

Howard Skinner,

*PGP Principal, Trainer, Appraiser, and Member of Primordial Federation, the Tutbury Practice.*

*E-mail: hds Skinner@doctors.org.uk*

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## Substance misuse: institutionalised neglect in general practice

The suite of articles in the recent edition of the *BJGP* is well received and reminds us of the changing landscape of drug misuse.<sup>1</sup> Implicit in the descriptions and suggestions is the expectation that we, as medical generalists, should be aware of these medical problems and be in a position to offer help, guidance, and referral when necessary.

It should not need to be said that the majority of the problems that present to the NHS are related to opiates, particularly injecting opiates, and that the rising number of deaths are from overdose of opiates.

The other changing landscape is driven by the 2012 Health and Social Care Act in England and Wales, and by parallel changes in Scotland. These changes are unravelling the carefully constructed shared care between primary and secondary care by commissioning third-sector agencies at the expense of statutory NHS provision and, in a contracting economy, spending a larger proportion of available budgets on non-medical interventions. The spectre of outbreaks of blood-borne viruses or bacterial infections should remind us of the dangers of trivialising drug taking in the medical sector.

At a critical turning point in funding and policy we should be careful to recognise the importance of primary care and that this role needs to be integrated into policy and funding arrangements. It seems extraordinary that drug treatment is not a core responsibility and that, as an Enhanced Service contractual arrangement, it can be included or excluded from our day-to-day work. General Medical Council guidance advises and reminds us of our responsibility to all patients to, 'provide effective treatments based on the best available evidence'. National guidelines both from National Institute for Health and Care Excellence and the Departments of Health point to the essential place that GPs have in managing drug users.

It is unacceptable that management of drug users and their problems, prescribing methadone, buprenorphine, or other appropriate medication, and cooperating closely with secondary care and the third sector should not be a core service requirement. Any other group of patients would have spotted and alerted us to this institutional neglect, which is hard to understand, but must be based on prejudice, maybe ignorance and fear, and sadly a systematic reorganisation, which apparently doesn't care.

Roy Robertson,

*GP, Muirhouse Medical Group and Professor of Addiction Medicine, University of Edinburgh.*

*E-mail: roy.robertson@ed.ac.uk*

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## Novel psychoactive substances

Gilani does well to highlight the increasing and concerning use of novel psychoactive substances (NPS) in the UK.<sup>1</sup> We have seen the damaging and unpredictable effects of synthetic cannabinoids in prisons and substance misuse services over the last 3 years.

The number of deaths attributable to NPS is increasing year on year and

prisoners are transferred to hospitals with tachyarrhythmia, dangerous hypertension, impaired consciousness, and seizures on an almost daily basis from some prisons. A number of deaths have been reported due to NPS abuse.

Worryingly, vulnerable prisoners are targeted and, anecdotally, individuals are bullied into smoking 'Spice' (as NPS are colloquially known) while bets are taken on how much can be smoked before the victim collapses.

It is to be hoped that the legislature can make suitable arrangements to criminalise the production, supply, and possession of these dangerous substances. But enforcement will have to be improved if such measures are to prove effective in reducing the harm created by NPS.

Iain Brew,

*GP, Prison Health Specialist and Medicolegal Doctor.*

*E-mail: iainbrew@nhs.net*

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