

A review of shared care protocols for the treatment of problem drug use in England, Scotland, and Wales

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SUMMARY

In 1995, the Department of Health instructed health authorities to establish protocols for the shared care of problem drug users. Response to this has been disappointing: 26 out of 120 health authorities have shared care arrangements in place, with the content of these differing widely.

Keywords: shared care, protocols, drug abuse.

Introduction

IN response to the White Paper, *Tackling Drugs Together*,¹ the Department of Health issued EL(95)114, instructing health authorities to establish protocols for shared care of problem drug users. The letter stressed the importance of joint participation between the specialist and the generalist, by information exchange beyond routine referral and discharge letters. This report uses the results of a review of these protocols to establish the extent and nature of different approaches across England, Scotland, and Wales.

Method

The authors were asked, as part of a joint Royal College of General Practitioners and Psychiatrists Working Party, to review the written request to the 120 health authorities (HAs) in England, Scotland, and Wales, asking for protocols or guidelines developed in response to EL(95)114. The content of these was reviewed under the following headings:

- criteria for patient suitability for shared care,
- guidelines for initial assessment,
- guidelines for prescribing and continued care, and
- extent of involvement of general practitioners (GPs) in shared care.

Protocols were rated by both authors, and discrepancies settled after discussion with a third party. Analysis was carried out using Epi-Info version 5.1.

Results

The response rate was 74% (89/120). Of these, 34% (30/89) made an initial assessment of their local drug problem and available resources, and 87% (26/30) had shared care arrangements, analysed here (Box 1). A GP was involved in authorship of protocols in 35% (9/26) of cases. This 'GP involved' group was compared with the 'no GP involved' group (17), using Fisher's

exact test, on every aspect of the protocols. Only significant differences are reported.

Criteria for patient suitability for shared care

The most supported criteria were: short duration of habit (19% [5/26]), small habit; i.e. <1g daily of heroin (12% [3/26]), homelessness (23% [6/26]), and if already registered with the GP concerned (23% [6/26]). Those criteria considered unsuitable were polydrug users (19% [5/26]) and injecting drug users (23% [6/26]). Of the 'GP involved' group, 44% (4/9) recommended a triage system to allocate suitable patients; significantly fewer than the 'no GP involved' group, with 88% (15/17) (Fisher exact test: two-tailed; $P = 0.02$).

Guidelines for initial assessment

Those guidelines included were: full history and physical examination (73% [19/26]), urine drug screen (81% [21/26]), consulting Home Office Addicts Index (62% [16/26]), contacting previous GP (38% [10/26]), and obtaining history from a partner (15% [4/26]).

Guidelines for prescribing and continued care

Guidelines on prescribing were included in 77% (20/26) of the protocols. Of these, methadone was included as liquid (90% [18/20]), tablets (15% [3/20]), and ampoules (20% [4/20]). Dihydrocodeine was included as tablets (25% [5/20]) and liquid (10% [2/20]). Other drugs recommended were naltrexone (30% [6/20]), lofexidine (35% [7/20]), and dexamphetamine (5% [1/20]). Titration of dose to withdrawal symptoms was recommended in 40% (8/20) of guidelines.

In respect of liquid methadone, 61% (11/18) provided guidelines on a maximum dose as follows: 40ml (4/11), 60ml (3/11), 80ml (2/11), >100mg (2/11). Daily collection was recommended in 60% (12/20) of protocols. Duration of prescription was stated in 50% (10/20) of protocols: up to six weeks (1/10), up to 12 weeks (2/10), and more than 12 weeks (7/10).

Guidelines for care, once stabilized, included: review of treatment goals (42% [11/26]), urine screens (62% [16/26]), gradual reduction (31% [8/26]), and regular GP appointments (23% [6/26]). Support for GPs included: attendance at training, reimbursement, and limiting the number of patients receiving a prescription (all 15% [4/26]).

Extent of potential involvement of GPs in care of problem drug users

Six levels of involvement were identified by the authors, and each HA response ($n = 89$) was allotted to one of these: no GP provision (13% [12/89]), informal agreement with a small number of GPs (44% [39]), GPs involved in general medical services only (6% [5]), shifted outpatient clinic (11% [10]), consultancy and liaison (7% [6]), and specialist GP (7% [6]).

Discussion

Few HAs involved GPs in developing shared care protocols,

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Estimate of prevalence of drug misuse in area	50% (15)
Identification of drugs misused	43% (13)
Estimate of current GP involvement	73% (22)
Estimate of unmet patient need	33% (10)
Identification of GP needs	73% (22)
Support	77% (17/22)
Training	82% (18/22)
Additional resources	55% (12/22)
Fast track referral	23% (5/22)

Box 1. Results of needs assessment carried out by 30 health authorities.

even though they would be expected to adhere to them. HAs that carried out needs assessments mostly looked at current GP involvement and how it could be expanded. Although liquid methadone was recommended in the majority of protocols, titration against withdrawal or dose assessment was not, despite the recent rise in accidental opiate overdose.² The GP should remember that the doctor signing the prescription takes ultimate responsibility. The majority of existing arrangements are informal agreements with a small number of local GPs involved. In our experience, this usually means that a few sympathetic GPs become inundated with referrals from multiple agencies; the latter's involvement is minimal once prescribing has commenced. This leads to GPs treating unsuitable patients, failing to make headway with them, and prescribing inappropriately. Ultimately, such GPs burn out and close their books to any further work with addicted patients. In addition, there is an *ad hoc* treatment of additional payments to GPs, with some HAs offering payments,³ while others — the majority — offer none.

A joint working group of the Royal College of Psychiatrists and the Royal College of General Practitioners has concluded that shared care can be achieved if there is close GP/specialist contact, integrated training/audit/agreed protocols, and clear responsibility for prescribing.⁴ Sadly, we are far from this ideal.

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