers – the term "problem gambling" being the official (DSM IV) diagnosis for this behavioural addiction.

It can be assumed that a significant proportion of this relatively large population would at some time or another be in contact with their GP and therefore possibly be candidates to be screened for such a problem or present with symptoms associated with the problem. If this was the case then GPs might have a unique opportunity to assess, intervene, treat and refer on.

Indeed the Royal College of General Practitioners (RCGP) provides a course – "Gambling Disorders in General Practice" – to address this very issue. This course was developed in collaboration with a number of providers, professionals, researchers and clinicians in the field with one of its principal aims being early intervention with the 3.5 million "at-risk" group.

The RCGP website states: *"This Gambling Disorders course enables you to identify and manage patients with problem gambling. The prevalence and impact of problem gambling is grossly underestimated and can range from lottery addictions to pathological internet-based gambling activities.*

It is essential as a GP to be able to identify patients at risk and this course is designed to help you improve the care and support you and your practice can provide by offering practical screening tools and the skills to manage problem gambling in general practice".

The success of this course is yet to be fully assessed, but it has proved popular amongst a specific group of GPs interested in addictions in general and the behavioural addictions in particular.

The popularity of gambling appears to be growing with more women gamblers and more internet gambling taking place. This would suggest that problem gambling would also grow in proportion. Indeed some have suggested that the problem might grow exponentially as a result of it being less public – via internet gambling at home, for example – and therefore, without the more public constraints of other people observing and checking one's more inappropriate and harmful behaviour, it becomes a problem that can get more easily out of control. This has been observed anecdotally at the National Problem Gambling Clinic within its client group.

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In a recent publication on the aetiology of the condition it is reported that *"Problem gambling is a relatively newly identified disorder which has aspects of a pure behavioural addiction, co-morbidity with existing mental disorders and neurological aspects, and is a complex, multifaceted and emerging field. Whilst the causal connection between problem gambling and co-morbid disorders/ conditions has not been established, we should be mindful that the definition and aetiology so far are embryonic, so to begin to view it from a bio-psycho-social perspective seems to be a usefully broad position to take.*

Pathological gambling is one of the few disorders that seems to sit more comfortably and convincingly within a behavioural explanation of its aetiology and cause at present. Currently the most pragmatic, effective and evidence-based way of treating the problem (and getting good results) is the behavioural and cognitive-behavioural approach, but it might not fully explain the aetiology of the problem. Variables such as mental co-morbidity and neuropathology are very likely linked to this behaviour and need to be incorporated in the explanation of the condition in the future." [1]

As stated above the aetiology of the problem is still emerging and factors such as gender (more men), age (younger), income (lower), occupation (unemployed) and relationship status (single), all tend to suggest risk factors but there also appear to be strong associations suggested with impulsivity and disinhibition which warrant further investigation.

Given that this is a growing problem which is still however relatively unrecognised, it would seem that the most pragmatic and immediate approach to identifying and treating it would be to begin at the general practice – the place where most people initially present with distress in their lives. With general practitioners' broader view of assessing problems it might be possible to make an early tentative diagnosis – often by noticing associated symptoms rather than the addiction itself – and then to consider referring on to the treatment which is most effective – in this case CBT. This involves a process whereby GPs themselves need to see the subtleties in patients' presentations where they may (most often) be presenting with other symptoms — anxiety, depression, substance misuse, relationship problems – which are masking the behaviour and/ or are comorbid to the gambling problem.

> ***"The popularity of gambling appears to be growing with more women gamblers and more internet gambling taking place"***

The ability for the GP to "tease" out this complexity with the patient and establish with them that the problem is indeed a gambling addiction might take some time and skill, and be determined by the nature of the relationship they have with the patient. Indeed this might be the essence of general practice and the unique role of the "family doctor" to be able to "see" into the patient's personal life in a way that others do not, and to be able to alleviate many different kinds of suffering experienced by those patients – in this case a rather un-medical disorder that requires a rather un-medical treatment.

To refer on to the appropriate treatment is the next challenge as there are so few registered CBT therapists or services that provide this intervention. They are however available and do provide successful evidence-based outcomes.

In the future it is possible that problem gambling will be treated as any other common mental health problem – relatively easily admitted to by the patient, effectively diagnosed, and the appropriate treatment provided – but until then it seems like the first port of call for anyone in distress is most likely to be their GP.

Andre Geel, Consultant Clinical Psychologist, Chair SMMGP Board

1 Reference: Bowden-Jones, H and George, S (2015) A Clinician's Guide to Working with Problem Gamblers. London, Routledge.

John Jolly writes a worrying report card on the state of the drug and alcohol treatment sector and gives a call to action for us all. Ed

The state of the sector: disinvestment in drug treatment is putting lives at risk!

England has the best drug treatment system in the world; it exists because of the vision of far sighted people from all political parties and the dedication of amazing staff, organisations, charities, and public officials over the last 50 years. Cuts in drug and alcohol funding, along with the lack of political leadership and the lack of priority in England may, in the coming years, have a major negative impact on some of the most vulnerable people in our communities. The moving of drug funding into Public Health England, where illicit drug use is not a strategic priority, has given a green light to local authorities (now responsible for funding public health in England) to disinvest in drug services.

There has never been a more urgent need to have clear English government leadership spelling out the responsibilities of local authorities along with the levers to ensure they deliver. What we have is localism, a post code lottery, a government washing their hands of responsibility like Pontius Pilate and senior political figures actively conspiring to undermine evidenced based practice.

We are sadly going to witness the end of the best drug and alcohol treatment system in the world unless we act quickly. Its decline will be marked by lost opportunities and an increasing death toll as we fail to respond to rapidly increasing numbers of drug related deaths, health needs, and fail to tackle issues such as hepatitis C, HIV and liver disease. We are also failing to resource "*harm reduction*", a phrase banished from the political lexicon like a dirty word.

Over the next 3 years, spending on drug and alcohol services is predicted by some officials to fall between 25% and 50%.

As DrugScope prepared its recently published State of the Sector Report, we in the field were unaware that the organisation itself was about to close.

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The report revealed:

- Evidence of deep and widespread disinvestment and planned disinvestment in drug and alcohol services (over 70 services indicating cuts in funding with an average net reduction of 16.5%)
- A third of local authorities indicating decisions to reduce funding in 2014/15 and 2015/16
- The massive scale of re-commissioning and tender renegotiation leading to the widespread disruption of services (54% of services since Sept 13 with another 49% indicating re-commissioning between Sept 14 – Sept 15)
- Cuts in frontline drug and alcohol staff across the country and increasing caseloads
- Worsening access to mental health services
- Worsening provision of outreach services
- Worsening access to housing and resettlement provision
- Worsening access to employment support
- Lack of provision for older clients
- Negative impact of prison staffing cuts on access to treatment
- Little confidence that Police and Crime Plans and Joint Strategic Needs Assessments/Joint Health and Wellbeing strategies reflected local needs
- Reductions in harm reduction services at a time of increases in drug-related deaths
- Commissioning processes that discriminate against excellent small and medium sized organisations delivering excellent local services.

There has been a change in the focus away from the needs of vulnerable addicted people with often multiple economic, social and health problems onto the needs of the wider population. The not insignificant needs of this far larger population will mean fewer resources to support those heavily dependent on drugs and alcohol with multiple and complex needs.

> ***“We are sadly going to witness the end of the best drug and alcohol treatment system in the world unless we act quickly”***

The provision of services to people with significant and multiple needs is being disrupted by frequent re-commissioning and system redesign. It has a hugely detrimental impact on the ability of organisations to care for people accessing services. It has had a significant negative effect on staff morale and the ability of organisations to invest their resources into the provision of services which are increasingly diverted to funding tendering capacity.

There is an increasing failure to address housing, mental health, employment and complex needs. There is a shocking lack of access to the employment market for people with a history of drug and alcohol misuse particularly where this is associated with criminal convictions. Specialist services addressing employment for this group were decimated in the government commissioning of the Work Programme. Changes to welfare benefits have impacted detrimentally on housing stability and the level of homelessness experienced by those who are drug and/or alcohol dependent is rapidly increasing. The decommissioning of many NHS providers is resulting in a decline in access to specialist mental health service provision in many areas.

People with drug and alcohol problems suffer prejudice and discrimination particularly if they commit the crime of also being poor. Sadly this right to discriminate is enshrined in UK equality legislation. As we approached the general election yet again we saw policies being suggested which focus on drug and alcohol users as being the undeserving benefit claimant if they are not in treatment. A requirement on local authorities to provide employment paying the living wage would be more constructive. It's often not that people with drug and alcohol problems are reluctant to work but that employers are reluctant to provide employment. We need a system of regulation that supports those experiencing problems with alcohol and drugs rather than criminalising and stigmatising people for being ill and vulnerable.

People who inject drugs are the group most affected by hepatitis C in the UK: around 90% of the hepatitis C infections diagnosed in the UK will have been acquired through injecting drug use. Across the UK 13,758 hepatitis C infections were diagnosed during 2013.

> ***“There's no time, no money, no staff, no resource but up and down the country people, organisations and service user groups are rising to the challenge”***

Around 2-in-5 people who inject psychoactive drugs such as heroin, crack and amphetamines are now living with hepatitis C, but half of these infections remain undiagnosed. PHE state “Interventions to diagnose infections earlier, reduce transmission and treat those infected need to be continued and expanded, with the goal of reducing the prevalence of hepatitis C.”

This year 97% of people with hepatitis C will be untreated. Imagine the outrage if this was breast cancer or lung cancer, particularly if the death rate was climbing year-on-year as it is with hepatitis C. Now imagine if you could completely cure everyone with breast cancer or lung cancer but decided to only treat 3% a year. Outrage! This is precisely what happens to those with hepatitis C. There is a real risk now that even this appallingly low figure will become unachievable as a result of changes in funding.

There is a growing palpable sense of “old school activism” in the sector. There's no time, no money, no staff, no resource but up and down the country people, organisations and service user groups are rising to the challenge. There is a palpable sense of determination; the power of networking is gearing up, sharing ideas, inspiration and the need to stand strong in the face of cutbacks.

Unless service user groups and a powerful alliance of GPs, NHS and third sector providers and charities are prepared to fight in the corridors of Whitehall and Westminster, and on the beaches of local authority cuts, I fear that the world's best treatment system is about to be decimated in 2015/16. I fear for the people we help and I pray that I am wrong. It's time to stand and fight.

John Jolly, CEO, Blenheim

Ewen Stewart describes the challenges the emerging use of club drugs cause for services, including responding to chemsex. Ed

Club drugs and chemsex: a challenge for many services

Drug Services across the UK are becoming increasingly aware of the need to meet the challenges posed by the growth of the use of novel psychoactive substances (NPS). These are drugs that are synthesised to mimic the effects of traditional recreational drugs and their use appears to have been growing exponentially since 2008. Use varies significantly across the UK both in terms of who is using them and in how they are being taken. Management of the many physical, psychological and social problems that NPS use brings is making drug services rethink their prevention/ harm reduction messages and treatments that they can offer clients. At the same time a different, but related, pattern of drug use is emerging which is going to require a shake-up of not only traditional drug services but many other health and social services as well.

Club drugs

Club drugs are psychoactive substances that are used recreationally in nightclubs, festivals, sex venues and house parties. They include[1]:

- established illegal drugs such as amphetamine methamphetamine, cocaine, ketamine, 3,4-methylenedioxy-N-methylamphetamine (MDMA), lysergic acid diethylamide (LSD)
- drugs which were legal but are now controlled (mephedrone, 4-hydroxybutyric acid [GHB]/ γ-butyrolactone [GBL])
- currently legal drugs such as novel psychoactive substances (NPS) marketed as plant food or bath salts.

Use of these club drugs is mainly amongst a whole new group of users from the club going and student populations, and particularly amongst the lesbian, gay and bisexual (LGB) community. Consultant psychiatrist Dr Owen Bowden-Jones who runs a club drug clinic in London says: 'Many of these drugs have stimulant and hallucinogenic properties similar to ecstasy. The exceptions are GHB/GBL, which act more like alcohol and have a high risk of overdose'. They are being used by many to enhance and prolong the clubbing experience although there are increasing numbers of users outside of that scene. Club drug users in England now constitute 5% of all adult presentations for drug treatment[2] and 14% of all presentations by those under 18[3].

Chemsex

Amongst men who have sex with men (MSM) there is a small but significant pattern of sexualised use of drugs called chemsex. Chemsex describes sex that occurs under the influence of drugs, which are taken immediately preceding and/or during the sexual session. The drugs most commonly associated with chemsex are crystal methamphetamine, GHB/GBL, mephedrone and, to a lesser extent, cocaine and ketamine. All, except ketamine, are stimulant drugs in that they typically increase heart rate and blood pressure and trigger feelings of euphoria. Crystal methamphetamine, GHB/ GBL and mephedrone also have a common effect of facilitating feelings of sexual arousal[4]. In the Sigma Research chemsex study[4] common themes reported by users were intensification and prolongation of the sexual experience and more adventurous sex. They also reported lack of self-esteem, inability to have sex without drugs and regret about sexual behaviour under the influence of drugs. Some men reported being victims of sexual assault whilst intoxicated.

Club drugs and harm

The range of harms associated with use of club drugs is broad. It includes, but is not limited to:

- Risk of overdose with unconsciousness and death (e.g. GHB)
- Severe psychiatric problems such as psychosis, depression and anxiety (e.g. methamphetamine, ketamine, ephedrine)
- Physical problems such as dental rot, seizures and strokes (e.g. methamphetamine), kidney and bladder problems (e.g. ketamine)
- Risky injecting in a population who do not access needle exchanges and are using drugs that may be taken many times a day
- HIV and sexually transmitted infection risk due to risky injecting and risky sexual behaviour in chemsex. Also risk of poor adherence to HIV medications during drug taking binges

1 Faculty of Addictions Psychiatry, Royal College of Psychiatrists (2014) One New Drug a Week Faculty report FR/AP/02, Future trends in addictions – discussion paper 2.

2 National Drug Treatment Monitoring Service, 2013a

3 National Drug Treatment Monitoring Service, 2013b

4 Bourne, A et al (2014) The Chemsex Study: drug use in sexual settings among gay and bisexual men in Lambeth, Southwark & Lewisham, Sigma Research, London School of Hygiene & Tropical Medicine, 2014.

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- Confusion leading to aggression and violence
- Intense comedown that can cause users to feel suicidal
- Physical and psychological dependency happening quite rapidly after a relatively short intense period of use.

Club drugs and treatment services

The users of club drugs are, and perceive themselves to be, different from the opiate and crack users that have been the main clients of drug services. They are more likely to be in employment and to have well connected social networks. They do not identify with the clients of traditional drug treatment services and therefore may not see those services as appropriate for their needs. This means that they are increasingly presenting to general practice, A+E, sexual health services and mental health services. Men who have sex with men who may have concerns about disclosing their sexual orientation and their sexual activities are presenting with drug problems at sexual health clinics.

Clinicians in non-drug health services feel they lack the knowledge and skills to deal with the problems related to and treatments for club drug use. Referral on to drug services may not be acceptable to these clients and even those services, more used to seeing opiate and crack users, may not be aware of interventions for club drug users.

The Faculty of Addictions Psychiatry from the Royal College of Psychiatrists has recommended that generic services, including primary care, should work to develop:

- a workforce trained in the detection, assessment and treatment of club drug-related problems
- a workforce with the cultural competence to engage club drug users
- clear pathways to refer complex cases (e.g. GHB/GBL detoxification, chemsex participants).

There are some specialist clinics and services that have been developed and which are building expertise in the management of problem club drug use. The most well-known of these is the Central and North West London Club Drug Clinic which was established in 2010. Described in a DrugScope report on NPS and club drugs in the UK[5], the clinic was set up when the local HIV unit identified a cohort of drug using HIV positive gay men who said they would only go to a drug problem service specifically geared to them. It is jointly run with London Friend, a LGBT voluntary service, and aims to closely link the sexual health clinic and drug services. Of the hundreds who have attended since it opened, around two thirds are gay men participating in chemsex. They often have a history of regular injecting, sharing of injecting paraphernalia and multiple sexual partners. The other third of attendees are a younger group made up of people from the squatting community (primarily using ketamine), students and professionals (using NPS like Benzo Fury). Many of them could be described as 'weekend users'. The report states that the issues leading them to present are varied, for example, a relationship breakdown or a caution at work — as well as related mental health issues such as anxiety disorders, depression, psychosis (mephedrone), visual distortions and auditory hallucinations.

Interventions and treatment

Treatment typically involves psychosocial interventions, which address basic motivation and prevent relapse[6]. Harm reduction provision including injecting equipment provision is also vital for the chaotic injecting picture that is seen in some users. This will need to involve co-ordinated work with managers of commercial sex-on-premises venues and dance clubs to facilitate development of clear harm reduction policies and procedures in those settings[4].

The Club Drug Clinic offers a mixture of medical and psychosocial interventions, including: GBL detox, urology assessments, psychiatric prescribing, relapse prevention, motivational interviewing and highly focused LGBT work (for example, addressing internalised homophobia). This reflects the recommendations of the Faculty of Addictions which recommends that services managing club drug users should:

- provide harm reduction interventions specific to particular club drugs and the offer of basic sexual health screening
- have specific treatment pathways and clinical protocols for all treatments (e.g. medically assisted GHB/ GBL detoxification)
- use peer support
- have clear mechanisms to make detailed records of harm associated with club drug use (current data collection systems [NDTMS] and treatment outcome measures [TOP] are primarily for heroin and crack users)
- develop specific resources providing latest information on harm
- build well-developed pathways to, and from, sexual health, urology, child and adolescent and pain management services.

There is a clear need to further develop treatment for people using NPS, but clinical experience of managing these drugs is limited, as is the evidence base for treatment effectiveness. Project NEPTUNE is an 18-month project, funded by the Health Foundation, aimed at raising clinical competencies in the management of club drug related problems.

In spring 2015 Project NEPTUNE published detailed guidance on NPS and club drugs, their effects, treatment approaches, aftercare and harm reduction. This is an independent clinical expert group that has developed guidelines on treating acute NPS problems. The guidelines give detailed information on NPS and club drugs, their effects, treatment approaches, aftercare and harm reduction. It is the key guidance for general practice, A&E, drug treatment and other services that deal with people who have NPS problems.

Ewen Stewart, GP and Clinical Lead Viral Hepatitis MCN in Lothian

Further reading

Public Health England, (2014) New psychoactive substances: A toolkit for substance misuse commissioners

5 DrugScope (2014) Business as usual? A status report on new psychoactive substances (NPS) and 'club drugs' in the UK , Prepared by DrugScope on behalf of the Recovery Partnership, May 2014'

6 National Treatment Agency for Substance Misuse (2012)Club Drugs: emerging trends and risks,

We caught up with The Alliance, a cornerstone of the drug treatment field to find out the latest state of play with this important advocacy service. Ed

Everything you wanted to know about The Alliance but didn't know who to ask

Can you give us a brief history of The Alliance, how it started and where it is now?

The Alliance was started in 2000 as The Methadone Alliance by Bill Nelles, with GP Dr Chris Ford giving medical advice and Alan Joyce and Beryl Poole as the first advocates. The aim of the organisation was to get drug treatment professionals and drug users working together to improve the quality of treatment provided to patients who are prescribed methadone. The Methadone Alliance was, and still is, particularly important to the drug using/ drug treatment community, as a large part of the organisation was user-led so that there was more understanding of what drug users/patients were experiencing.

In the mid 2000's, 'Methadone' was dropped from the name, and we became simply The Alliance. The name change reflected the fact that we were helping people being prescribed opioid substitutes other than methadone, primarily buprenorphine, and also supporting people using substances other than opiates.

In a nutshell, what does The Alliance do nowadays?

Today The Alliance offers advice and support to anyone who is using drugs, or is a drug treatment service user. The majority of members are people who are prescribed methadone or buprenorphine. If people are having any problems with the service or doctor that provides their drug treatment, we can help and advise them on that including helping with any problems people might feel they're having with their prescription or their keyworker.

We have a forum where people can get advice on anything and everything drug and drug treatment related. For example, one hot topic at the moment is the coercion that many patients feel they are experiencing from drug services to either reduce their dose of methadone/ buprenorphine, or to come off altogether, when the patient is quite happy and stable and does not wish to reduce or come off their medication. The forums are a wealth of information on all aspects of drug use, drug treatment and recovery as well as a great source of support for people whatever stage they are at in their recovery.

> *"there are many different recovery methods …abstinence need not necessarily be the end goal for all people"*

Who should visit The Alliance forums?

Anyone can visit The Alliance forums, but I think it would be of most relevance to people who are either thinking about getting into drug treatment, those being prescribed an opioid substitute such as methadone or buprenorphine, those that have been through the drug treatment system, and families and friends of people who use drugs or are in drug treatment. The majority of new members that we get are people that are experiencing problems with their drug service provider, and then they end up staying for the support and friendship the forum can offer.

We have people in all stages of recovery, from those still in active addiction to those in abstinence based recovery, so there really is a vast wealth of different knowledge that people can draw on. If you can't speak to anyone in your life that truly understands what addiction and its treatment is like, that can be a very lonely place to be. That is why the forum can be an invaluable resource for information and support.

A lot of our members have families that are not supportive of their choice to use methadone or buprenorphine as part of their recovery, so it's important for them to have somewhere that they can unload their problems with people who are not going to judge them, and who understand what they are going through.

We also have a section for families and friends, so that friends and families of people in treatment, or using drugs, can come and speak to other people and learn more about drug treatment, which can be very daunting if you have never had any experience in that area before.

Does The Alliance have a position on recovery?

Our position on recovery is that there are many different recovery methods, and that abstinence need not necessarily be the end goal for all people. I think it's unfortunate that the term recovery is often seen as being exclusively related to abstinence by the recovery movement. For many people that The Alliance support, total abstinence from opioids is either not achievable or maintainable, so it's very important that the option of opioid substitute treatment is there for them as it is part of their recovery journey and without it, life would be very different, and not in a good way.

However, if people feel ready and able for abstinence, we would fully support and encourage them. Harm reduction is just as important as recovery, especially to The Alliance and its members, but unfortunately over the last few years, it seems to have fallen out of favour slightly, which we find very worrying. Especially as many people, myself included, are now in recovery via harm reduction.

What is the best way of getting in contact with The Alliance?

The Alliance used to run a telephone helpline service but unfortunately, due to the government cuts having an impact on the organisations that gave us funding, and the fact that medically assisted recovery is not en vogue currently, funding has been hard to come by over the last few years, and The Alliance has suffered as a result. We are working hard to secure more funding so that we can once again staff the Helpline.

At the moment, the best way to reach us is the forum:
www.m-alliance.org/forum

Sapphire, The Alliance

What do the recent changes in the drug driving legislation mean? Kevin Ratcliffe takes us through the basics including useful advice for patients. Ed

Drug driving legislation change

It is unlikely that you will have missed the fact that on 2nd March 2015 the new drug driving regulations became law. Specifically, section 56 of the Crime and Courts Act 2013 inserted a new section 5A into the Road Traffic Act 1988 making it an offence to drive with a blood concentration above a specified limit for certain specified controlled drugs. The Road Traffic Act already contains an offence of driving whilst impaired by drugs (irrespective of whether this is illicit use or medicinal use), and this offence will continue unchanged. However, the new offence refers to driving, attempting to drive, or being in charge of a vehicle with certain controlled drugs in the body above specified limits. The drugs and their limits are as follows:

Illegal Drugs – low limits set, zero tolerance approach	**Threshold limit in blood (µg/L)**
Benzoylecgonine (cocaine metabolite)	50
Cocaine	10
Delta-9-tetrahydrocannibinol (cannabis)	2
Heroin (as 6-MAM)	5
Ketamine	20
Lysergic acid diethylamine (LSD)	1
Methylamphetamine	10
MDMA (ecstasy)	10

Medicinal Drugs – risk based approach, higher limits (generally above the normal therapeutic range)	**Threshold limit in blood (µg/L)**
Amphetamine	250
Clonazepam	50
Diazepam	550
Flunitrazepam (no longer licensed in UK)	300
Lorazepam	100
Methadone	500
Morphine	80
Oxazepam	300
Temazepam	1000

Roadside drug screening devices are being developed that use oral fluid to detect for these drugs. A positive screen would result in the individual being requested to provide a blood sample for evidential purposes.

It is likely that there will be a high degree of concern amongst patients following the introduction of this legislation and this is understandable. The penalties for a drug driving conviction include a minimum one year driving ban, a fine of up to £5000, up to a year in prison, and having a criminal record. The driving license will also show the drug driving conviction and this will last for 11 years. A drug driving conviction can cause other problems such as increased car insurance costs, employment problems (especially if the work involves driving), and may cause trouble with foreign travel to countries such as the USA. Even more seriously, the penalty for causing death by dangerous driving under the influence of drugs is a prison sentence of up to 14 years.

The new law does however allow for the statutory "medical defence". A person being investigated for drug driving would generally be entitled to raise the statutory medical defence if:

- The drug was lawfully prescribed, supplied or purchased over-the-counter for medical or dental purposes; and
- The drug was taken in accordance with advice given by the person who prescribed or supplied it, and in accordance with any accompanying written instruction consistent with the advice from the prescriber or pharmacist.

The Department for Transport (DoT) have stated that if the police are satisfied that a driver is taking the relevant medicine on the advice of a healthcare professional or in accordance with the leaflet that accompanies the medication, the police will not prosecute them for this offence. However, it should be noted that if the police have evidence that an individual's driving was impaired due to drugs (whether prescribed or not), they can still prosecute under section 4 of the Road Traffic Act 1988, for which there is no statutory medical defence.

> *"The penalties for a drug driving conviction include a minimum one year driving ban, a fine of up to £5000, up to a year in prison, and having a criminal record"*

For some people, the impact of this new law may not be immediately apparent as some medicines metabolise into drugs on the list. For example, those taking co-codamol may screen positive for morphine. Those taking selegiline may screen positive for amphetamine. In addition, some of the drugs on the "illegal drugs" list may have limited medicinal uses, such as Sativex (a cannabis-based medicine occasionally used to reduce spasticity in multiple sclerosis).

Key messages for patients

Ultimately, it is the driver's responsibility to decide whether their driving is, or may be, impaired on any given occasion. However, prescribers and pharmacists are responsible for providing appropriate clinical advice to patients about their medications, including where there is a risk that driving may be impaired. Such advice could include the following (list not exhaustive!!):

- Not to drive if experiencing symptoms that suggest that driving might be impaired, such as feeling sleepy, poor coordination, feeling dizzy, impaired or slow thinking, visual disturbances.
- Not to drive at times when risks may have temporarily increased, such as when starting a new medication, or when the dose of the medication is increased/ decreased.
- To take extra care when circumstances change and may lead to an increased risk, and to avoid driving should this occur. For example:

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- drug interactions with other prescribed or over-the-counter medications
- co-prescribing, where the patient is in contact with more than one treatment service
- a developing/ deteriorating medical condition (for example a recent marked loss of weight)

- To avoid alcohol. All of the controlled drugs affected by this legislation result in a significantly greater road safety risk when taken in combination with alcohol, even in small amounts
- If in doubt, do not drive.

However, to put this into perspective, it is probably appropriate to quote from the DoT guidance that has been issued to healthcare professionals on drug driving:

A patient suffering from a condition that is being treated by a medicine that is also one of the specified drugs for the new offence should normally be encouraged to keep taking their prescribed medicine for that clinical reason in accordance with the advice of the prescriber or pharmacist. If the patient has been driving in line with such advice, and has no reason to think themselves impaired to drive (for example, not having developed new symptoms such as sleepiness), they can be advised they will be entitled to raise the statutory "medical defence".

Current professional practice means that healthcare professionals prescribing or supplying medicines already take into account the risks of medicines (including potential impacts on driving) and advise accordingly. This has now become even more pertinent in light of this new legislation.

Kevin Ratcliffe FRPharmS IP FFRPS, Consultant Pharmacist (Addictions)

Chris Ford outlines the issues surrounding naloxone and argues we should be doing more to spread the distribution of this important drug both nationally and globally. Ed

Saving lives is this easy: increase access to naloxone

What do we do with a medicine that prevents certain death for people with a particular condition – and is safe, cheap, and easy to administer?

1. Immediately make it widely accessible to those who can administer it when such a life-or-death situation arises?
2. Make it available to no one except doctors and emergency room workers?
3. Endlessly debate the particulars on how and when it should be widely introduced?

If you picked number one, congratulations—you're a reasonable person.

Unfortunately, you're also incorrect. With few exceptions answers two or three apply in the vast majority of the world when it comes to the medicine naloxone.

All over the world, overdose remains a leading cause of death among people who use drugs, particularly those who inject. Increasing the availability and accessibility of naloxone, an effective opioid antagonist used to reverse the effects of opioid overdose, would reduce these deaths overnight. On a global scale, however, exactly how and where naloxone is used remains unclear. IDHDP (International Doctors for Healthier Drug Policies) is seeking to find out why this is and what can be done to change it.

Some form of community-based distribution programmes for naloxone exist in at least 16 countries. These include Afghanistan, Australia, Canada, China, Germany, Georgia, India, Kazakhstan, Kyrgyzstan, Russia, Tajikistan, Thailand, United Kingdom, United States, Ukraine, and Vietnam. But the quality of data pertaining to how naloxone is used is very variable. Increasing our knowledge about the current use of naloxone will help us to advocate for increased availability and accessibility.

What we do know is that the availability of naloxone is growing in several countries. Scotland implemented a national programme in 2010 and outcomes there have demonstrated its effectiveness in reducing drug overdose deaths. In China it is available in an increasing number of hospitals. Canada and Estonia have pioneered programmes on take-home naloxone.

In the USA policy-makers have called for greater availability and accessibility of naloxone after opioid overdose deaths more than tripled between 2000 and 2010. In some States, distribution expanded from emergency rooms, paramedic services, and needle-exchange programmes to police stations. In Quincy, Massachusetts all police began carrying naloxone in October 2010 and this led to a 70 percent decrease in overdose deaths.

> ***"Naloxone should be issued to everyone who uses opioids, both prescribed and illicit, and to everyone who is at risk of relapse to heroin and other opioids"***

In November 2014 guidelines from the World Health Organization (WHO) recommended increased access to naloxone for people who are likely to witness an opioid overdose, including people who use opioids, as well as their families and friends. Naloxone is also included on the WHO's list of "Essential Medicines." The role of naloxone in addressing opioid overdose was recognised for the first time in a high-level international resolution in March 2012. Members at the UN's 55th Commision on Narcotic Drugs unanimously endorsed a resolution promoting evidence-based strategies to address opioid overdose. Recently, European Monitoring Centre for Drugs and Drugs Addiction (EMCDDA) published a very useful literature review of the effectiveness of take-home naloxone.

But what is happening in England? After falling for four years, the number of heroin/ morphine overdose deaths in England and Wales

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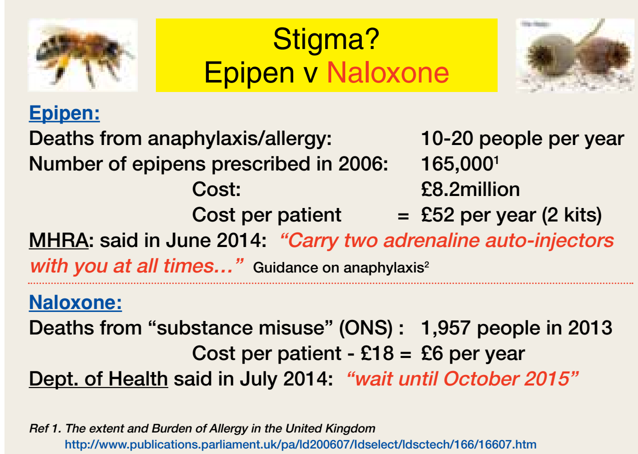
increased by 32% from 2012 to 2013 (latest figures available). Why is this the case? There may be many reasons but there has certainly been a lot of procrastination nationally and locally about introducing naloxone! Whilst Scotland and Wales have national programmes of take-home naloxone, England is hiding behind localism and bureaucracy.

The evidence for naloxone is overwhelming and the Advisory Council on the Misuse of Drugs (ACMD) recommended wider availability of naloxone in May 2012 (having previously recommended it in 2002) to tackle the high numbers of fatal opioid overdoses in the UK. It also encouraged the government to ease the restrictions on who can be supplied naloxone whilst encouraging them to investigate how people supplied with naloxone can be suitably trained to administer it in an emergency and respond to overdoses. Seventeen months later in December 2013 the MHRA started an investigation into "wider availability of naloxone.", It took a further nine months for the minister to reply to the ACMD in July 2014 to say it had been agreed by the Department of Health that it would be taken forward and MHRA were drafting new regulations. However, these new regulations wouldn't come into effect until October 2015 to "allow organisations to plan for the training, which will be an integral part of the ACMD recommendation."

When we asked people before the first "Naloxone Action Summit" last October, organised by IDHDP and the Blenheim Project, what the main barriers to naloxone were, there was a lot of consistency in their answers which included; local lethargy, stigma, lack of understanding and knowledge, lack of staff willingness, competing priorities, ambivalence from prescribers, conflicting priorities, ambivalence from commissioners and confusion on who could or should hold the medication. Nationally the barriers identified included; lethargy, a lack of clear national guidelines and instruction, confusion about the Medicines and Healthcare Products Regulatory (MHRA) consultation and the October 2015 changes in regulations, poor awareness and lack of funding.

There are also many myths going around: that naloxone is expensive; that it's not seen as a priority and that it encourages more drug use – all untrue. The MRHA delay in changing the regulation regarding naloxone is disappointing and to leave this any longer is tantamount to letting people die unnecessarily from drug overdoses.



Cost argument thanks to Dr Judith Yates

Naloxone can be prescribed by a doctor or non-medical prescriber (NMP) on an FP10 or can be issued by a pharmacist or nurse via a PGD (Patient Group Direction). Alternatively, its supply can be authorised by a doctor or NMP on a named patient basis using a PSD (Patient Specific Direction), enabling anyone involved in the patient's care (such as their keyworker) to issue the naloxone.

Naloxone should be issued to everyone who uses opioids, both prescribed and illicit, and to everyone who is at risk of relapse to heroin and other opioids. It should also be issued to their carers, with the written permission of the patient. Naloxone should be issued to everyone having completed an opioid detoxification in the community or in prison and just prior to release from prison, all situations where there is an increased risk of overdose. It should also be issued to all people starting opioid substitute treatment, when attending a low threshold service or needle syringe programme, and when visiting their GP or A&E if using opioids.

If you haven't been trained then ask for training and/or do the great SMMGP naloxone e-module.

We know through a freedom of information request that 72 (that is a staggering 54%) of local authorities do not provide take-home naloxone, 48 (36%) do but we await further information to see quite what this means in practice, 9 (7%) are due to roll out a naloxone scheme and for 4 (3%) no information was available.

So what can you do? Get involved with NAG (Naloxone Action Group) England. Go to the website https://nagengland.wordpress.com for more information. See if your area is in the 54% not providing naloxone and find others to champion the cause and bang on the commissioners door and demand it. If you are in the 36% who say they provide it, find out what that actually means in practice and feed information back to Release.

The long awaited Public Health England guidance on naloxone was launched in February and it is a helpful document but unfortunately it is only "advice" to local authorities. It doesn't name and shame nor pressurise the 54% of local authorities having no "take-home naloxone" – we must do that. Naloxone is a safe and cost-effective tool that saves lives and is proven not to cause people to use more drugs.

There is no excuse not to offer it if we truly care about recovery and human life.

To build on these gains, we need more data. Internationally IDHDP wants to find out more about the availability and accessibility of this life-saving intervention. To that end, we've created the Global Naloxone Survey, an attempt to compile information about; where it is available, who can use it, and is it available on prescription or can anyone get it? We then will analyse what would help to make it more available, such as funding, training and clearer guidelines and campaigns.

From early results it appears that naloxone is available in just over half of all countries but its accessibility is limited and it is often only available on prescription and/ or to health workers.

If you haven't already please complete our short

Global Naloxone Survey

Thank you

Chris Ford and Sebastian Saville,
Clinical Director and Executive Director of International Doctors for Healthier Drug Policies

Can we do more to identify mental health problems in those with problem drug and alcohol use? John Westhead highlights the importance of screening for those with dual diagnosis. Ed

Screening for mental health issues in substance misuse services – could we do better?

For the purposes of this article the term dual diagnosis will refer to any co-occurring mental health and substance misuse problem. The recognition of dual diagnosis is of vital importance in achieving better outcomes promoting recovery, reducing exploitation reducing risk of violence and preventing premature death. Families and social networks are vital to recovery and early intervention seeks to preserve these as much as possible.

Despite the importance of early detection both mental health and substance misuse workers tend to underestimate the extent of dual diagnosis and only a small proportion of those who need care for dual diagnosis receive treatment. Furthermore many of those who commit suicide have been in contact with services within the last week (49%), or the previous 24 hrs (19%) indicating vital opportunities to intervene were missed.

“Although screening tools are useful aids .... practitioners need to be wary of “tick box” approaches that take the focus away from the service user’s lived experience”

So why are mental health problems missed by practitioners? The factors that contribute to this arise from the patient, the practitioner and the interaction between their different perspectives. From the patient perspective, people fail to seek help for mental health problems for many reasons. Mental illness retains a stigma and Priest et al [1] found that others might view a person with depression as unbalanced, neurotic and irritating. Often people don’t think anyone can help, think that they should be able to cope or that the problem will get better by itself. People are often too embarrassed to discuss it with anyone and are afraid of consequences such as being compulsorily detained under the Mental Health Act. Given these perspectives it is important to avoid giving messages that might reinforce these perceptions and not to leave it to the person to ask for help as these factors suggest that they may never actually do so.

The practitioner might also be aware of the stigma around mental health problems and might have fears about the impact of negative labels or the person taking offence. In addition, time pressure or uncertainty about how to respond if they do identify a problem can increase the reluctance to screen. Sometimes people are not asked because they don’t “fit the picture”, but it is important to avoid stereotypes and narrow definitions of what a person with a dual diagnosis may present like. Rigid care pathways can also reduce access if these pathways are at odds with the person’s own conception of their problem.

Often there might be different perspectives between the professional and the patient as to the role of substances in relation to a person’s mental health problem. Objective wisdom about the effects of substances can often be at odds with the perspectives of the service user. Stimulants, cannabis and hallucinogenic drugs are often viewed by professionals as exacerbating perceptual difficulties, particularly hallucinations and paranoia, but a series of studies in the 1980s and 1990s indicated that people with a diagnosis of schizophrenia used these drugs because they were seen as relieving depression and increasing energy and relieving the “negative” symptoms of schizophrenia. People may be diagnosed as having schizophrenia, but a high proportion also meet the criteria for depression and anxiety and these might be viewed by the person as more problematic than hallucinations. If the practitioner assumes the substance is part of the problem, but the service user views it as part of the solution, then a dialogue is necessary to try to develop a shared perspective that respects the view of the service user. Keeping an open mind and asking the service user to monitor and record the effects of substances on mood and symptoms might be a more respectful and ultimately systematic way of understanding the relationship between the substance and their state of mind for the individual concerned.

Box 1 Screening questions for common mental health problems

Mental Health Problem	Questions	Scoring
Depression	During the last month have you often been bothered by feeling down, depressed or hopeless? having little interest or pleasure in doing things? Is this something you want help with?	If the person answers “Yes” to either question consider depression An additional question recommended for post-natal women. If answered “yes”, offer treatment
Anxiety	Over the last two weeks, how often have you been bothered by the following problems? Feeling nervous, anxious or on edge Not being able to stop or control worrying (GAD -2) Do you find yourself avoiding places or activities and does this cause you problems?	Not at all – 0 Several Days – 1 More than half the days – 2 Nearly every Day – 3 If 3 or more over the two questions consider an anxiety disorder This question can be asked if the person scores less than 3 but you remain concerned. If yes consider an anxiety disorder.
With people with language or communication difficulties	On a scale of 1 to 10 how distressed have you been in the last week (Distress Thermometer)	Ask family/carer about specific symptoms
Source	NICE (2011)	

A variety of screening questions exist (see box 1) which can be a useful way of ensuring that problems are identified in a systematic way. These tools often have longer versions such as the GAD7 and the PHQ-9 that allow slightly more detailed measures and help to determine symptom severity. The longer tools can also be used to measure treatment response. Respondents in the study by Delgadillo et al [2] found these tools acceptable, though they also appreciated a more in-depth clinical assessment where they had more chance to expand. These tools are aimed at identifying

1 Priest R G, Vize C, Roberts A, and et al. (1996) Lay people’s attitudes to treatment of depression: results of opinion poll for Defeat Depression Campaign just before its launch. British Medical Journal 313, 858–859

2 Delgadillo J, Gore S, Jessop, D, Payne, S, Singleton, P and Gilbody S (2012) Acceptability of mental health screening in routine addictions treatment, General Hospital Psychiatry 34 (4) 415-422

…continued from previous page

anxiety and depression, though other mental health problems such as bipolar disorder, schizophrenia, personality disorder and Post Traumatic Stress Disorder all frequently co-occur alongside substance misuse problems. Other tools exist including the Psychiatric Research Interview for Substance and Mental Disorders (PRISM) which is specifically designed for assessing psychiatric disorders in those who have substance misuse problems, and although it provides more detailed information it requires more time to complete.

Although screening tools are useful aids in the screening of mental health problems, practitioners need to be wary of "tick box" approaches that take the focus away from the service user's lived experience. People tend to open up and seek help if they find that the person is interested and has been helpful in the past and these characteristics make people more prepared to answer screening questions. Confidentiality, advance warning, preparation, patient readiness and timeliness should all be considered when suggesting screening. When screening identifies a problem it is important to offer a positive treatment response as otherwise this undermines the value of screening.

Finally, try to maintain a balance between being realistic and positive. Mental health problems, like substance misuse problems can persist or reoccur, so practitioners need to prepare for setbacks. However, terms such as "chaotic and complex" which are often applied to people with dual diagnosis can portray pessimism which is easily picked up by the person and then incorporated into their own self-image, leading to low levels of self-efficacy. By focusing on developing strengths practitioners can approach a person with a more hopeful and optimistic attitude. In the words of one service user "She had faith in me and she trusted me and it was the first time a doctor had ever given me trust and we worked together."

John Westhead, Senior Lecturer in Mental Health Nursing, Shrewsbury and Telford Hospital NHS Trust

For a copy of the article with full references visit:

http://www.smmgp.org.uk/html/others.php#099

Simon Greasley of The Alliance is Dr Fixit to someone who is worried that they will be detoxed without their consent. Ed

Dr Fixit on advocacy

Dear Dr Fixit,

I have been in and out of treatment on a methadone prescription for the last 10 years. I have detoxed successfully 3 times but have really struggled to stay drug free and have gone back to heroin use after a few weeks/ months. I work full time and spend a lot of time with my kids who are now grown up and am also an active member of my local book club. I have not used heroin for quite a while but do not want to detox again as I just don't do as well when I come off methadone and feel that my life is really good right now. My local treatment provider is putting a huge amount of pressure on me to detox, to the point where I am scared they are about to reduce my methadone when I really do not want this to happen. Can you help?

Answer provided by Simon Greasley, The Alliance

The Alliance has a number of similar concerns raised just like yours. It seems that in some areas commissioners are saying one thing and service providers another. The focus on treatment exits seems to override patient centred care in some cases.

> ***"you should be in control of your treatment just the same as anyone else with a long term medical condition"***

The Alliance does offer online support and we urge you to join the site for more help. It sounds like you are doing well on your methadone and it would seem a shame to change that; you may find you have to educate yourself on national clinical guidelines and it may be useful to print them off or take relevant sections to your key worker appointments. We hope you have a care or treatment plan in place, and you should have it put in the plan that you do not want to detox at the moment. This may be something that changes in the future, but you sound very clear in your letter that methadone is working well for you, and it sounds as if you have a busy life at work and home and from experience detox will not be the right option for you now.

Raise concerns with the manager of the service in writing if you have problems, and we can help you with this. If you get no resolution then it will need escalating further to the commissioner who is in charge of local drug services. You can get the name from your service provider or council website. In general these steps tend to be enough; rarely cases need taking to PHE (Public Health England). You can also ask for a medical review and second opinion from a different service.

While the SMMGP forum cannot help with your questions as they do not deal with patients' questions about their treatment, the resource library has lots of useful information. Here is a link to the Department of Health guidelines from the library

http://www.smmgp.org.uk/html/clinical.php

The NICE guidelines can be found here

http://www.nice.org.uk/guidance/ta114/resources/guidance-methadone-and-buprenorphine-for-the-management-of-opioid-dependence-pdf

http://www.nice.org.uk/guidance/ta114/resources/ta114-drug-misuse-methadone-and-buprenorphine-understanding-nice-guidance2

Here is a link the The Alliance forum

http://www.m-alliance.org/forum/index.php

Lastly is there a local service user group you can be a part of? If not then maybe you could start one, get mobilised, ask for funding to attend conferences and events; you should be in control of your treatment just the same as anyone else with a long term medical condition.

COURSES AND EVENTS

Advanced Certificate in the Community Management of Alcohol Use Disorders

On-line training course, plus face to face day

Introduction
SMMGP is introducing a new advanced course on the management of alcohol use disorders in primary care.

The course is designed for practitioners such as those who wish to advance their skills to 'Practitioner with Special Interest' level.

Content
The content of the course focuses on the management of alcohol use disorders including:

- How to design a primary care based alcohol service
- Understanding local commissioning structures and processes
- How to design robust care pathways
- How to engage with local commissioners to influence service design
- Comprehensive assessment
- Patient log
- Management of complex physical and mental health issues
- Management of special groups including pregnant women, people with dual diagnoses, older people and people who use drugs and alcohol
- The central role of psychosocial interventions
- Prescribing, including community detoxification for people with complex problems
- Relapse prevention and harm reduction

Format
The format of the course comprises both theory and practice. Throughout the course participants will work towards completing a framework of skills and knowledge that will include online e-modules and workbook; attendance at face to face training; undertaking a field visit; and assignments and reflective learning from clinical practice.

Each participant will be guided through the process by a tutor. The total study time will be 10 days and the course will require completion in a minimum of 6 months and a maximum of 24 months. A CPD certificate will be awarded on completion of the course.

Target audience for this course includes GPs, nurses and pharmacists and other primary care practitioners. Participants will be expected to have completed the RCGP Certificate in the Management of Alcohol in Primary Care Level 1 and must work with some people with alcohol use disorders http://www.rcgp.org.uk/smah/#Alcohol

Accreditation / Endorsement will be sought from Royal College of General Practitioners (RCGP), Royal College of Nursing (RCN), and Centre for Pharmacy Postgraduate Education (CPPE).

Date of course Registration for this course is now open.

Cost : The cost of the course is £1700.00 (No VAT is charged).

Registrations Please contact Sarah Pengelly by email on megan@morganpengelly.co.uk

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