



# Drug and Alcohol Problems

*One in a series of curriculum statements produced by the Royal College of General Practitioners:*

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# Acknowledgements

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This curriculum statement has drawn on various national guidelines and policies, current research evidence and the clinical experience of practising general practitioners.

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## Key messages

- The use of illicit drugs, such as heroin or cocaine, is common.
- All general practitioners have a responsibility for providing general medical care to drug-using adults.
- General practitioners are ideally placed to identify drug misuse before it becomes problematic and to be able to intervene effectively.
- Drug use is amenable to treatment, using a combination of psychological, social and medical interventions.
- Substitution treatment, such as the use of methadone, is effective and properly administered results in improvements in social, medical and psychological functioning, and a reduction in criminal behaviour.
- General practitioners must be familiar with ways of identifying excess alcohol consumption.
- Despite the prevalence of patients presenting to general practitioners with problems relating to heavy alcohol intake, they often fail to make the association.<sup>1</sup>
- General practitioners should be aware of the morbidity (physical, psychological and social) caused by alcohol.
- Health professionals can have a major impact in reducing alcohol consumption in their patients by a simple technique called *brief intervention*.

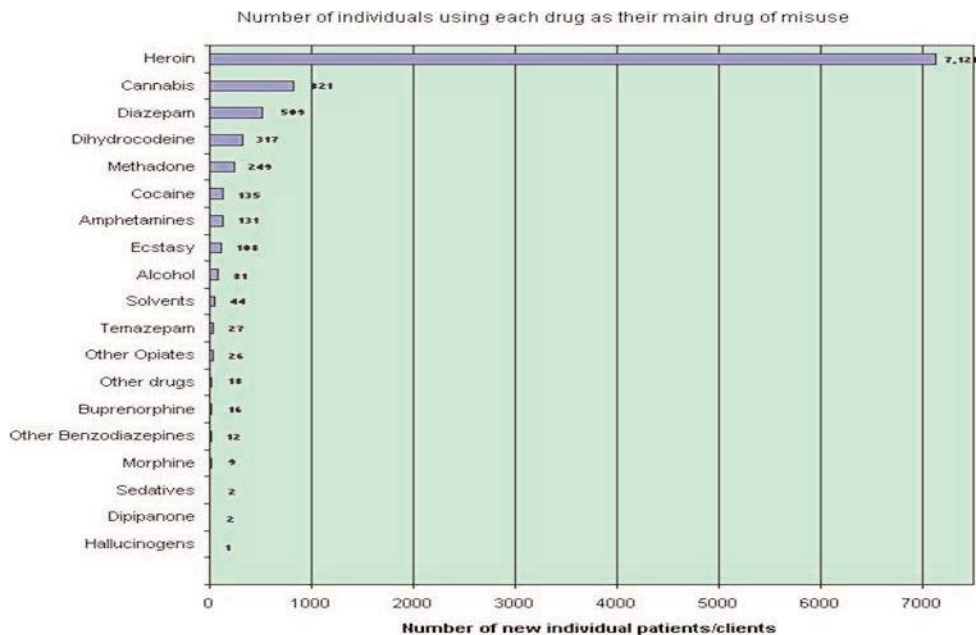
# Introduction

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## Rationale for this curriculum statement

Alcohol and psychoactive substances have been woven into every society since the beginnings of the human race. The use of illicit drugs (heroin, cocaine, ecstasy, amphetamines and cocaine) in the United Kingdom has risen year on year over the last few decades and national figures for England (2001/2) report that the number of users (predominately heroin) in treatment with drug services and general practitioners (GPs) is around 150,000.<sup>2</sup> The breakdown of the main illicit drugs used in Scotland (Figure 1) demonstrates the spread of drugs misused.

**Figure 1: Main illicit drugs in Scotland: year ending 31 March 2002<sup>3</sup>**



GPs and primary healthcare teams play an important part in addressing the health and social problems associated with drug and alcohol use, and GPs have been at the heart of many of the recent developments in the treatment of substance misuse across the NHS. This has included the provision of care to opiate users and the provision of harm reduction and brief intervention to drug and alcohol users.

Over the last decade the RCGP has been providing leadership in the field of primary care substance misuse and has been instrumental in changing the attitudes of many GPs such that the management of these patients is now seen by many as part of normal general practice either as part of routine care or as an enhanced service. Perhaps the turning point in the involvement of GPs in the care of drug users was following the publication

of a joint statement in April 2000, from the RCGP and the General Practitioners Committee of the British Medical Association. This statement reflected the change in attitude in primary care's involvement in the care of drug users and reaffirmed from the two leading UK primary care organisations the responsibility of GPs to care for these patients. The statement made was as follows:

*The RCGP and GPC believe that GPs should offer appropriate care to all patients on their list. Where patients have problems with substance abuse, appropriate care will include aspects of primary care normally provided by the practice health care team, shared care with other services and referral to other appropriate services. Certain GPs may develop experience in their care of substance abuses, and the number and location of these doctors should ideally, be sufficient to avoid substantial workload falling onto only a few GPs.'*

A survey of GPs in England and Wales in 2005 has found that half of all GPs who responded had seen an opiate user in the preceding four weeks and half of these (25% of the total sample) had prescribed opiate-substitute therapies. Extrapolated across the whole GP population approximately 62,000 opiate misuses were being seen by GPs over a four-week period in 2001.<sup>4</sup> These figures represent a substantial increase in the numbers of GPs involved in the care of drug users compared with the results of a similar survey conducted a decade earlier.

The National Treatment Agency for Substance Misuse, the RCGP and the Royal College of Psychiatrists have recently published<sup>5</sup> a joint paper outlining the roles and responsibilities, clinical governance arrangements and other key areas for doctors working with drug users at different levels of expertise. The document builds on the work carried out by the RCGP in defining criteria, standards and evidence required for practitioners working with drug users and a training programme established to deliver these criteria. These publications provide essential guidance for trainees and trainers in both hospital and general practice working at generalist, intermediate (practitioner with special interest) and specialist levels of service provision.

Nearly one-fifth of patients treated in general medical practices report drinking alcohol at levels considered 'risky' or 'hazardous' and may be at risk of developing alcohol-related problems as a result. Excess alcohol use plays a significant part in the epidemiology of health and social problems, and is responsible for significant morbidity. The true impact on the public's health of excess alcohol consumption is difficult to evaluate but is likely to be considerable as Table 1 below illustrates.<sup>6</sup>

**Table 1: Burden of excess alcohol consumption to health and social care**

● Expenditure of £95m on specialist alcohol treatment
● Over 30,000 hospital admissions for alcohol dependence syndrome
● Up to 22,000 premature deaths per annum
● At peak times, up to 70% of all admissions to accident and emergency departments
● Up to 1000 suicides
● 1.2m violent incidents (around half of all violent crimes)
● 360,000 incidents of domestic violence (around a third) that are linked to alcohol misuse
● Increased anti-social behaviour and fear of crime – 61% of the population perceive alcohol-related violence as worsening
● Up to 17m working days lost through alcohol-related absence
● Between 780,000 and 1.3m children affected by parental alcohol problems
● Increased divorce – marriages where there are alcohol problems are twice as likely to end in divorce

Source: *Alcohol Harm Reduction Strategy for England*, 2004, [www.strategy.gov.uk/work\\_areas/alcohol\\_misuse/index.asp](http://www.strategy.gov.uk/work_areas/alcohol_misuse/index.asp)

## UK health priorities – UK drug treatment priorities

The National Treatment Agency for Substance Misuse (NTA) *Models of Care of the Treatment of Adult Drug Misuses: framework for developing local systems of effective drug misuse treatment in England* (2002)<sup>7</sup> sets out a programme

of action and reform to address the needs of drug users and ensure that the quality of services is improved for them. The document sets out the national standards and service models together with local action and national underpinning programmes for implementation, a series of national milestones and performance measures. The range of difficulties experienced by drug misusers is conceptualised as domains, commonly grouped as four domains that can then be used to assess whether drug misusers are improving or achieving better outcomes in these areas. The four key domains addressed in *Models of Care* are as follows:

### **1 Drug and alcohol use:**

- Drug use, including type of drugs, quantity and frequency of use, pattern of use, route of administration, source of drug
- Alcohol use, including quantity/frequency of use, pattern of use, whether above ‘safe’ level, alcohol dependence symptoms.

### **2 Physical and psychological health:**

- Psychological problems, including self-harm, history of abuse/trauma, depression, severe psychiatric comorbidity, contact with mental health services
- Physical problems, including complications of drug/alcohol use, pregnancy, blood-borne infections/risk behaviours, liver disease, abscesses, overdose, enduring or severe physical disabilities.

### **3 Social functioning:**

- Social problems (including child care issues, partners, domestic violence, family, housing, employment, benefits and financial problems).

### **4 Criminal involvement:**

- Legal problems (including arrest, fines, outstanding charges/warrants, probation, imprisonment, violent offences, criminal activity).

*Models of Care* also provides a conceptual framework to aid rational and evidence-based commissioning of drug treatment services in England (see Appendix 3).

## **Hierarchy of goals of drug treatment**

For some years now a range, or hierarchy, of goals of drug treatment has been identified in the UK; these were determined by the Task Force to Review Services for Drug Misusers, in 1996.<sup>8</sup> These relate to the above domains and are:

- Reduction of health, social and other problems directly related to drug misuse
- Reduction of harmful or risky behaviours associated with the misuse of drugs (for example sharing injecting equipment)
- Reduction of health, social or other problems not directly attributable to drug misuse
- Attainment of controlled, non-dependent or non-problematic drug use
- Abstinence from main problem drugs
- Abstinence from all drugs.

The hierarchy of drug treatment goals endorses the principle of harm reduction, which refers to the reduction of the various forms of drug-related harm (including social, medical, legal and financial) until the drug user is ready to come off drugs.

## Treatment of drug misuse

*Treatment of drug misuse needs to address the social, physical and psychological components of care.* The role of pharmacological treatments is as follows:

- Management of withdrawal symptoms
- Reduction of physical, social and psychological harms to the individual and the public associated with illicit drug use by prescribing a substitute drug or drugs (for example methadone maintenance treatment in which aims may include cessation of injecting; reduction or cessation of illicit heroin use; and reduction or cessation of other high-risk behaviours)
- Relapse prevention and maintenance of abstinence
- Prevention of complications of substance use (for example, hepatitis B immunisation, the use of thiamine to prevent Wernicke's encephalopathy and Korsakoff's syndrome).

## Treatment of alcohol misuse

Having identified harmful drinkers, simple, brief interventions delivered by general medical practitioners and other primary healthcare staff are effective in reducing drinking levels to low-risk levels among hazardous and harmful drinkers.<sup>9</sup> The intervention can be as basic as five-structured advice and the effect can still be shown in follow ups for up to two years.

There are a number of large-scale systematic reviews and meta-analyses showing brief intervention is effective in reducing alcohol use amongst hazardous and harmful drinkers. The results of these are summarised in the Health Development Agency's *Prevention and Reduction of Alcohol Misuse: evidence briefing*, March 2005, [www.nice.org.uk/aboutnice/whoweare/aboutthehda/hdapublications/prevention\\_and\\_reduction\\_of\\_alcohol\\_misuse\\_\\_evidence\\_briefing\\_2nd\\_edition.jsp](http://www.nice.org.uk/aboutnice/whoweare/aboutthehda/hdapublications/prevention_and_reduction_of_alcohol_misuse__evidence_briefing_2nd_edition.jsp).

# Learning Outcomes

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The following learning objectives relate specifically to drug and alcohol problems. This RCGP curriculum statement should be used in conjunction with the other curriculum statements, especially the *core* RCGP curriculum statement 1, *Being a General Practitioner*, and *Care of People with Mental Health Problems*.

## Primary care management

The work of the GP increasingly involves the care of drug users in partnership with the wider primary health-care team, both within their own practice, in the local community, and also with specialists in secondary care and in partnership with the voluntary and criminal justice sector. This role involves understanding the special needs of a disadvantaged and challenging group, and requires problem-solving skills at the teamworking and management level as well as at the clinical one.

Thus primary care education must promote learning that integrates different disciplines within the complex team of the NHS. Specialty registrars (GP) must learn the importance of supporting patients' decisions about the management of their health problems and communicating how that care will be delivered by the NHS team as a whole.

## The knowledge base

### Symptoms and signs:

- Of opiate misuse – needle track marks, pinpoint pupils, runny nose, drowsiness
- Of stimulant use – agitation, skin ulceration
- Suggestive of cannabis use – red eyes, irritability, anxiety, panic disorder
- Manifestation of alcohol problems:
  - ◆ physical: accidents, victim of violence, obesity, dyspepsia, erectile dysfunction, fits, foetal alcohol syndrome, liver damage, anaemia, neurological and central nervous system problems
  - ◆ psychological: anxiety, depression, attempted suicide
  - ◆ social: loss of employment, disorderly conduct, domestic violence, drink-driving, relationship problems or breakdown.

### Common and/or important conditions:

- The common complications of drug-using or misusing habit:
  - ◆ those related to the drug used (e.g. heroin, cocaine, alcohol, cannabis)
  - ◆ those related to the route of use (such as injecting, inhalation)
  - ◆ those related to the lifestyle related to a drug-using habit (poor nutrition, poor dentition, social problems).

- Have an understanding of the aetiology, presenting symptoms, treatment and prevention of HIV infection, hepatitis A, hepatitis B, hepatitis C
- The health and social burden of excess alcohol consumption.

### **Investigations:**

- Have an understanding of the nature and role of urine, and other tests in the management of drug treatment
- The use of screening tools for alcohol such as Cut down Annoyed Guilty Eye-opener (CAGE) and Alcohol Use Disorders Identification Test (AUDIT).

### **Treatment:**

- The National Clinical Guidelines for the care and management of a drug-using patient
- The principles and practice of appropriate safe prescribing for patients who use drugs
- The principles and practice of dose induction and safe prescribing for the drug-using patient
- The range of treatment interventions available including pharmacological interventions
- The impact that health professionals can make by providing brief intervention for excess alcohol use.

### **Emergency care:**

- Have an understanding of the aetiology and prevention of drug-related deaths
- Alcohol-related emergencies such as fits, delirium and psychosis.

### **Prevention:**

- Have an understanding of the term harm reduction, the strategies that can be employed in harm reduction and the advantages and disadvantages of undertaking a harm reduction approach to treatment.

## **Person-centred care**

- Adopt a person-centred approach, whilst acknowledging the conflicts between a perceived self-inflicted problem and a right to evidence-based treatment.
- Enable drug and alcohol abusers to recognise that a problem exists, engage in delineating their difficulties and deciding on appropriate interventions.
- Demonstrate an awareness of the special challenges of establishing and maintaining rapport with patients with drug and alcohol misuse problems, especially given the chaotic and challenging ways in which they may use the service.

## **Specific problem-solving skills**

- Describe the ways in which patients who use illicit drugs present to services.
- Describe how to assess the prevalence of drug and alcohol issue problems and needs among their practice's population.
- Demonstrate understanding of the difference between dependent and problematic drug and experimental drug and alcohol use.
- Identify physical, social and psychological problems associated with drug use.
- Describe how to assess risk and suicidal ideation.
- Describe what action to take when there is an immediate risk of danger to drug users.

## A comprehensive approach

- Describe the factors that lead to the neglect of health and health care in this group and take steps to counter these.
- Describe how to manage the associated physical health problems of people with drug misuse problems.
- Demonstrate understanding of the relationship between drug misuse and offending behaviour.
- Demonstrate understanding of the relationship between drug misuse and mental health problems.
- Demonstrate understanding of the concept of recovery and the principles of promoting recovery (see Appendix 1).

## Community orientation

- Demonstrate awareness of the extent and implications of stigma and social exclusion.
- Demonstrate understanding of how to challenge inequality through:
  - ◆ working in partnership with other agencies to secure appropriate health and social interventions for individuals
  - ◆ contributing to the health improvement programme that reflects the perspective of the local population.

## A holistic approach

- Demonstrate understanding of the impact that social circumstances can have on drug misuse and that recovery is contingent on the effective management of those social circumstances.
- Demonstrate an awareness of the vulnerability of children whose parents are drug users and understand the role that the child may adopt as carer in such circumstances.<sup>10</sup>
- Demonstrate an awareness that the causes of drug misuse are multifactorial.
- Demonstrate cultural sensitivity.

## Contextual aspects

- Demonstrate knowledge of the Misuse of Drugs Act (1971) and how it impacts on health professionals in their treatment of drug users.
- Demonstrate an awareness of the political changes that impact on the management of drug users.

## Attitudinal aspects

- Demonstrate an awareness that their own attitudes and feelings are important determinants of how they manage:
  - ◆ people who self-harm
  - ◆ people who misuse drugs or alcohol
  - ◆ people who know more about their illnesses than their doctors do
  - ◆ people who engender strong emotions in us for many reasons.
- Demonstrate an understanding that their personal values and attitudes should not inappropriately influence their professional decisions or the equality of patients' access to care.

## Scientific aspects

- Demonstrate an understanding that a critical and research-based approach to practice is particularly important in drug misuse treatment, where evidence on effective treatment is often of poor quality.

## Psychomotor skills

Demonstrate how to conduct a:

- Mental state assessment
- Suicide risk assessment
- Drug use risk assessment.

# Further Reading

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## Examples of relevant texts and resources

BRITISH MEDICAL ASSOCIATION AND ROYAL PHARMACEUTICAL SOCIETY OF GREAT BRITAIN. *The British National Formulary 50* London: BMJ Books, 2005

BURY M. *Health and Illness in a Changing Society* London: Routledge, 1997

DEPARTMENT OF HEALTH, SCOTTISH OFFICE HOME AND HEALTH DEPARTMENT, WELSH OFFICE. *Drug Misuse and Dependence, Guidelines on Clinical Management* London: HMSO, 1991

DEPARTMENT OF HEALTH, SCOTTISH OFFICE DEPARTMENT OF HEALTH, WELSH OFFICE, DEPARTMENT OF HEALTH AND SOCIAL SERVICES, NORTHERN IRELAND. *Drug Misuse and Dependence. Guidelines on clinical management* London: The Stationery Office, 1999

GERADA C (ed.). *RCGP Guide to the Management of Substance Misuse in Primary Care* London: RCGP, 2005

JONES R, BRITTEN N, CULPEPPER L, *et al.* (eds). *The Oxford Textbook of Primary Medical Care* Oxford: Oxford University Press, 2004

SHELLEVIS FG, VAN DER VELDEN J, VAN DE LISDONK EH, *et al.* Co morbidity of chronic diseases in general practice *J Clin Epidemiol* 1993; 46: 463–73

WANLESS D. *Securing Good Health for the Whole Population: final report* London: HSMO, 2004

WRIGHT N. *Homelessness: a primary care response* London: RCGP, 2002

## Web resources

### Driving under the influence of drugs: an internet resource

This site was developed by the British Medical Association in response to a request made at their ARM (Annual Representatives Meeting) in 2001 to consider ways of supporting the police in their fight against drug driving by raising awareness and educating the public on the potential dangers. This site provides an outline of the current situation with regard to drug driving and what actions the BMA would like the government to take. Specific issues covered include: tests for drug driving; summary of research; and projects in the UK and international research. [www.bma.org.uk/ap.nsf/content/drivinginfdrugs](http://www.bma.org.uk/ap.nsf/content/drivinginfdrugs)

### Drugs.gov.uk

This website is for anyone who works in the drugs field or is carrying out research in this area. It has up-to-date information including the latest on government policy, research, legislation and the Drug Strategy Aims, news and press cuttings, drugs events and conferences, good practice and guidance, help with planning and running local campaigns. There is also a downloadable photo library, a case studies section and a ‘Talking Shop’ area with a user forum.

[www.drugs.gov.uk/](http://www.drugs.gov.uk/)

### National Treatment Agency for Substance Misuse

The National Treatment Agency for Substance Misuse (NTA) aims to increase the availability, capacity and effectiveness of treatment for drug misuse in England. The NTA works in partnership with central government, drug action teams, treatment commissioners, providers and service users, carers and families, researchers, academics, trainers and criminal justice agencies to improve drug treatment.

[www.nta.nhs.uk/](http://www.nta.nhs.uk/)

## Scottish Drugs Forum

The Scottish Drugs Forum (SDF) is a national non-government drugs policy and information agency working in partnership with others to coordinate effective responses to drug use in Scotland. SDF aims to support and represent, at both local and national levels, a wide range of interests, promoting collaborative, evidence-based responses to drug use.

[www.sdf.org.uk](http://www.sdf.org.uk)

## **SIGN Guideline: *The Management of Harmful Drinking and Alcohol Dependence in Primary Care***

The Scottish Intercollegiate Guidelines Network (SIGN) was formed in 1993. Its objective is to improve the quality of health care for patients in Scotland by reducing variation in practice and outcome, through the development and dissemination of national clinical guidelines containing recommendations for effective practice based on current evidence. SIGN has a programme of 113 evidence-based clinical guidelines – published, in development or under review – covering a wide range of topics.

[www.sign.ac.uk/guidelines/fulltext/74/index.html](http://www.sign.ac.uk/guidelines/fulltext/74/index.html)

## **Substance Misuse Management in General Practice**

Substance Misuse Management in General Practice (SMMGP) is a developing network to support GPs and other members of the primary healthcare team who work with substance misuse in the UK. The project team produces the Substance Misuse Management in General Practice newsletter, *Network*, and organises the annual conference, 'Managing Drug Users in General Practice'. The first conference was held in 1996. It was organised through the Royal College of General Practitioners (RCGP) HIV Working Party (which since 2001 has been renamed the RCGP Sex, Drugs and HIV Task Group).

Management and partnership arrangements have now been made with the Royal College of General Practitioners, Trafford Substance Misuse Services, and the National Treatment Agency. These arrangements ensure that SMMGP remains rooted in primary care while being close to the policy centre. The project was commissioned by the RCGP to develop and run the RCGP *Certificate in the Management of Drug Misuse – Part 1*, and has enabled over 300 GPs to obtain the full Part 1 certificate. More details on the Part 1 can be found in the RCGP section of its website.

*This is the best website for GPs on drug misuse.*

[www.smmgp.org.uk](http://www.smmgp.org.uk)

[www.smmgp.org.uk/html/rcgp.php](http://www.smmgp.org.uk/html/rcgp.php)

## **Turning Point**

A social care organisation providing a wide range of substance misuse services across England and Wales. These include community drug services, services for clients with complex and multiple needs, specialist alcohol services, crack services and young people's services. Its site contains more detailed information on all of their service locations.

[www.turning-point.co.uk/](http://www.turning-point.co.uk/)

# Promoting Learning about Drug and Alcohol Problems

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## Work-based learning – in primary care

The period of time spent in general practice is ideal for gaining a better understanding of the care of drug users. The specialty registrar (GP) will have the opportunity to care for drug users who have physical and psychological and social problems, and who may be in receipt of substitute medication. Many will experience contact with secondary care services and will be cared for by different members of a wider multiprofessional team.

The specialty registrar should be encouraged to look after some of the practice's drug-using patients throughout the placement and follow them along their journey to gain a better understanding of their problems and of the social and medical care that they receive.

The specialty registrar should take the opportunity to visit local voluntary organisations, e.g. Turning Point, to gain a better understanding of their important role in supporting people with substance and alcohol misuse in the community.

## Work-based learning – in secondary care

Placements in addiction specialist or community drug and alcohol services are ideal for doctors training to be GPs. Care must be taken to ensure that the learning is focused on the needs of the specialist registrar who is placed in the department as part of a GP training programme. Such placement has been in operation in South London for the last eight years, where the SHO undertakes his or her psychiatric attachment placed in a community drug and alcohol services (CLAS) team.<sup>11</sup>

## Non-work-based learning

Drug-using patients often have many complex psychological, social and physical problems, which provide rich subjects for tutorials and case-based learning.

As indicated above, the SMMGP is a developing network to support GPs and other members of the primary healthcare team who work with substance misuse in the UK. The project team produces the SMMGP newsletter, *Network*, and organises the annual conference, 'Managing Drug Users in General Practice'.

## RCGP Certificate in the Management of Drug Misuse

Part 1 to the RCGP Certificate in the Management of Drug Misuse was launched at the 9th National Conference 'Management of Drug Users in Primary Care' in Cardiff. Part 1 is ideal for GPs working at a generalist level, as part of a shared-care scheme, especially those intending to provide treatment to drug users as part of a locally or nationally enhanced service (L/NES).

The course is mapped to the Drug and Alcohol National Occupational Standards (DANOS) and is endorsed by the National Treatment Agency for Substance Misuse. At the moment Part 1 is only available to GPs, but it is being developed for nurses, user advocates and others. The course is to be delivered in two stages: e-modules and face-to-face training. The e-learning modules began in June 2004 and can be accessed at [www.doctors.net.uk](http://www.doctors.net.uk) in the Education section by anyone who has a GMC number. The training days are run locally and nationally.

Part 2 is a continuation of the existing certificate and is aimed at practitioners wishing to become GPs with a Special Clinical Interest or a practitioner with Special Interest. There is an expectation that candidates will have completed the Part 1 certificate or equivalent training (recognised by the RCGP or sister organisations), or can demonstrate that they already have the generalist competencies. Part 2 is open to GPs, nurses, pharmacists, user advocates, expert patients, psychiatrists, shared-care workers, and others with appropriate background.

### **Learning with other healthcare professionals**

The specialty registrar is encouraged to learn alongside other professional colleagues who will be involved in the care of drug users. This will enrich the learning experience and all parties will be able to draw on the expertise of others. (See above for details about Part 2 of the RCGP Certificate in the Management of Drug Misuse.)

# Appendix 1

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## Guiding principles for the development of the recovery process<sup>12</sup>

### Principle I

The user of services decides if and when to begin the recovery process and directs it; therefore, service user direction is essential throughout the process.

### Principle II

The mental health system must be aware of its tendency to promote service user dependency.

### Principle III

Users of service are able to recover more quickly when their:

- Hope is encouraged, enhanced and/or maintained
- Life roles with respect to work and meaningful activities are defined
- Spirituality is considered
- Culture is understood
- Educational needs as well as those of families/significant others are identified
- Socialisation needs are identified
- They are supported to achieve their goals.

### Principle IV

Individual differences are considered and valued across the life span.

### Principle V

Recovery from mental illness is most effective when a holistic approach is considered; this includes psychological, emotional, spiritual, physical and social needs.

### Principle VI

In order to reflect current 'best practices' there is a need for an integrated approach to treatment and care that includes medical/biological, psychological, social and values-based approaches. A recovery approach embraces all of these.

### Principle VII

Clinicians' and practitioners' initial emphasis on 'hope' and the ability to develop trusting relationships influence the recovery of users of services.

**Principle VIII**

Clinicians and practitioners should operate from a strengths/assets model.

**Principle IX**

Users of service with the support of clinicians, practitioners and other supporters should develop a recovery management or wellness recovery action plan. This plan focuses on wellness, the treatments and supports that will facilitate recovery, and the resources that will support the recovery process.

**Principle X**

Involvement of a person's family, partner and friends may enhance the recovery process. The user of service should define whom they wish to involve.

**Principle XI**

Mental health services are most effective when delivery is within the context of the service user's locality and cultural context.

**Principle XII**

Community involvement as defined by the user of service is central to the recovery process.

## Appendix 2

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### Hidden harm – children of drug users<sup>10</sup>

Parental drug use in isolation is not automatically correlated with poor parenting and many drug users do manage to provide good parental care, especially if they are in appropriate treatment. On the other hand, chaotic parental drug misuse may compromise the health and development of a child at any stage. Effects vary according to the child's age and stage of development, and problems may be cumulative and are often multiple. In assessing drug-using parents, it is important to assess the quality of parenting overall rather than focusing exclusively on drug use. Other professionals such as social workers, teachers and health visitors should be involved in this process.

Examples of the range of problems that may be faced by children whose parents have unstable drug use include:

- Increased risks of accidents
- Physical and emotional abuse (usually neglect)
- Poverty
- Inadequate parental supervision
- Inappropriate parenting practices
- Intermittent or permanent separation
- Inadequate accommodation, frequent changes of residence
- Risks associated with toxic substances and inappropriate individuals in the home.

The ratio of male to female drug users approaching treatment services is around 3:1, though community-based surveys involving out-of-contact users makes the ratio much closer to 2:1, indicating that while there are probably greater numbers of male drug users, female drug users may be more reluctant to approach treatment services, due to the increased stigma attached to female drug use and fear regarding children and the involvement of social services.

### Prevalence of children at risk

- We estimate there are between 200,000 and 300,000 children in England and Wales where one or both parents have serious drug problems. This represents about 2–3% of children under 16. Only 46% had their children living with them; 54% had children living elsewhere (usually with other family members or friends) including 9% whose children were in care.
- We estimate there are between 41,000 and 59,000 children in Scotland with a problem drug-using parent. This represents about 4–6% of all children under 16. There are estimated 10,000–19,000 children in Scotland living with a problem drug-using parent.

## Appendix 3

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### Asking about drugs

- Ideally doctors should ask all patients about their drug use (prescribed and non-prescribed), e.g. 'Do you smoke cigarettes? What about alcohol? And do you use any other drugs?'
- Given the opportunity many patients will volunteer problem drug use.
- The doctor should then ask:
  - ◆ What do you use?
  - ◆ How much per day? Per average week?
  - ◆ What route? (oral, injecting, smoking)
  - ◆ Longest period of abstinence?
  - ◆ Treatment history.

### Brief intervention for alcohol problems

Brief intervention involves the following:

<i>F</i>	Feedback	Assessment and evaluation of the problem
<i>R</i>	Responsibility	Emphasising that drinking is by choice
<i>A</i>	Advice	Explicit advice on changing drinking behaviour
<i>M</i>	Menu	Offering alternative goals and strategies
<i>E</i>	Empathy	The role of the counsellor is important
<i>S</i>	Self-efficacy	Instilling optimism that the chosen goals can be achieved

### Harm minimisation for alcohol

Harm minimisation interventions include advising where drinking should be avoided. These include:

- Before or during driving
- Before swimming
- Generally, before or during active physical sport
- Before working or in the workplace when appropriate functioning would be adversely affected by alcohol
- When taking medication, where alcohol is contraindicated.

## Appendix 4

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### Models of Care framework

The National Treatment Agency for Substance Misuse (NTA) *Models of Care of the Treatment of Adult Drug Misusers: framework for developing local systems of effective drug misuse treatment in England (2002)*<sup>7</sup> sets out a programme of action and reform to address the needs of drug users and ensure that the quality of services improved for them.

*Models of Care* Part 1 and Part 2 provide a *national framework for drug treatment services* in England that should be used as a guide for all drug action teams (DATs) as they proceed with their plans to expand and improve the drug treatment services in their area.

The overriding concept behind *Models of Care* is that DATs should be seeking to develop an *integrated drug treatment system* in their area, not just a series of separate services. In the last few years, DAT members have received increasing funding to expand the capacity of the various modalities of treatment, but it is also felt that efforts must be made to combine these modalities into a seamless system of ‘care pathways’ for patients. The *Models of Care* approach describes how these processes of care would work, based on the menu of treatment services that have already been incorporated into DAT treatment plans, but now expressed in terms of four treatment ‘tiers’.

Tier 1	Non-substance misuse specific services requiring interface with drug and alcohol treatment
Tier 2	Open-access drug and alcohol treatment services
Tier 3	Structured community-based drug treatment services
Tier 4	Residential services for drug and alcohol misusers

The Royal College of General Practitioners has clarified the tiers at which practitioners with varying levels of skills may work.

GP providing core services	Tier 1
GP providing essential services	Tier 1
GP providing locally enhanced services	Tier 1
GP providing nationally enhanced services	Tier 1–2
GP with special clinical interest providing enhanced services	Tier 1–2
GP with special clinical interest providing services to PCO	Tier 2–3
Specialist generalist providing specialist services under GMS or specialist PMS arrangements	Tier 3–4

## **Implementing *Models of Care***

Implementing *Models of Care* requires the development of a number of locally agreed screening and assessment instruments. It also requires the establishment of care coordination for clients with complex needs.

A toolkit has been developed that contains top tips and a number of instruments developed by the various Enhancing Treatment Outcome (ETO) pilots that have been running throughout the country. These tools include assessment forms, care plans and a number of other items that may be useful in addressing these issues. See [www.nta.nhs.uk/](http://www.nta.nhs.uk/) for more information.

# References

- 1 JONES R, BRITTEN N, CULPEPPER L, *et al.* (eds). *The Oxford Textbook of Primary Medical Care* Oxford: Oxford University Press, 2004
- 2 DEPARTMENT OF HEALTH. *Provisional Statistics from the National Drug Treatment Monitoring System in England, 2001/02 and 2002/03* London: Department of Health, 2003
- 3 NHS SCOTLAND (SCOTLAND'S HEALTH STATISTICS DATABASE). *Main Illicit Drug Use: year ending 31 March 2002 percentage of individuals using each drug as their main drug of misuse, by sex* Edinburgh: NHS Scotland, 2005, [www.drugmisuse.isdscotland.org/publications/03dmss/themes/index.htm](http://www.drugmisuse.isdscotland.org/publications/03dmss/themes/index.htm) [accessed January 2007]
- 4 STRANG J, SHERIDAN J, HUNT C, *et al.* The prescribing of methadone and other opioids to addicts: national survey of GPs in England and Wales *Br J Gen Pract* 2005; 55: 444–51
- 5 NATIONAL TREATMENT AGENCY FOR SUBSTANCE MISUSE. *The Roles and Responsibilities of Doctors in the Provision of Treatment in Drug and Alcohol Misusers* London: Department of Health, 2005, [www.nta.nhs.uk/publications/documents/nta\\_doctors\\_roles\\_and\\_responsibilities\\_sept\\_2005.pdf](http://www.nta.nhs.uk/publications/documents/nta_doctors_roles_and_responsibilities_sept_2005.pdf)
- 6 THE PRIME MINISTER'S STRATEGY UNIT. *Alcohol Harm Reduction Strategy for England* London: The Prime Minister's Strategy Unit, 2004, [www.cabinetoffice.gov.uk/strategy/work\\_areas/alcohol\\_misuse.aspx](http://www.cabinetoffice.gov.uk/strategy/work_areas/alcohol_misuse.aspx)
- 7 NATIONAL TREATMENT AGENCY FOR SUBSTANCE MISUSE. *Models of Care of the Treatment of Adult Drug Misusers: framework for developing local systems of effective drug misuse treatment in England* London: Department of Health, 2002
- 8 THE TASK FORCE TO REVIEW SERVICES FOR DRUG MISUSERS. *Report of an Independent Survey of Drug Treatment Services in England* London: Department of Health, 1996
- 9 Possibly the best summary of the effectiveness is found in: SCOTTISH INTERCOLLEGIATE GUIDELINES NETWORK (SIGN). *The Management of Harmful Drinking and Alcohol Dependence in Primary Care National Clinical Guidelines* Edinburgh: SIGN, 2003, [www.sign.ac.uk](http://www.sign.ac.uk)
- 10 GRUER L. *Hidden Harm: responding to the needs of children of problem drug users* London: Advisory Council on the Misuse of Drugs, 2005
- 11 GERADA C, BARRETT C, BETTERTON J, *et al.* The Consultancy Liaison Addiction Service – the first five years of an integrated, primary care based community drug and alcohol team *Drugs: Education, Prevention and Policy* 2000; 7: 251–6
- 12 NIMHE. *Emerging Best Practices in Mental Health Recovery*, <http://kc.csip.org.uk/upload/Best%20Practices%20in%20MH%20Recovery%20Poster.pdf>