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Supporting GP's in Improving Substitute Prescribing for Opiate Users in UK General Practice

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Summary

UK General Practice is now undertaking an increasing role in drug treatment but it hasn't always been that way. Over the previous 20-30 years, much of the drug treatment in the UK has been poor with little involvement of General Practice. From the mid 90s there was the beginning of government support for general practice to be involved in this area of work. Many developments have occurred which have try to address the barriers and provide support such as 1) A network of support and training; 2) An annual conference, a newsletter and web site; 3) The RCGP Certificate course and 4) Writing of guidance's specifically for care in general practice. All these measures have begun to change the face of drug treatment in the UK from general practice undertaking less than 5% to now about 30% and still rising.

Key Words: General Practitioners - Treatment of Opiate Users - Public Policy

Introduction

Drug dependence is a very common problem, affects almost all communities in the UK and continues to increase. The range of drugs that people are using is increasing, but still opioids are the most commonly used, usually heroin.

UK General Practice is now undertaking an increasing role in drug treatment but it hasn't always been that way. The care of the patient including substitute prescribing of

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methadone, buprenorphine etc is increasing and there is an expanding body of evidence that the primary care setting is an effective means of delivering treatment for opioid dependence [1]. There was also a need for appropriate training, support services and accessible evidence-based guidance specifically aimed at primary care [2].

History of care of drug users in UK general practice

Over the previous 20-30 years, much of the drug treatment in the UK has been poor. There are a multitude of reasons for this including the marked increase in the number of people presenting, the authority of psychiatry, the previous philosophical dominance of abstinence-based treatments and the questioning of the practice of harm reduction including maintenance prescribing.

For many years and right up to 1991 UK Department of Health Clinical guidelines [3], UK GPs were discouraged from working with people with drug problems and if they chose to do the work they were encouraged to provide detoxification, usually with a slow methadone reduction.

This led to a GP workforce who were not skilled in methadone maintenance, thus restricting access to a highly effective form of treatment for chronic dependent opioid users. Methadone maintenance also allows for large numbers of primary care based patients to receive a wide range of general health and harm reduction interventions. It also led to a drug-using community who felt that GPs were not there to provide for their needs, with many people unsure of the value of methadone and fearful of it as a highly addictive substance. There was little to no GP friendly training and almost all drug services were psychiatry led.

Methadone reduction, sometimes enforced, became the most common treatment modality in large parts of UK. Up until 1991, according to the existing DH 1991 guidelines [3], reduction was the only modality that General Practice was competent to deliver and thus further limiting GPs perceptions of appropriate treatment.

Things began to change

In 1995 the NHS executive letter to health authorities [4] and the Task Force Review [5] began to acknowledge the role of general practitioners and shared care. But still the emphasis on reduction did not really change until the 1999 guidelines reflected the greater acceptance of the role of the GP and for the first time promoted maintenance as a valid treatment option for GPs [6].

Although it was increasingly being accepted that general practice had an important place in drug treatment, there were still barriers, such as the lack of training and lack of support. A number of developments were to take place which addressed the support GPs needed in making this work more mainstream and widespread.

Birth of a Network

About the same time in 1995 a number of schemes began to develop which supported general practitioners taking on working with people who use drugs. Most schemes offered training and some schemes even began to pay GPs, as prescribing substitute medication was regarded as outside normal general medical services [7, 8].

Also around this time, several interested individuals came together and identified that there were many other isolated practitioners doing the work. An annual conference addressing the 'Management of Drug Users in General Practice' was organised by the group and granted important backing of the RCGP (Royal College of General Practitioners). A newsletter was launched with the first edition being sent out to 245 people and distributed via the conference network. The newsletter and the conference became central to the developing network for primary care called SMMGP (Substance Misuse Management in General Practice).

SMMGP newsletter (now named Network) has increased and now goes out, as hardcopy, to over 8000 individuals and organisations with many more issues downloaded via a much visited SMMGP website http://www.smmgp.org.uk. The website has rapidly expanding hits and popularity and is now possibly the biggest primary care clinical site in UK.

Drug treatment in all treatment modalities

In corresponding pattern, numbers in all drug treatment modalities have increased, including those in primary care (see figure 1). Some localities now have entirely primary

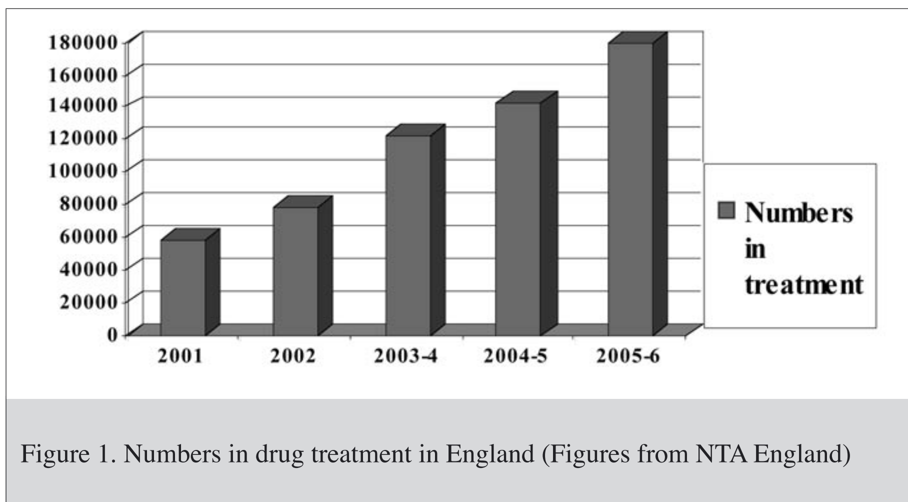


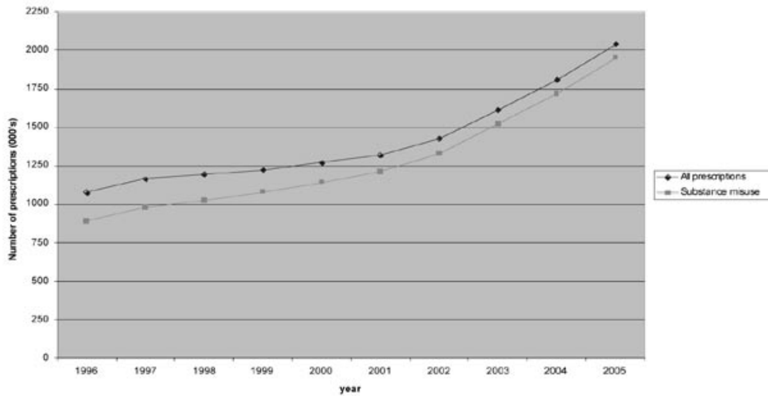
Figure 1. Numbers in drug treatment in England (Figures from NTA England)

care/GP based services.

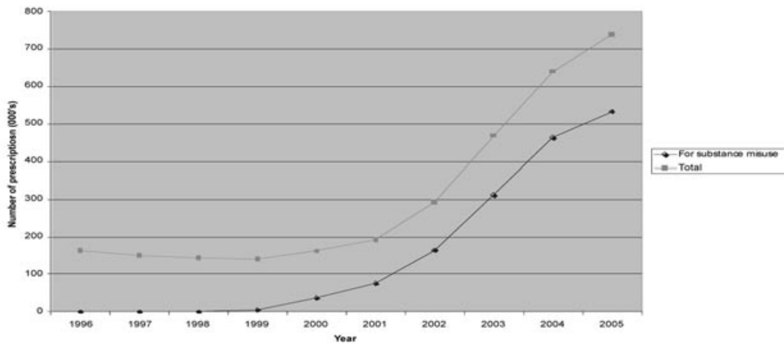
The approximate numbers of people in treatment for the year 2003-4 was 126,000;

rising to 143,000 in 2004-5 and continuing to rise for 2005-6 to 179,628 [9]. There was also a corresponding increase in GPs being involved in drug treatment during this period.

At the same time there has been a corresponding increase in the prescribing of



Total number of Methadone prescriptions - Total vs for substance misuse



Total number of Buprenorphine prescriptions - Total vs for substance misuse

Figure 2. Total number of methadone and buprenorphine prescriptions

methadone and buprenorphine (see figure 2)

RCGP drug training scheme and certificate

The RCGP Certificate in Drug Dependence was developed in 2002 further strengthening the primary care network and supporting the introduction of the revised clinical guidelines 1999 [(6)]. The certificate started as a one part course, to improve the competency and skill of doctors who were already working with drug users. It was soon realized that there was also a need for: a) the course to go multidisciplinary and b) a more basic entry level course to support doctors and others just beginning this work and or working in shared care arrangements. So in 2004 the certificate was redeveloped into two separate components, part 1 and part 2.

Part 1:

Part 1 was designed for GPs working at a generalist level, who were often working within a shared care scheme. Initially available only to GPs, the course was mapped to the Drug and Alcohol National Occupational Standards (DANOS) and delivered in two stages. Other professionals needed to undertake their equivalent of part 1 but from August 2006 the part 1 has been open to all. Anyone can now access by going to: www.rcgp.org.uk/substancemisuse

Stage 1 - Electronic learning – 2 modules approximately 2 hours each to complete.

Stage 2 - Locally organised face -to- face training following accredited format and content, the equivalent of 6 hours continuing professional development (CPD).

Stage 1 Electronic Learning

This consists of two modules written by leading practitioners in the field with an e-learning format developed in partnership with Doctors.net.uk. The modules are delivered electronically and include a multiple-choice questionnaire (MCQ) and case study scenarios.

In the first e-module you meet Tracey, a twenty-three year old drug user, carry out an initial assessment and provide harm reduction advice. In the second you meet Mary who requests a detoxification using buprenorphine and explore a range of treatment interventions.

The e-modules compliment each other and for those who do not want a Part 1 certificate they can be completed as stand alone units. However, anyone who wishes to receive the RCGP Part 1 certificate must complete and pass the two e-modules and attend accredited face-to-face training.

Stage 2 Face-to-Face Training.

The face-to-face training is run nationally, regionally or locally. There is a standard format with handbook and learning resources which cover:

- Basic drugs awareness
- Principles of assessment and care planning for drug users

- ° Principles of maintenance prescribing, detoxification and relapse prevention treatments
- ° Principles of harm reduction, the role of talking therapies in substance misuse management and the principles of safe prescribing including how to write a prescription
- ° Case management, record keeping, onward referral and liaison skills

Once both parts are satisfactorily completed the candidate receives the Royal College of General Practitioners Certificate in Drug Dependence Part One. Then certificate holders will need to continue on-going training to maintain their competence and confidence.

Over 4,000 doctors have undertaken the e-modules and about 1400 have complete part 1.

Part 2

This part of the certificate is aimed at higher academic level and at a higher level of practitioner specialism. The current criteria for entrance criteria is to have completed Part 1 and had at least 2 years experience in the field. Part 2 is multi-disciplinary and is open to all including GPs, Pharmacists, Prison Doctors, Nurses and User Advocates. Until 2006 other professionals have needed to undertake their equivalent of part 1 but this is now open to all.

The Part 2 course involves about 8 days study and classes with some additional course work. It is run in small groups and involving significant debate and peer review of topics. So far there have been 4 phases completed, which have consisted of 865 GPs, 190 nurses, 180 pharmacists & 22 user advocates.

Development of guidance for primary care

During the development of the course it became apparent that there was little to no guidance for primary care and even the national guidelines were rapidly becoming outdated. In particular, the arrival of new licensed drugs such as buprenorphine, the increase in polydrug use and the significant rise in the use of cocaine, commonly as crack, has brought new challenges to general practice.

A series of guidance documents have been developed specifically for general practice, by expert panel including general practitioners, pharmacists, psychiatrists and most importantly people who use drugs. Guidance for the use of buprenorphine in primary care', 'Guidance for hepatitis vaccination in primary care', 'Guidance for the management of people who use cocaine' and 'Guidance for the use of methadone in primary care' have so far been developed [10, 11, 12, 13]. Additionally guidance for the management of hepatitis C and guidance for the use of benzodiazepines are currently being developed. The methadone guidance was the most recently launched in November 2005 and 10,000 copies were distributed in under 2 months.

The importance of these guidance documents are that they are developed by primary care and are accessible to all patients and professionals. They are evidence-based, draw-

ing on research literature and clinical experience, both in the UK and internationally. Where there is evidence specific to primary care this was used. Where there was no specific evidence base for primary care the guidance drew upon recommendations from experts in the field to address these gaps.

On-going training and continual professional development

The certificate is also supported by on-going training events/professional development programme covering a range of topics including hepatitis, HIV, pregnancy, detoxification, pain management, relapse prevention and specific training events to support the guidance documents.

National trend in primary care drug treatment

The national trend in primary care drug treatment continues to increase nationally. The face of drug treatment in the UK has changed from general practice undertaking less than 5% to now about 40% and still rising (see Table 1). There is still inconsistency of coverage and some areas are over 50% and some only at 30% (see figure 3). The target for the coming year is 44%.

Table 1. Percentage of GPs involved with drug treatment by area

	2001/2	2002/3	2003/4	2004/5	2005/6
London	17.7	10.6	14.8	20.1	30.6
East Mds	14.5	10.6	14.8	20.1	30.6
West Mds	5.3	20.9	27.7	34.5	42.1
Eastern	9.4	23.6	26.9	29.0	34.5
North East	17.8	29.8	36.2	42.2	50.1
North West	25.7	32.6	36.3	41.9	45.7
South East	31.3	33.4	34.5	36.7	40.8
South West	30.4	34.8	36.4	41.9	45.4
Yorks and Humber	15.3	24.9	32.1	33.0	32.4
Total number of Dats reporting	91	133	142	132	122
National Ave (%)	20	27	31	36	40

Support from National Organisations

Alongside this there is support from national organisations including the Royal College of General Practitioners (RCGP), SMMGP and Alliance, as well as the National Treatment Agency (NTA), the Royal College of Psychiatrists and the Royal Pharmaceutical Society (RPS).

Conclusions

This trend to increased support and training for general practice has helped lead to a far more experienced, competent and confident primary care/ GP workforce and this competent and confident workforce is increasingly challenging poor practice in drug treatment.

By this additional support drug use can be managed successfully in general practice. One of the keys to this is working with the person and not purely focusing on one drug. The relationship with the patient is a positive part of treatment, and by working with them, whatever they are using and where ever they are in their drug career or treatment journey we can show marked improvements in their health and well-being and empowering them to decide on the right treatment for them.

General practice is a good place to manage people who use drugs and retention rates are very high. We can also care for their general health rather than purely their drug problem. General practitioners can be shown that managing drug use is no different than managing anyone else with multiple problems and multiple medications and we can keep people in treatment whatever they are using and wherever they are on their treatment journey. We can ensure treatment is as flexible as possible and includes substitute prescribing and non-prescribing options and involve users in their own treatment package.

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