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A survey of NHS services for opiate dependents in Scotland

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• Identify what is effective – and cost effective – practice in prevention, treatment, rehabilitation and availability and in addressing the needs of both the individual and the community.

• Disseminate effective practice based on sound evidence and evaluation to policy makers, DATs and practitioners.

• Support DATs and agencies to deliver effective practice by developing good practice guidlines, evaluation tools, criteria for funding, models of service; and by contributing to the implementation of effective practice through the DAT corporate planning cycle.

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A Survey of NHS Services for opiate dependents in Scotland

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Scottish Executive Drug Misuse Research Programme

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CHAPTER 1 Introduction

Introduction

Heroin is recognised as a serious drug of abuse[1]. Department of Health guidelines on clinical management for drug misuse and dependence (sometimes known as the 'orange book')[2] outline a range of drug treatments and other therapeutic interventions appropriate for treating opiate dependents. These treatments vary in what they set out to achieve, according to what is deemed appropriate for individuals. For example, some interventions aim to establish stability through maintenance prescribing. Other treatments work towards short or medium term withdrawal using both prescribed opiates and non-opiate drugs. When these interventions have been accomplished, other interventions geared to either relapse prevention or abstinence maintenance can be introduced. For each form of intervention there are pharmacological and psychological treatments available.

Methadone has been regarded as a drug of great importance in the treatment of drug misuse. The strong evidence base for its effectiveness has largely been demonstrated through on-going maintenance treatment[3-6]. It is the main treatment drug for heroin addiction because of its effectiveness orally (enabling cessation of injecting), as well as its long acting and non euphoriant properties. Its effectiveness has been particularly demonstrated when it has been accompanied by counselling and other interventions[7].

Until recently, methadone was the only medication with a product licence for the treatment of active opiate users. In recent years other options have become available. For example, there is a body of evidence supporting the use of lofexidine for opiate detoxification[8-10]. Also, in recent times, buprenorphine has been used both in the management of opioid withdrawal[11] and as an opiate maintenance therapy[12]. It has been demonstrated to lead to less severe withdrawal symptoms than clonidine.[13] However, as a maintenance treatment, its benefits over methadone have been less clearly demonstrated[14]. Naltrexone has been used as a relapse prevention treatment following withdrawal from opioids[15]. Its benefits are best demonstrated among 'motivated' individuals[16].

In the context of treating opiate addicts, it is believed by some that the clinician of today is relatively spoilt for choice with regard to selection of specific pharmacotherapy[17]. In this light, it is important to assess how these choices are made. The Department of Health guidelines emphasise the necessity for clinicians to monitor outcomes at the aggregate as well as individual level, and to adjust future treatments in the light of new evaluations. The present investigators were unable to find systematically collected data that addressed this (Medline Search 1993-2001, personal communication with Scottish Drug Specialists' Committee and the Scottish Division of the Royal College of Psychiatrists, Substance Misuse Section). The lack of any systematic information about current provision and practice across Scotland is a significant barrier to progress. Thus, a systematic appraisal of what treatments are being offered throughout Scotland, and what informs the decisions made, is both timely and important.

Aims

The main aims of the study were to investigate:

- the **range of options** made available in different areas within the Scottish NHS boards for treating patients with opiate dependence.

- the **processes** that underlie clinical decision making.

CHAPTER 2 Methods

Methods

Three categories of respondents were approached to participate in the study; clinicians with special responsibility for substance misuse, representatives from Drug Action Teams (DATs) and NHS personnel with a responsibility for commissioning out of area referrals.

Semi-structured interviews by telephone were the principal method used to elicit the information required. However, DAT corporate plans also provided a useful source of information on service provision, particularly in the early stage of the project.

1) Clinicians with special responsibility for substance misuse

Potential participants were identified through the Scottish Division of the Royal College of Psychiatrists (Substance Misuse Section). A letter was sent to their members, inviting them to take part in an in-depth telephone interview focusing on the treatment of opiate dependents. Further participants were identified through personal communication with Royal College members. The aim was to identify a sample of clinicians with special responsibility for substance misuse that was widely representative of Scottish NHS Board areas.

Twenty-four relevant clinicians from all NHS Boards (with the exceptions of Orkney and Shetland) were approached to participate in the study. Twenty-one agreed to take part (one agreeing to a shortened interview and one agreeing to give a written response rather than an interview). Two declined and one could never be reached to confirm participation. Twenty of the twenty-one participated. The one remaining agreeing clinician was not interviewed due to scheduling difficulties.

The twenty participating clinicians, between them, represent all NHS Boards except Orkney and Shetland. One clinician per NHS Board was interviewed, with the exception of Greater Glasgow (5 participants), Argyll and Clyde (3 participants) and Edinburgh (2 participants).

Prior to interview, participants were sent advanced notice of the planned questions about prescribing, to allow them to make investigations if necessary. In some circumstances, participants, in estimating, would be giving a 'rough' idea of the proportions of various drugs they prescribed. This should be borne in mind when interpreting data collected from the clinical interviews.

An interview schedule was used to conduct the structured interviews. This is available from the EIU on request. The following components of the interview are the focus of this report:

- Opiate drugs prescribed
- Methadone dose and supervision
- Short-term/long-term prescribing
- Abstinence
- Non opiate drugs prescribed
- Use of Protocols
- Counselling
- Alternative therapies
- Treatment settings
- Professional make up of the addiction service
- Links with other health care settings and other non-NHS care settings
- Likes and difficulties of working with opiate dependents

Although 20 clinicians participated in the survey, the total of responses for different questions addressed in the schedule varies. In some circumstances this was due to the direction the interview followed. For some questions, some clinicians did not feel comfortable or were not able to make an estimate. For example, this occurred in the case of estimating the proportions of opiate dependents prescribed methadone who were on a scheme of maintenance. One clinician, working in an area of low prevalence of opiate dependence, did not have any opiate dependent clients at the time of interview. It was considered inappropriate to ask this participant to make estimates of proportions of various clinical activities delivered to an opiate dependent caseload. A greatly reduced version of the interview schedule was used with the participant who agreed to a shortened interview.

The interviews were tele-recorded and transcribed. Quantitative data were entered into SPSS for Windows and used to produce frequency tables. Qualitative data were analysed according to the 'Framework' method which involves a systematic process of sifting, charting and sorting material according to key issues and themes[18].

2) Representatives from Drug Action Teams (DATs)

Drug Action Team representatives were identified from the 'Contact' persons named in the 'Drug Misuse in Scotland' website[19] (Drug Strategy Co-ordinators and Drug Development Officers). They were written to and invited to take part in a telephone interview on the topic of services to opiate/opioid dependents. Nineteen DAT contacts (representing 20 DAT areas) were asked to take part in a telephone interview. Seventeen, representing eighteen DAT areas, agreed to participate and gave information on services in their areas. The two DAT representatives who declined, each suggested a nursing professional in their areas as being a better source of information. Interviews with these individuals were set up accordingly. Some service agencies were contacted directly where DAT representatives were unable to provide information.

The DAT Corporate Action Plan Treatment Table for 1999-2000[20] was used as a frame to discuss current NHS, Local Authority and Voluntary Sector provision for opiate/opioid dependents within their DAT area. All but one of the interviews were tele-recorded.

Information collected from the DAT representatives are not reported in the present report. The data collected will be used by the Effective Interventions Unit as part of their integrated care work due to be published later in 2002.

3) NHS personnel with a responsibility for commissioning out of area referrals

During the course of the interviews with clinicians and DAT representatives, interviewees were asked to identify who in their area had a responsibility for commissioning out of area referrals. Once identified, individuals within each NHS Board area were contacted and asked if they could provide information on the following:

a) For the financial year April 2000 to March 2001, to what services were people with an opiate/opioid problem referred, beyond those services provided in the NHS Board area?
b) Of those places identified under (a), how many people were referred to each place?
c) How are the decisions made about the outcome of applications for out of area services for this client group? Are there particular criteria that need to be fulfilled before agreement?

Key informants in all 15 NHS Board areas provided information. These data are set out in this report.

CHAPTER 3 Results

1) Interviews with clinicians

The vast majority of clinicians were consultant psychiatrists (17; 85%). The remaining 15% comprised a clinical assistant, clinical director and medical co-ordinator. They were asked to estimate the proportion of their caseload consulting for addiction and the proportion of their addiction caseload consulting for opiate dependence. These estimates are shown in Table 1.

It is clear that the majority of these clinicians working in this area in Scotland have drugs and/or alcohol as their total case load (74%) but there is still a significant minority that have it only as a component of their work (26%). Strikingly, a very high proportion of their addiction caseloads are focused solely on opiates suggesting that other drugs problems, such as misuse of amphetamines, are not really a focus of these clinicians' work (Table 2). One clinician had no clients with an opiate dependence at time of interview. Two clinicians' work was focused on co-morbidity.

Table 1 Estimated % of caseload consulting for addiction

Estimates made	N (%)
100%	14 (74)
85%	1 (5)
50%	2 (11)
25%	1 (5)
20%	1 (5)
Total	**19**

Table 2 Estimated % of addiction caseload consulting for opiate dependence

Estimates made	N (%)
90 – 100%	10 (58)
80 – 89%	1 (6)
70 – 79%	1 (6)
60 – 69%	2 (11)
20 – 29%	1 (6)
10 – 19%	1 (6)
"miniscule"	1 (6)
Total	**17**

Opiate Drugs prescribed

Methadone

All clinicians reported that methadone prescribing was available in their NHS Board areas. Sixteen (80%) were involved in prescribing methadone for opiate dependence. The four (20%) participants who did not prescribe methadone themselves, treated clients who were prescribed methadone from another source (e.g. General Practice or other clinicians on their team). Contact with DAT representatives confirmed that methadone is also prescribed in Orkney and Shetland. Of 16 clinicians who estimated, 8 of them (50%) had either all or nearly all of the patients they saw with an opiate dependence on methadone. The remaining 8 clinicians estimated between 60 and 90%. The proportion of clients that clinicians estimated

as being on a scheme of maintenance varied widely, suggesting different views on clinical practice (Table 3).

Table 3 Estimated % of opiate dependents on a scheme of maintenance

Estimates made	N (%)
90-100%	3 (20)
80-89%	2 (13)
70-79%	3 (20)
60-69%	1 (7)
50-59%	4 (26)
20-29%	1 (7)
'small'	1 (7)
Total	**15**

Dihydrocodeine

Clinicians were asked about prescribing of dihydrocodeine. Twelve of 20 (60%) stated that there was dihydrocodeine prescribing taking place within their specialist addiction service. Three of these clinicians (15%), representing two NHS Board areas, worked in areas where there is some dihydrocodeine prescribing as substitution. It was estimated between 20% and 29% of patients with an opiate dependence were being prescribed dihydrocodeine in this group. The remaining 9 (45%) who were involved in some dihydrocodeine prescribing were doing so either as a precursor to a lofexidine detoxification, or because they had taken on the treatment of a patient already established on a dihydrocodeine prescription. In this group, dihydrocodeine was being prescribed for less than 10% of their opiate dependent patients.

Buprenorphine

Two clinicians (10%) representing two NHS Board areas were involved in small amounts of buprenorphine prescribing. Two (10%) had carried out small pilots of buprenorphine. Six (30%) of the clinician participants who were not prescribing buprenorphine, when asked about it, indicated an interest as the following quotes illustrate:

R15: buprenorphine I would like to. I'm not prescribing it at all at the moment but I would like to.

R17: we're thinking about buprenorphine because it seems to be better, you know methadone and then switching them to buprenorphine for the last steps and then off and then naltrexone.

Buprenorphine prescribing has been discussed within the Scottish Substance Misuse Division of the Royal College of Psychiatrists. A Scottish trial comparing buprenorphine with methadone has been proposed with some funding support agreed by Scoering Plough. The demonstrated continued interest in buprenorphine would support efforts to fulfil this possibility and thereby establish an evidence base for its effectiveness.

Methadone Dose

Clinicians were asked what the highest dose of methadone was that they would ever prescribe and what made a 'high' dose applicable. There is quite a variation in what is considered to be the top dose. Eight (42%) clinicians stated that they did not have a top dose. Of 11 clinicians who did state a top level, this varied from 70 to 150 mg.

There were various circumstances in which clinicians reported prescribing high doses (table 4). The most common was that this level of prescribing was required for the client to be stabilised. Circumstance in which clients continued to inject was the second most common reason for being prescribed a 'high' dose.

Table 4 Circumstances clinicians reported as making a 'high' level appropriate

Reasons given	N
Level is as required to reach stability	8
Where a client is continuing to inject	5
Where the client is a long term user	2
Where the client has a co-morbidity	1
Where the client is a rapid metaboliser of methadone	1
Where the client has come to the service already established on a 'high' dose	1
Total	**16**

The quotes below illustrate why the responses in Table 4 were given.

R13: depends on what they stabilise on, start with 40 then bump up as necessary

R4: someone who's persistently continuing to inject despite you know a largish dose and they are at risk of coming to severe harm despite you know prescribing at a reasonable level.

R17: the one I can think of at the moment is a long-term drug user who was using an awful lot of heroin and was very difficult to stabilise and is now very stable at that dose, 115 I think, 110 maybe but certainly over 100.

R10: It tends to reduce the mental health issues, and the behaviour when you're prescribing you know highish quantities of methadone.

R20: we have done their serum methadone level and have found that despite being on a substantial dose they are still on fairly low serum methadone level.

Two (of 15) clinicians indicated that 'high' methadone doses could be avoided if other interventions are included:

R7: I have had people coming from other areas who have been reportedly incapable of stabilising on dosages of say 120, 130 mg of methadone and none of them have required more than 80 mg to stabilise here and that has got a lot to do with psychological therapies and help that they can get, the structure that the methadone is prescribed within.

Methadone supervision

Clinicians were asked about how people received their methadone. Half of clinicians (9;50%) reported that all (or nearly all) of their clients were receiving methadone supervised daily. A further 3 clinicians estimated that 90% of their clients received daily supervision. The remaining clinicians reported a lower proportion of clients (range 10-75%). In the early stages of treatment daily supervised was the norm (eg the first 3 months, the first six months).

Beyond that there was variation. Nine (50%) continued with daily supervised beyond the initial period for all or nearly all those prescribed methadone.

Fourteen of 19 (74%) stated that methadone dispensing was done from community based pharmacies in their areas. Four (21%) stated that dispensing took place in the treatment setting as well as in community based pharmacies. One (5%) stated that methadone was only dispensed within the treatment setting.

Clinicians were asked for their views on daily supervised prescribing. Eleven (61%) clinicians expressed concerns which related to issues of privacy, respect and stigmatisation encountered through consumption on premises. However, sometimes these concerns were off set by issues of safety. Concerns about safety were expressed by 7 of 18 (39%) clinicians.

R3: the community pharmacy - very few have any kind of private areas so they're taking their supervised methadone in full view of the general public so there is issues of confidentiality, dignity, all sorts of things that have had to be kind of set aside because of the concerns about the leakage of methadone in the black market and fatalities arising from that.

R5: it's about safety…the public safety…I don't think that it is either politically or morally acceptable for there to be significant amounts of methadone leakage from the system.

Two expressed concern about dispensing double doses on a Saturday and during public holidays:

R11: In an ideal world we would have the majority of patients on entirely supervised daily dispensing. We would like to abolish the Saturday double dosing if possible.

Three of 18 (17%) highlighted the advantage of supervised daily consumption, principally because it provided boundaries for their patients. One clinician saw daily dispensed methadone as being motivating to patients.

R10: it is better to start with certain boundaries, especially in the first three months.

R19: that trip down to the chemist can be motivating, get people up out of bed, get them organised.

One clinician expressed a reluctance to move towards 100% daily supervised dispensing:

R6: Its about normalisation. You try to get people away from drugs, you are trying to stop them being stigmatised and you are trying to get them back into work so that drugs are less important in their lives and that they get on with the rest of their life. Having to attend the chemist daily, drink the methadone in front of their neighbours, they become stigmatised. They become stigmatised in that they have to go to the chemist every day and it is very difficult to make that compatible with putting drugs behind you and getting a job and moving away from the drug scene.

Another clinician would have liked more flexibility in the system and pointed out another concern of supervised daily dispensing:

R15: a lot of people get nobbled by dealers when they get to the pharmacies…having to go every day makes life very difficult for them.

Short term/Long-term methadone

Clinicians were asked what circumstances would cause a shift from short-term to long term methadone prescribing (according to their own definitions of 'short' and 'long'). Many responded by indicating that long term prescribing from the outset was the usual or desired scenario as the following quotes illustrate:

R4: I'm not really saying very often to people these days 'this is a short-term intervention'. Although if that's what they want and that's all they'll accept we sometimes go along with that to start with.

R10: I think that's an illusion really [short-term methadone treatment] …methadone in the initial stages is used more as a stabilising mechanism, in order to enhance people's quality of life and reduce risk.

R14: I'm thinking of long-term methadone maintenance from the outset…the evidence best shows and then programmes that try to use it as a detox agent do badly and have higher death rates.

R20: my experience of short-term methadone is [that it is] a complete waste of time and the relapse is incredibly high.

For some clinicians, methadone prescribing was not defined as long or short at the outset:

R6: starting a prescription of methadone, there is no sort of plan about whether it be short-term, medium-term or long-term.

R7: Even if you have someone who looks like they are going to stabilise out quite quickly, you never know what's going to happen.

Sixteen participants identified reasons why they would initiate long term prescribing from the outset. These are shown in table 5. The most common reasons include the assertion that methadone is (by definition) a long term treatment and that long term prescribing is often necessary for those with other health problems and a long history of heroin use.

Table 5 Reasons why long term prescribing would be initiated from outset

Reasons given	**N=16**
Methadone *is* a long term treatment	5
Other health complications (eg co-morbidity, HIV+, Hep C +)	3
Long history of heroin use	3
Complicated social circumstances	2
To achieve stability	2
Pregnancy	1
Client choice	1
Chaotic injecting	1
Client previously been on a maintenance script	1
Client moved to the area already on a long term script	1

Where patients have been on a short-term methadone treatment and moved to long-term treatment, reasons why this shift would occur are shown in table 6. The most common reason for a shift from short to long term prescribing is client relapse.

Table 6 Clinicians' reasons why they shift from short to long term prescribing

Reasons given	N=13
Client relapses	7
Client having psycho/social difficulties	2
Client doing well (don't want to rock the boat)	2
Client becomes pregnant	1
Stressful life event (eg bereavement)	1
Where the service has exhausted all avenues to help the client reduce	1

Abstinence

Clinicians were asked what proportion of their patients with an opiate dependence they thought could achieve abstinence, and over what period of time. Three participants (19%) commented on factors that militate against abstinence:

R9: I have a notion that we have a culture which doesn't expect people to achieve abstinence, and that that to some degree becomes self-fulfilling.

R13: I think more people can achieve abstinence. I feel that a lot of people have been prescribed methadone and take what they want to take out of the literature or press…it's a psychological barrier more than just the drug.

R15: my attitude is that technically there isn't any reason at all why the people shouldn't detox. I don't feel that people should have to be on methadone forever, as some doctors do.

Nine of 16 participants (56%) identified a sub-group ranging from 5% to 33% who could achieve abstinence over a relatively short period (the time period given ranging from six months to two years). Circumstances were identified which make this favourable.

R2: the younger group have almost a kind of better, quicker prognosis of getting onto abstinence and naltrexone.

R5: people who aren't injecting, who are maybe from better organised social backgrounds, more employability and less criminality.

R12: we've got the younger, less experienced users in some places who when they are ready to change…quite a lot of them manage it fairly easily.

Five participants (31%) indicated that the majority of people could achieve abstinence but that it would take a long time.

R3: If you think of the natural history of the condition being about ten years, I would expect most of the clients to achieve abstinence within that timeframe.

R6: eventually, over 10, 15 years, most will achieve abstinence, but there is probably a core of about 20% that are probably going to be maintenance for the rest of their lives.

R9: we are beginning to see a movement into people who have been on scripts for maybe 8, 10 years, and I think we are seeing a much higher level of abstinence in that group. I think we are maybe looking at 70 to 80% who, once they've made up their mind that methadone is an absurdly restrictive way of life, finally become very fed up of it and I think that's probably the most powerful dynamic of all.

Some participants noted the need for social issues to be addressed before abstinence could be considered.

R17: there's so many things that have to be in place before you can really get to grips with abstinence…so many social issues…Most of the people I see are from deprivation categories 6 and 7 and you know the infrastructure just isn't in place to see them moving on, although hopefully that's all going to change.

Non-opiate drugs prescribed

Clinicians were asked about their prescribing of specific non-opiate drugs. Their responses are summarised in table 7. All clinicians reported that they prescribed lofexidine. Twelve of 17 (71%) estimated that they prescribed lofexidine for less than 5% of their opiate dependent patients. The remaining 5 clinicians all estimated 20% or under. Only one clinician prescribed clonidine and estimated this was to only 1% of opiate dependents. All but one clinician were involved in prescribing naltrexone.

Table 7 Non-opiate drugs prescribed by clinicians

Drug	N prescribing (%)
Lofexidine	20 (100)
Clonidine	1 (5)
Naltrexone	19 (95)
Benzodiazepines	18 (95)
Mood stabilisers	11 (58)
Major tranquillisers	12 (63)
Anti-depressants	15 (79)
Anti-spasmodics	7 (37)
Anti-emetics	10 (53)
Anti-histamines	5 (28)
Non-benzodiazepine sedatives	13 (68)

Twelve of 17 (71%) estimated that they prescribed naltrexone for less than 5% of their opiate dependent patients. The remaining 5 clinicians all estimated between 5% and 15%. The small proportions of lofexidine and naltrexone probably reflect the small numbers of patients attached to the specialist service who would be detoxifying:

R10: [about lofexidine] the people who I see have severe, chaotic drug problems…we really do encourage GPs to prescribe it.

R18: [about naltrexone] I see so few patients that are suitable.

Eighteen (95%) clinicians were prescribing benzodiazepines for opioid dependents. Of 14 who estimated a proportion, the range varied from <5% to >80%. Eleven (58%) clinicians prescribed mood stabilisers to opiate dependents. All of 10 clinicians who estimated a proportion of opiate dependents they were prescribing mood stabilisers for, estimated 10% or less.

Twelve (63%) clinicians were involved in prescribing major tranquillisers. Of 10 who estimated a proportion, the range varied from <5% to >50%. Fifteen (79%) of clinicians prescribed anti-depressants to opiate dependents. Estimates ranged from prescribing <5% to >30%. Two clinicians did not prescribe anti-depressants because it was NHS Board policy for anti-depressants to be prescribed in General Practice. Anti-spasmodics were being prescribed by 7 (37%) clinicians. Six estimated a proportion. The range varied from <5% to 10%. Of the 10 (53%) clinicians prescribing anti-emetics, 9 estimated a proportion. This ranged from 'none at present' to 10%. Only 5 (28%) clinicians prescribed anti-histamines. Of 4 who estimated, the proportion was 10% or less. Non-benzodiazepine sedatives were prescribed by 13 (68%) clinicians. The proportions estimated by 12 of these clinicians varied from 'none at present' to >70%. Table 8 shows other drugs mentioned by clinician participants as being used in the treatment of opiate dependence.

Table 8 Other drugs prescribed to opiate dependents

Others mentioned	**N = 6**
Co-phenathrope	1
Methadone tablets	1
Propranalol	1
Multi-vitamins and thiamine	1
Anti-biotics	1
Ascorbic acid	1

Protocols

Clinicians were asked whether there was a protocol that supported the way they prescribed. Thirteen of 18 (72%) seemed clear that there were protocols which they followed:

R7: We are on a [NHS Board] wide prescribing policy, which is adopted by the area medical committee, so both general practitioners and the specialist services all prescribe within the same prescribing policy.

R8: Its based on the orange book and so on. It's been discussed through the NHS Board, through the local health care co-operative and the GP sub and by any ad hoc committee that has been formed to look at particular specs.

R10: We are not just replicating the orange handbook from the Department of Health, we've actually provided protocols and assessment tools and procedures that are based on good quality standards…it's a compilation of good work.

Two participants (11%) were unaware of any protocol. One participant (6%) was in the process of developing a protocol. One (6%) believed there was one but did not think they necessarily followed it, and one (6%) did not see a need for protocols:

P17: I don't think it is right to have a medical protocol but we must stick within the orange guidelines…we absolutely insist on that and if our doctors stick to that then I'm quite happy.

Counselling

Clinicians were asked what counselling provision there was, either within their addiction service or to which to refer people to. Counselling was not specifically defined in the question but left

to the participant to define and describe. Within their addiction services, 13 of 20 participants (65%) indicated there was a keywork system through which people received counselling. In the majority of circumstances, this was being carried out by nurses. Less frequently it was carried out by social workers or a drugs worker. Fourteen participants (70%) also indicated that they referred patients to external counselling services, either local authority (5), voluntary sector (8) or NHS Community Mental Health Teams (2).

In terms of types of counselling, most services offered a mixture of interventions, as the following quotes illustrate:

F7: it's a bit of a sort of hotch potch of different things.

F18: a kind of an ecclectic mix of various things.

Eleven participants (55%) mentioned relapse prevention. Nine (45%) participants mentioned cognitive behavioural techniques. Six (30%) mentioned motivational interviewing / enhancement and two (10%) mentioned anxiety management. Ten participants (50%) indicated that counselling was offered systematically. If patients did not want counselling it was not pushed.

R2: There would be 'Is this an issue that you would like some support with?' and if the answer is 'no thank you' we wouldn't push it.

R13: Always offered. It's not always taken up

In two settings (10%) counselling was seen as mandatory.

R7: We don't prescribe without the person attending our other work, so the two go together. You are more likely to get counselling and not prescription than a prescription and no counselling.

R9: if they turn up for the script and they don't come up for counselling…you find yourself being detoxed very rapidly.

Where counselling was not mandatory its importance was still noted:

R5: [about its relationship to prescribing] It's integral

R8: I think that the prescribing is embedded in the counselling.

R10: I tend to believe that counselling is more important than prescribing in fact.

Some participants felt their service to be unable to meet all the counselling needs:

R9: Sexual abuse counselling is a very common need…we sometimes don't have the number of counsellors that we need to fulfil the need.

R17: …I'm not a bereavement counsellor or alcohol counselling…we do refer them on for specialist types of counselling.

Respondents were asked what they hoped to be gained from counselling. The responses are shown in table 9. Overall, clinicians hoped that clients were able to define goals, gain an insight into their problems and develop problem solving as part of the counselling process.

Table 9 What is hoped the client will gain from counselling

Gains mentioned	N=15*
Define goals	7
Gain insight into problem	6
Develop a problem solving approach	6
Address specific personal problems (eg relationship, past abuse)	2
Support	2
Ability to manage anxiety, improve sleep	1
Enhancement of self-esteem	1

* Three participants indicated that the goals of counselling were too individualised to be able to define

Alternative Therapies

Clinician participants were asked whether any alternative therapies were offered. Within their own services 15 of 19 (79%) indicated that none were being offered at present. One service provided relaxation training. Two services offered Reiki. Another service had a member of staff trained in reflexology and Reiki but it was not thought to be available in a universal sense. In one service, Tai Chai was available as a diversional activity. Six participants (32%) were aware of alternative therapies being offered through voluntary sector agencies in their area (acupuncture, aromatherapy). Six participants (32%) showed an interest in providing alternative therapies. One participant had plans to establish a homeopathic clinic.

P3: we have a nurse who has acupuncture training…if we had additional resources we would be offering that but at the moment it's a theoretical possibility that we're not able to fulfil.

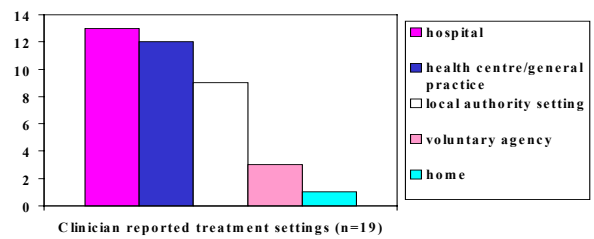
P10: one of the members of the Harm Reduction Team is going along to a diploma course in complimentary therapies…it's opportunistic. It isn't part of the service now, but it is encouraged.

P15: …not at the moment but there are going to be. We are seeking to provide that as an option.

Treatment Settings

The settings where clinicians consulted with patients are shown in Diagram 1. The most commonly reported places were traditional health care settings but a sizeable minority (42%) were offering clinics in local authority settings and some (16%) in voluntary agency settings.

Diagram 1 Clinician reported treatment settings



Six of 20 (30%) clinicians had access to dedicated NHS in-patient beds for patients with a straight forward opiate dependence, a further seven participants (35%) managed to access beds opportunistically, though this was not always easy. It was also noted that psychiatric in-patient beds were not the best location for detoxifying patients.

R7: it can be extremely difficult to get our hands on a bed.

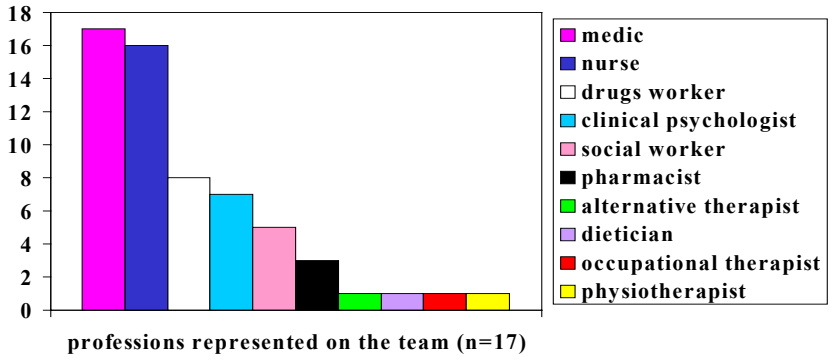
R19: occasionally we can manage to do that for a pure drug problem rather than a co-morbidity problem but there's great difficulty accessing them

R12: some addict clients don't like being mixed in with "loonies", you know that's something, quite a barrier to people.

Professional make up of the addiction service

Clinician participants were asked to describe the professional make up of their service. Diagram 2 shows the professionals which participants stated as being part of their team. The denominator is the number of services (17), rather than the number of participants, as three teams had representation from two participants.

Diagram 2 Clinician reported professions represented on team



One team had six different types of professionals represented. Three teams had 5. Five teams had 4. Three teams had 3 and five teams had 2. Of 15 clinicians who commented on the cohesiveness of their teams, all of them gave positive statements indicating that their teams were close working groups. They were asked what the benefits and limitations were of working within their teams (tables 10 and 11). The most common benefits were the mutual support provided by their team and that colleagues were enthusiastic, like-minded and trustworthy. Five participants stated that there were no limitations to team working. The most commonly cited limitation was that there team was under resourced.

Table 10 Clinicians' perceived benefits of working in the addiction team

Benefits of working in this team	N=15
Mutual support	6
Good colleagues eg enthusiastic, like-minded, trustworthy	5
Happy environment leads to greater clinical effectiveness	2
Offers client a more holistic approach	2
Working together achieves optimal effectiveness	2
Learn form each other	1
Easy within team cross referral	1
Perceived well by the community	1
Perceived by clients as cohesive unit	1
Good communication	1
Opportunity for staff to develop	1

Table 11 Clinicians' perceived limitations of working in the addiction team

Limitations of working in this team	N=15
There are no limitations	5
Under resourced	4
Inter professional dynamics – potential for conflict	3
Team grown too big/spread out	2
Lack of training	1
Staff turn over	1
Following team protocol may restrict individual freedom	1

Links with other health care settings

Maternity services

Clinicians were asked about the links the addiction service had with maternity services. Ten NHS Board areas (67%) have formalised arrangements in place for providing a service to opiate dependent pregnant women. These arrangements take the form of working from shared protocols (Ayrshire and Arran, Forth Valley and Lothian), providing joint clinics (Dumfries and Galloway and Grampian), providing specialised obstetrics services (Greater Glasgow), specialised midwifery services (Argyll and Clyde, Fife and Tayside) and providing drug liaison workers (Lanarkshire). There was general expression from clinician participants that where such arrangements were established, links were good. Further, in areas where formalised arrangements were not in place, informal arrangements were thought to suffice.

R20: Very good, very good links with obstetrics, an exception that proves the rule.

R12: …the numbers are incredibly small, so it does tend to be *ad hoc*.

Mental Health services

Clinicians were asked about the links the addiction service had with mental health services. Ten of eighteen clinicians (56%) described the links between the addiction service and other

mental health services in a positive light. Links were generally viewed to be close in NHS Board areas perceived to be 'small':

R11: It's a small catchment area and the RMOs for addiction are also general psychiatrists so there is quite an integrated system.

R12: Locally [the addiction service] grew up as really another one of the community mental health teams…its very much based within the mental health services so working links and communication links are basic and strong.

Where NHS Board areas had dedicated co-morbidity teams (2 areas) general links between addiction services and mental health services were seen to have improved:

R9: The relationship is growing and becoming increasingly productive and increasingly about shared care between the two arms.

Seven of 18 clinicians (39%) expressed either mixed or negative views on the links between their service and other mental health services. Attitudes of staff within mental health services was noted recurrently as a problem:

R6: Some psychiatrists are more open to substance misuse as an issue amongst their patients; others see it as an exclusion criteria.

R8: …some teams are more comfortable than others in terms of working with these folks.

R10: It's sort of close enough from the strategic perspective…the problem of course is the individual cases, where you have individual people who are either too judgemental or ignorant to even consider certain things.

One clinician highlighted the difficulties in linking with mental health services for the treatment of patients with major depression:

R20 We have terrible trouble getting any of these chaps seen. When they have been seen they get a letter back that leads you to believe they haven't really been. Its almost as if the agenda has been set before they come in, that this is predominantly a drug problem.

One clinician saw the difficulties experienced in these links as being due to a lack of formality in the arrangements:

R7: There are interface issues…Its in people's gift to offer us services, as opposed to it being built into the fabric of the service that they will offer these services.

One clinician, to enhance relations, described the following strategy:

R3: We do try to cultivate almost kind of personal relationships with these people [consultant colleagues in general psychiatric services] so that you know them and you can kind of speak man to man with them.

Clinicians were asked to estimate the proportion of patients they saw who had a dual diagnosis. These figures have not been reported here because the term 'dual diagnosis' was not clearly defined in the question so it is difficult to know what level of concurrent mental health problem clinicians were referring to in their responses. Of eighteen clinicians however all of them did indicate that a proportion of patients they were seeing had a dual diagnosis. It was viewed to be on the increase:

R5: There's no doubt that there is an increasing number of people have a co-morbid problem and we have significant numbers of people now who have enduring mental illness and serious intractable drug dependence.

Clinicians were asked what was in place to ensure that patients with dual diagnosis were being treated adequately. Five of eighteen (28%) indicated that these patients would be seen by the consultant of the addiction service, though where possible patients with a dual diagnosis would be linked into Community Mental Health Teams. This was not always easy:

R6: If their drug use isn't too bad, then we can get them involved in their local psychiatric team, but if their drug use is still active, then they won't be seen usually in that context…I think adult psychiatry finds the management of some of those patients more difficult than they need to, because it tends not to involve itself in substance misuse management. If it did it might find that it could do better with treatment responses on some of the severe and enduring mental illness conditions. The access to psychiatric treatment for some of the patients that we see is limited by the resources that we have available, which are much less than the psychiatric sector teams have so some patients get a poor service with regards to their severe and enduring mental illness, than they would do had they not had a drug problem.

Five of eighteen clinicians (28%) indicated a joint working arrangement between addiction services and adult psychiatric services:

R4: we actually allocate the care plan jointly between the Community Mental Health Team and the Drugs Team.

R5: we would co-work people with enduring mental illness and various drug problems, otherwise they would be managed in one or other of the services depending on which was the predominant problem.

One team had a co-morbidity CPN with a caseload consisting entirely of people with enduring mental illness and drug dependence that managed their caseload in conjunction with adult psychiatry. Six of eighteen clinicians (33%) representing two NHS Boards stated that they would liaise with a specialised co-morbidity team for patients with a severe and enduring mental illness. One of eighteen clinicians (6%) provided an integral service where addiction was part of the psychiatric caseload. One of eighteen clinicians (6%) indicated that patients would be seen by both services:

R2: they see both services, in fact they probably see two consultant psychiatrists.

Accident and Emergency

Clinicians were asked about the links the addiction service had with Accident and Emergency Departments. Overall there seemed to be very little systematic integration of services. Eight of 18 clinicians (44%) stated that there were no formal links. Three of 18 (17%) did have some kind of direct liaison in place. These links seemed to work best in areas which had a small catchment:

> R11: They're actually seen by one of the [addiction service] nurses who goes up and makes sure things are going well…its helped by the fact that its quite a small area.
>
> R16: there's a sort of little A&E arrangement down in X, now the GPs run it and they would call me if they had a drug problem so the links are close and well worked.

One service was in the process of appointing liaison staff at the point of interview. Five of 18 (28%) indicated that they liaised indirectly with Accident and Emergency through a Liaison Psychiatry Service. One clinician (6%) stated that the addiction team offered a telephone advice service. One clinician (6%) described a very mixed set up of links between the addiction service and two accident and emergency service:

> R9: In X we have a really good relationship with A&E, to the point where they use their short stay ward as almost an addiction short stay ward…they recognise their responsibility in terms of joint working with addictions…In Y its completely different, in as much as they can't see them out the door fast enough.

The latter set up described above was also reflected in another clinician's experience:

> R20: one of the staff asked why they [patients with opiate dependence] were waiting so long at the local infirmary and they said "Well what we do with these people is we put them in the cubicle and leave them hoping that they will leave".

Five of 18 clinicians (28%) indicated that they were involved with training or production of protocols on the treatment of opiate dependence for informing hospital doctors, including those in Accident and Emergency. Some clinicians' comments indicated that there was room for improvement, even in areas which had established links:

> R11: in our clinical strategy, for development of services, we would want a post for drug and alcohol liaison and it would be money well spent.

Primary Care

Clinicians were asked about the links they had with primary care. Thirteen of 19 clinicians (68%) were involved in a shared care set up organised along the following lines:

> R7: the GP refers into the specialist service for initiation, assessment, investigation and isolation of treatment and then the GP takes over that person's care once they are in an agreed state of stability.

Generally under such circumstances, some prescribing was being done by the specialist service and some by General Practitioners (GPs). Across NHS Board areas, the involvement of GPs in shared care seemed enormously varied. Some specialist services are supported by GP specialists which while valuable to the service, were also seen to create a barrier to other GPs participating:

> R2: the model has this kind of specialist GP, I think that's done more to dissuade the rest of the GPs from having any involvement because they think they've got a local expert they can send everyone to, so there's little involvement from the generalist GPs.

The need to have involvement and close links with GPs was viewed to be crucial to many clinicians:

> R6: We couldn't manage the whole problem by ourselves.
>
> R7: the fact that we have close relationships with general practitioners means we do not get a lot of maverick prescribing
>
> R10: when you have GPs who no matter what you do, do not want to know or are stuck in their own methods or judgements…that's very frustrating…clients have to go and re-register again and wait.

Two of nineteen clinicians (11%) provide a service where all the prescribing was carried out in General Practice. Both clinicians noted how this could be restrictive:

> R14: the way the system works in X, unless your GP is willing to prescribe you won't access methadone…there is a large group of GPs in one area I deal with who are opposed to methadone and so therefore send me people who should be on methadone. I end up being pressured to try a detox where its unlikely to succeed.
>
> R12: we would like to move towards being a limited prescribing service, ideally we'd like to take on the sort of top slice of more difficult clients, and be much more closely involved in that, we're not able to do that on the present resources… if we worked with the most difficult cohort, I think we'd get more GPs involved in shared care schemes

Two of 19 clinicians (11%) provided a service aimed at patients with a co-morbidity both of whom thought their relations with primary care were generally good:

> R15: because of the nature of our clients we're normally communicating quite closely with GPs about them and again I think our links with GPs are pretty good.

One of 19 clinicians was involved in providing a service to opiate dependents where prescribing was carried out purely by the specialist service, supported by specialist GPs. Prescribing clinics were distributed across five localities within voluntary sector and local authority drug agencies. No generalist GPs were involved in prescribing and would see opiate dependents only for general medical purposes. This system was seen to have advantages:

R9: in out lying areas…if a particular practice decided not to prescribe methadone, then clients would end up having to access another GP practice 40 or 50 miles away. This way, although they have to take a bus journey to the substitute prescribing clinic, they can be guaranteed of the service…the clinics are geographically tactically spaced out so that things are reasonably equitable.

One of 19 clinicians was the sole prescriber to opiate dependents, when the situation arose. This was in a NHS Board area with a low prevalence where there was not seen to be a need for a shared care service.

Of seventeen clinicians who commented, twelve (71%) indicated that links with primary care were, on the whole good. Five clinicians (29%) indicated that links with primary care were very variable. Clinicians were asked to comment on whether they felt their own effectiveness was enhanced by the links they had with other health care settings. Thirteen of 18 (72%) of the clinicians comments indicated that the links did enhance their effectiveness as is illustrated by the following comments:

R7: I would say that most of the times that we have linked up with other organisations, I think, this is what I believe anyway, you get synergy, I think you get much more than the sum of the two parts, if you actually work out a way of working together and that has been my experience. Not just with health systems but with social services and the voluntary sector.

R9: the more all embracing a package you can offer someone, especially this particular group who is a very health-needy group, the better I feel about what we've offered, and therefore the more effective I feel.

R11: being able to manage the numbers better and being able to functionalise the clinics to meet the needs of the more severe and enduring mentally ill.

R16: it does help in targeting the package of care and for continuity of care in the community, so I think those links are essential.

R17: I think we are strengthened by our links.

R19: without working at those links I'd be a lot less effective. I kind of really think that smoothes the way.

Two of eighteen clinicians (11%) had mixed views on whether their effectiveness was enhanced. A further three (17%) did not see that presently their effectiveness was enhanced.

Clinicians were also asked in what ways their effectiveness was limited by the links they had with other health care settings. Of nineteen, 12 (63%) did not perceive their effectiveness to be limited by these links. Of those who did perceive limitations in effectiveness, the reasons are outlined in table 10

Table 12 Reasons why effectiveness was perceived to be limited by links with NHS Settings

Reason	N=7
When service overburdened with cases who could be managed out with the specialist service	3
Links need to be closer	3
Attitude of some other NHS staff	1

These points are illustrated by the following quotes:

R2: I think the perception of other health care professionals is that if there is a drug problem it should come to us and for a time we absorbed that and were happy to deal with that but the problem has now become so large that we've got to kind of unpick that and try and devolve a lot of responsibility back to those very people who are now not used to dealing with the problems.

R13: I would like to have more input into the detox facilities at the psychiatric hospital.

R21: There is to some extent a tendency for drug users to be stigmatised or to evoke judgemental attitudes particularly from healthcare professionals who may cling to the traditional medical model of delivering care and support.

Links with non-NHS care settings

Social Work

Clinicians were asked to comment on the links they had with social work services. Of the twenty participating clinicians, 17 (85%) worked in areas where there was some dedicated social work provision for drug clients either within the addictions service itself or provided within the local authority. Of that 17, eight (47%) commented on the links with social work as being close. Whereas, three of 17 (18%) had mixed views about the closeness of their working with social work services

R5: what the local authority provides in terms of drug treatment is totally integrated…common referral and assessment.

R9: the social service addiction service…is completely integrated, to the point of being on the verge of pooling budgets and pooling management.

R15: in the last year we've had a dedicated social worker, she's done a lot of liaison work for us. Relationships are good with local social work teams when the need arises its usually over child care issues.

R11: it [the addiction service] does link with the specialist [social work] addiction service…its still at quite a formative stage…we're doing a detox clinic for people that are fairly new to their heroin addiction and there is a reasonable chance that they might detox successfully and go on naltrexone and the key working for those patients is shared with social work staff…we also have other jointly key worked patients over longer-term use and specialist clinics…that's a bit variable in terms of there is no agreed standards or if there is an agreed standard it is not met for sharing of information…and shared goals.

Two of 17 (12%) commented on the closeness of the links as being on the verge of a great change. Their service was in the process of setting up community addiction teams that would be half health and half social work. In contrast, three of 17 (18%) viewed the links with social work as not being close:

R2: in years gone by we actually had a sort of full-time member of our team who was a social worker but that was kind of withdrawn so we're left with this… presence one morning a week.

R3: there is historical antipathy almost, between health and social work that is difficult to overcome…it works really well in some areas and other areas you would never see a social worker and it is really hard to find one who is going to give the drug-user the time of day.

R14: not very well…I don't think my own service is well integrated. I encourage people to go to social services agencies or refer in writing sometimes.

Of the 3 clinicians (15%) who worked in areas that did not have any dedicated social work provision, 2 viewed the links they had with social work as being inadequate:

R7: we don't have a dedicated social worker who has an interest in addiction or deals with drug users at all. We are just part of the general community care fight for money…we are not in a place where there are consistent good relationships with the social work department on the management of drug users, absolutely not.

One of three clinicians working without dedicated social work provision felt the links they had with social work services were adequate.

Criminal Justice

Clinicians were asked to comment on the closeness of the links they had with criminal justice departments. Of 17 who commented, four (24%) described the links as good, 9 (52%) as adequate or mixed and 4 (24%) described the links as not being close. Two of the clinicians who described the links as close were working in areas which had been piloting the Drug Treatment and Testing Order:

R10: I think we're one of the successful cases now because we have integrated very well with the Criminal Justice Department with the Drug Treatment and Testing Order.

Where the links were seen to be adequate, some expressed that there was not a need to have closer links:

R4: there is not any need for us to be running in each other's pockets. They tend to get in touch when required and we are the same.

Of the 4 who described the links as not being close, one identified a difficulty with criminal justice:

R2: it seems like a perverse incentive that for people to get to residential rehab often if they commit a crime and get into the Criminal Justice System, they have a better chance of getting to rehab than if they access that through the treatment service and there doesn't seem at the moment to be any communication between the two services, they work to a different set of targets and a different agenda to the treatment service.

Voluntary Sector

Clinicians were asked to comment on the links they had with voluntary sector services. Five of 17 (29%) commented on there being a lack of voluntary sector services in there area:

> R5: there isn't a big presence of non-stat
>
> R20: voluntary sector is a bit under-represented.

Seven of 17 (41%) described the links they had with the voluntary sector as being close. They described how they linked in positive terms:

> R7: we will jointly manage people, we take referral in both directions without any problems, we set up a referral protocol which we try and move people quickly from one service to another if need be.
> R12: we meet them, usually we don't feel any conflict of approach or any boundary problems…we work easily and well with them.

Nine of seventeen (53%) described the links they had with the voluntary sector as not being close. This seemed particularly so in areas which had strong links with statutory services:

> R14: no formal links, just kind of piecemeal sometimes…I think the social service type agencies predominate.

Clinicians were asked to comment on how the links they had with non-NHS services impacted upon their effectiveness. Thirteen of 17 (76%) stated that their effectiveness was enhanced by these links and 12 of 17 (71%) identified limitations. Where reasons were given they are listed in tables 13 and 14. The last item on table 14 'if service are too integrated' referred to a situation where services were a 'one stop shop'. This was perceived to have possible limitations as if all services are seen as 'one', an individual who has a dispute with one part of the service, may then feel estranged from the whole service and feel they have nowhere else to turn to.

Table 13 Ways in which links with non-NHS settings enhance effectiveness

Enhance	N=9
Allows services to offer a more holistic package	3
Shares the workload	2
Avoids duplication	1
Clients get a consistent service	1
Involving other services helps client re-integrate	1
Joint working is most effective working	1

Table 14 Ways in which links with non-NHS settings limit effectiveness

Limit	N=12
Potential for conflict, philosophical differences	5
Duplication occurs where links are poor	3
Increases work load – liaising with other organisations/meetings	2
Negotiating can be irritating and frustrating	1
If services are too integrated	1

Likes and Difficulties of working with opiate dependents

Clinicians were asked to comment on what they liked most and found most difficult about working in their area of work. Their responses are summarised in table 15 and table 16. Overall, clinicians found it rewarding to see the health gains that are achievable with this client group and found the work satisfying and challenging. The variety of problems presented also added to the rewards of working with opiate dependents.

Table 15 Clinicians' likes about working with opiate dependents

Like about working with opiate dependents	N=18
Rewarding to see the health gains that can be made in this client group	7
Satisfying	5
Challenging	5
Variety – get to treat a whole range of problems	4
Fascinating/interesting	3
Good team/fellowship of the clinic	2
Rewarding to give time to people who are not used to respect	2
Fits my personal working approach eg problem solving, systematic	2
Being able to deliver an intervention to a vulnerable group	1
Identify with the underdog	1

Conversely, a number of limitations in working with this client group were highlighted. Clinicians commented that they were a demanding group and this could result in a high volume of work in a context of limited resources.

Table 16 Clinicians' difficulties with working with opiate dependents

Most difficult about working with opiate dependents	N=19
Very demanding client group	4
Negative attitude of some other professionals towards patient group	4
Volume of work, pressure	3
Lack of resources	3
Being lied to	2
Powerlessness to influence social circumstances of patients	2
Severity of problems	1
Wasted lives, deaths of young people	1
Getting the balance right between harm minimisation and treatment	1
Negotiating the boundary between mental illness and social deviancy	1
Lack of success towards abstinence	1
Poor quality of the research base	1

Out of area referrals

Numbers and locations of referrals out of area, supplied by relevant NHS Board or Trust representatives are shown in table 17. NHS referrals tended to be for detoxification treatment. Rehabilitation referrals would be covered, in most circumstances, by Local Authority and have not been addressed in this study. Fifteen NHS Board areas had made out of area referrals during the time frame specified. In some cases the figures given also include alcohol.

Not all NHS Board areas could describe formalised processes for making decisions on commissioning out of area referrals. As one responded put it, 'there was no science to it'. Considerations mentioned are shown in table 18. Over half of respondents indicated that a specialist referral was required, and a third stated that there needed to be evidence that internal services had been exhausted.

Table 17 NHS Out of Area Referral for treatment of opiate dependence (Apr 2000 – Mar 2001)

NHS Board area	Places referred to	Total Number
Argyll and Clyde	Castlecraig	1
	Detox 5	1
	Red Tower	1
Ayrshire and Arran	Castlecraig	3
	Phoenix House	1
Borders	Tunstal Unit	1
	Ronachan House	1
Dumfries and Galloway	Castlecraig	3*
Fife	Castlecraig	}45
	The Links	
	Brenda House	
Forth Valley	None	0
Grampian	Detox 5	40
Greater Glasgow	Castlecraig	100*
	Red Tower	**
Highland	Castlecraig	11***
Lanarkshire	Castlecraig	32****
	Detox 5, London	1
Lothian	Castlecraig	4
	Detox 5	7
	Phoenix House	1
Orkney	None	0
Shetland	None	0
Tayside	Phoenix House	2
	Red Tower	1
Western Isles	None	0

* Unclear what referral is for. Figure includes alcohol and drugs
** Figures not available but partially block funded.
*** Unclear what referral is for. Figure includes alcohol and drugs.
**** 25 for drugs, 7 for drugs and alcohol

Table 18 Considerations on approving out of area referrals

Considerations	N = 15
Specialist referral (has to come from clinician with responsibility for addictions)	9
Has to be evidence that internal services have been exhausted	5
Decision making power devolved to clinician responsible for addictions	4
Assurance that system in place to provide rehabilitation/support	3
GP can refer directly	3
Client has social support	2
Decisions made 'blind'	1
Time period restricted to six weeks	1
Inability of local services to provide support	1
Solely an opiate addiction (in the case of Detox5)	1
Cost Effectiveness of the treatment	1
Patient choice taken into account	1
Confidentiality (patients who work in the community that will not accept treatment within the locality eg health workers)	1

CHAPTER 4 Conclusions and Recommendations

Conclusions

1. Methadone prescribing is almost universally available across Scotland. There is some variation in the form that methadone prescribing takes. This may, at least in part, reflect the needs of the local population. Variation in the following was reported:
    - dose of prescription and rationale
    - supervision arrangements
    - the degree to which it is integrated with counselling services.

2. Small amounts of buprenorphine prescribing are evident in two NHS Board areas. There is interest among clinicians in other NHS Board areas in looking at the potential contribution of buprenorphine prescribing in opiate users.

3. More than half of the clinicians were involved in dihydrocodeine prescribing. The rationale for doing this was not consistent among clinicians. Dihyrocodeine is not currently licensed for the management of opiate dependence.

4. Lofexidine and naltrexone prescribing were widely available, but tended to be for relatively small proportions of clients. This may be a reflection on the small number of patients who were detoxifying.

5. Alternative therapies were variably available, and these tended to be provided opportunistically by a staff member in the addiction team who happened to be trained to provide a specific therapy. A third of respondents were aware that alternative therapies were offered through voluntary sector agencies locally.

6. Participants generally worked in multi-disciplinary teams, usually including doctors, nurses and drugs workers. Clinical psychologists, social workers and in some cases pharmacists are commonly represented on multi-disciplinary teams.

7. There are varying degrees of partnership working between and within statutory and non-statutory services. Most areas report improving relationships with maternity services. Greater difficulty is reported in reaching mutually satisfactory working relationships with local mental health services.

8. 'Out of area' referrals were made to a wide range of agencies in 2000/2001. In most cases, the clinician responsible for addiction in each area approved these referrals. There was limited information on why out of area referrals were used.

Recommendations

1. DATs should regularly review existing service provision and partnership working between agencies and professions**.** A co-ordinated and integrated approach to service delivery should be implemented to maximise service effectiveness, service communication, value for money and ease of client journey, whilst minimising service duplication.

2. There is significant variation in clinical practice in both the style and context of methadone prescribing. In addition, a number of different drugs (e.g. dihydrocodeine, buprenorphine, naltrexone and lofexidine) are being used across the country, some with licence, some without. We recommend that attention be given to the development of local service protocols based on the Department of Health Guidelines on Clinical Management and that these protocols are regularly reviewed.

3. Benzodiazepines appear to be widely used in the context of substitute prescribing programmes. As there is little evidence to support this[21] as well as growing concern about

the safety of this[22]. We recommend that local service protocols based on the Department of Health Guidelines on Clinical Management should be developed regarding the use of benzodiazepines in substitute prescribing programmes and that these are regularly reviewed.

4. There seems to be a wide variety of counselling and psychosocial interventions linked into substitute prescribing. There should be greater integration of psychosocial interventions with prescribing practices. We recommend the establishment of standards for substitute prescribing services and that the Quality Standards Board for Scotland could make a helpful contribution in establishing these.

5. It is apparent that alternative therapies are being used on an opportunistic basis. Greater attention needs to be given to identifying what contribution or further contribution these therapies might make to the treatment of opiate dependents in each NHS Board area.

6. In each NHS Board area there needs to be clarity of the processes involved in out of area referrals in terms of how they are used to meet individual need and greater understanding of the relationship between external services and local resources.

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Scottish Executive Effective Interventions Unit Dissemination Policy

1. We will aim to disseminate the right material, to the right audience, in the right format, at the right time.

2. The unit will have an active dissemination style. It will be outward looking and interactive. Documents published or sent out by the unit will be easily accessible and written in plain language.

3. All materials produced by the unit will be free of charge.

4. Material to be disseminated includes:

- Research and its findings
- Reports
- Project descriptions and evaluations
- Models of services
- Evaluation tools and frameworks for practitioners, managers and commissioners.

5. Dissemination methods will be varied, and will be selected to reflect the required message, and the needs of the target audience.

These methods are:

- Web-based – using the ISD website 'Drug misuse in Scotland' which can be found at: http://www.drugmisuse.isdscotland.org/eiu/eiu.htm

- Published documents – which will be written in plain language, and designed to turn policy into practice.

- Drug Action Team channels – recognising the central role of Drug Action Teams in developing effective practice.

- Events – recognising that face-to-face communication can help develop effective practice.

- Indirect dissemination – recognising that the Unit may not always be best placed to communicate directly with some sections of its audience.

6. This initial policy statement will be evaluated at six-monthly intervals to ensure that the Unit is reaching its key audiences and that its output continues to be relevant and to add value to the work of those in the field.

Further copies are available from:
Effective Interventions Unit
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We welcome feedback on this report.

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