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Shared care for treatment of opioid dependence and the new General Medical Services contract

AIMS AND METHODS

An audit of clients in specialist and shared care services was undertaken in 2003 and in 2005 to investigate the capacity, quality of prescribed medication and profile of clients, and to assess the impact of the new General Medical Services contract on drug misuse treatment.

RESULTS

Capacity in specialist services increased by 55% from 2003 to 2005, but not in shared care, and type and dosage of prescribed medication improved for shared care. Profile of clients suggests that stable clients are treated within shared care.

CLINICAL IMPLICATIONS

Attention should be given in training general practitioners to provide shared care treatment, increasing the number of clients accepted in shared care, and considering new treatment models.

In 1998, the Government set a target to double the number of people in treatment both within statutory and non-statutory drug services by 2008 and increase year-on-year the proportion of individuals misusing drugs successfully sustaining or completing treatment (Department of Health, 1998). Changes to treatment provision in primary care were included in the new General Medical Services contract for general practitioners (GPs). The new contract formalised the involvement and participation of GPs providing substitute-prescribing treatment. This was in line with government policy that promoted GPs as having an important role in modern healthcare for drug users (Department of Health, 1998). Prescribing treatment within primary care services is commonly known as shared care. This was defined by the Department of Health as 'the joint participation of GPs and specialists in the planned delivery of care of patients with substance misuse problems informed by an enhanced information exchange beyond routine discharge and referral letters' (Department of Health, 1996). A range of models have since developed in the delivery of shared care. In Hertfordshire there was not an agreed shared care prescribing protocol between primary care and specialist services until 2004. Shared care for drugs misuse was in operation in a number of ways, with or without the support of specialist services. Once the new General Medical Services contract for GPs came into operation in 2004, it was agreed that shared care should only be provided by those GPs on the enhanced services contract having received appropriate training and remuneration. A maximum number of clients had been agreed for each practice. The Hertfordshire protocol supports close collaboration between primary care and specialist services. This is in line with the national framework, *Models of Care for Treatment of Adult Drug Misusers* (National Treatment Agency for Substance Misuse, 2002).

The audit reported here was undertaken by specialist services in two cycles, in October 2003 (before the new General Medical Services contract) and again in September 2005, with the following aims: (a) to identify which clients receiving treatment in specialist services

were appropriate for shared care; (b) to assess the impact of the new General Medical Services contract on drug misuse treatment, including capacity and quality of treatment.

Method

All clients receiving treatment at the time of the audit within the specialist services in north west Hertfordshire or in the shared care scheme with their respective GPs supported by specialist services were included in the sample. Clients in the shared care scheme unsupported by specialist services were not included in the audit. All the information required was obtained from the client's case notes using a purposely developed collection form. Data collected included prescribing activity; quality of treatment provided such as type and dosage of medication, arrangements for medication dispensing; clinical characteristics of clients; and social characteristics such as current employment and type of accommodation. In 2003 a narrow approach was used in identifying clients in specialist services appropriate for shared care; only those clients attending services on a monthly basis were considered suitable for transfer to shared care. In 2005 clients identified by the audit to be suitable for shared care were discussed with whole team to enable a collective agreement.

Results

The audit reported no increase in prescribing activity within primary care between 2003 and 2005. The clients in shared care for 2005 were registered with 14 surgeries, compared with 18 surgeries in 2003. In 2003 there were 31 clients receiving treatment in shared care and 82 receiving treatment from specialist services (total of 113 clients). In 2005 the audit reported a total sample group of 157 clients with 30 in shared care and 127 in treatment with specialist services – an increase of 55% within specialist services.

The quality of treatment was assessed by the type and dosage of medication prescribed for substitute



treatment. In 2003, 20% of clients in shared care were prescribed buprenorphine; this increased to 33% in 2005. In shared care in 2003, one client received dihydrocodeine tablets, while another received morphine sulphate tablets. In 2005 there was no prescribing outside guidelines within shared care (Department of Health *et al*, 1999). In specialist services the percentage of buprenorphine prescribing from 2003 to 2005 increased from 10% to 17%.

From 2003 to 2005 in shared care the mean daily dose for methadone mixture increased from 28.37 mgs (9–55 mgs) to 40 mgs (8–85 mgs). The mean daily dose of buprenorphine increased also, from 7 mgs (2–16 mgs) to 8 mgs (0.8–16 mgs). The methadone mean daily dose for the specialist services group remained the same, 50.69 mgs (10–100 mgs) in 2003 and 49 mgs (10–100 mgs) in 2005. The mean daily dose of buprenorphine increased from 6.97 mgs (4–10 mgs) to 9 mgs (2–16 mgs).

For the shared care group in 2003 the majority of clients attended on a fortnightly basis, while in 2005 50% were attending on a fortnightly basis and 43% were attending every month. None were attending on a weekly basis in 2003; this was not the case for 2005 with two clients attending on a weekly basis. In 2003 and 2005 in specialist services 50% of clients attended appointments on a fortnightly basis, with just over 30% in each of the groups attending on a weekly basis.

The medication dispensing arrangements for shared care changed from 52% in 2003 collecting their medication on a daily or three times weekly arrangement to only 17% in 2005 (with none under supervision). The majority of the remainder were collecting on weekly or fortnightly arrangements. In specialist services a comparable number, 82% in 2003 and 81% in 2005, were collecting their medication on a daily (with 7% under supervision) or three times weekly arrangements, with the rest collecting their medication on twice weekly, weekly or fortnightly arrangements.

Although 50% of clients in both specialist services and shared care had a history of injecting behaviour, none of the clients in shared care in either 2003 or 2005 were injecting at the time of the audit. Illicit drug use (excluding cannabis) was reported by 65% clients in specialist services for both 2003 and 2005, while in shared care there was a reduction from 52% in 2003 to 34% in 2005.

In shared care, 32% of clients were in paid employment in 2003, and 90% in 2005. In specialist services, the percentage of clients in employment remained roughly the same (34% in 2003 and 31% in 2005). The vast majority of clients in both shared care (100%) and specialist services (93%) in 2003 and 2005 were reported to be living in a type of accommodation rather than homeless.

Discussion

It was expected that the enhanced General Medical Services model of shared care would have (a) increased treatment capacity, which would have had the effect of increasing treatment options and choice, and (b)

improved the quality of treatment offered. It was expected that enhanced training and appropriate remuneration would increase the number of GPs providing shared care, and, with time, the increased clinical experience and structured collaboration with specialist services would increase clinicians' confidence, which would lead to increased treatment capacity. However, the results of this audit suggested that there was no increase in activity in shared care between 2003 and 2005, with a reduction in number of surgeries providing shared care services. Some of the GPs that had been treating people with a substance misuse problem decided not to adopt the enhanced model and were therefore not eligible under the new contract to provide shared care services. Also, after an initial attempt to enlist GPs on the enhanced model of prescribing treatment at the time of the new General Medical Services contract, this was not repeated the following year, which could be attributed to the imposed new costs on primary care trusts to fund this type of care. As a result only a low percentage of GPs trained had actually adopted the enhanced model. In addition to the above two factors, the maximum number of clients per surgery was not reviewed following the first year of the new General Medical Services contract. In 2005 the audit identified 52 clients in specialist services who were considered by the clinical team to be suitable for shared care. Nine clients were successfully transferred. Of the remaining clients, 24 were registered with surgeries providing shared care treatment, but the surgeries had reached their identified limit of clients for shared care. These warning signs indicate that the maximum number of clients per surgery should be reviewed as confidence and experience of GPs increases with time; trained GPs might have to consider offering shared care treatment to clients registered with surgeries elsewhere, and more GPs may be required to be trained and provide shared care treatment.

As far as the quality of treatment offered is concerned it is evident that although the mean dose of prescribed methadone in 2005 still falls below the national average dosage for maintenance (56.7 mgs) (Commission for Healthcare Audit and Inspection, 2006), there was an increase of 41% in shared care services. However, the audit does not distinguish between maintenance and reduction regimens. A high percentage of clients on a reduction regimen could affect the mean daily dose. The mean dosage for buprenorphine for both shared care and specialist services has also increased. This increase is in line with Department of Health Clinical Guidelines (1999), which highlight greater benefit of maintaining individuals on a daily dose between 60–120 mgs of methadone (and higher in exceptional cases).

Of note is that in 2005 only medication licensed for use in substitute-prescribing treatment was in use in the shared care group; this was not the case in 2003. In 2005 the use of medication outside recommended guidelines was limited to specialist services and was confined to complicated presentations and case management.

The lifestyle characteristics for the shared care group demonstrate a level of stability that is acceptable



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with the criteria for suitability for shared care described in the joint working protocol for Hertfordshire (paid employment and accommodation). This is also supported by the finding that prescribing appointments and instalments for dispensing medication are in accordance to expectations. Shared care clients, by virtue of their stability are often seen fortnightly or monthly with pick-up instalments at twice weekly, weekly or fortnightly intervals. The audit did not distinguish between types of accommodation (i.e. rented or owned property, living in a hostel or with friends), therefore results should be interpreted with caution. However, employment seems to be an important factor in differentiating the two groups of clients.

The audit reported here suggests that although the new General Medical Services contract has not increased treatment capacity within primary care, it has improved quality of treatment offered, and clients in shared care are more stable than clients in treatment with specialist services. Further work is required to develop ways of overcoming identified barriers preventing successful and effective implementation of the enhanced model of shared care services.

Declaration of interest

None.

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Primary consultation clinics in child psychiatry: an evaluation of referrers' views of the service

AIMS AND METHOD

To collate referrers' views on primary consultations in child psychiatry, feedback data were collected by questionnaires over a 12-month period.

RESULTS

Referrers found reports clearly written, informative and helpful, but wished for further, more direct involvement, support and follow up, and also for a clear plan of action for the children referred.

CLINICAL IMPLICATIONS

Primary consultation clinics should be further developed and audited in the future, in view of the recent changes in child and adolescent mental health services.

Consultation clinics in child and adolescent psychiatry are not uncommon. The consultation clinics in Derby were set up by the child and adolescent mental health service and serviced the area of central Derby, which has a population of 250 000. The service was provided by two psychiatrists and primary mental health workers.

The child and adolescent mental health services in Derbyshire are sectorised primarily into central Derby and surrounding rural area services. There are two bases in central Derby, with the Town House providing tier 3 services and the Mill providing tier 1 and 2 services and housing the mental health workers. At other bases, situated in the surrounding towns, the different tiers of service are mostly provided under one roof. Housing the primary mental health workers and therapists at two different sites created communication and logistical problems and stretched consultant psychiatric and

managerial support. Central Derby has two full-time consultants, and the service receives over 800 referrals a year. The child psychological services are separately provided and based at the children's hospital site. There are currently no established learning disability services for children; this need is provided for by the generic child and adolescent mental health teams. Recruitment problems and the recent exodus of therapists and mental health workers due to governmental changes such as Agenda for Change (2004) and the extension of responsibility for child and adolescent mental health services to cover up to the age of 19 years, has placed further stress and strain on the generic teams. There is therefore now an urgent need for new ways of working for psychiatrists in child and adolescent mental health services teams, and consultation (rather than direct hands-on involvement