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Editorial

Substance misuse and primary care mental health

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The treatment of substance misuse continues to pose challenges in the field of mental health and in primary care settings, despite decades of research and the availability of a range of treatment interventions.

At the recent 2010 Wonca World Conference in Cancun, Mexico, the Wonca Working Party on Mental Health held a workshop on substance misuse. Many participants expressed their frustrations about the lack of resources and expertise available in their various countries to deal with substance misuse problems, particularly in the primary care setting. There were also good examples given of successfully integrated services which illustrate that both patients and the community benefit from treatment provided in primary care settings, including the Matrix Model of Substance Misuse proposed by Rawson *et al*.[1]

The Matrix Model was initially designed in the 1980s to provide outpatient treatment for stimulant abusers, and has been of benefit to many people addicted to a range of substances, including metamphetamine and cocaine. The goal of the Matrix Model is to provide a framework by means of which substance misusers can stop drug use, remain in treatment, learn about issues critical to addiction and relapse, receive direction and support from trained therapists, receive education for family members affected by addiction, become familiar with self-help programmes and make themselves available for regular urine drug monitoring. It is suggested that a well run primary care system with an appropriate skill mix is capable of delivering many of the elements of the Matrix Model. The Matrix Model has been extensively developed by the US National Institute of Drug Abuse (NIDA). In 2007, it was estimated that approximately 10 million people in the USA aged 12 years and above had abused metamphetamine within their lifetime and that approximately 500 000 people in the USA aged 12 and above were current users. These statistics suggest that, in order to improve the population's access to appropriate substance misuse interventions, primary care also has a role to play.

Planning and commissioning services for substance misuse are very important. The UK National Treatment Agency for Substance Misuse has provided evidence that with good planning, an integrated substance misuse service can be successfully delivered using a tier system approach.[2] This suggests that first tier services include non-substance abuse specific services such as primary care and general hospitals, homelessness services and general psychiatric services, which play an identification and assessment role including general health promotion and primary and secondary prevention of substance misuse related complications. The second tier is more specific to substance misuse and includes open access drug misuse services such as needle exchange programmes run by local pharmacies, low threshold prescribing, liaison with substance misuse services, motivational interviewing and brief interventions. The third tier includes more structured community based specialist substance misuse services such as community based detoxification services and structured day programmes. The fourth tier includes residential substance misuse specific services, including inpatient detoxification services and specialist residential drug rehabilitation, and includes a further sub-tier of substance misuse services provided by highly specialist non-substance misuse specific services such as forensic psychiatry services, specialist liver disease units and HIV specialist units.

It was felt that the UK NHS template would be useful when planning and commissioning a substance misuse service and that it is possible to deliver tiers one to three in primary care settings. Workshop participants agreed that there was a need for non-governmental organisations to play a role in the management of substance misuse and that there was also a need for training to be made available to primary care workers worldwide, to decrease the levels of therapeutic nihilism related to the management of substance misuse. It was suggested that

primary care doctors in low and medium income countries, where access to trained specialists in substance misuse is poor, could be trained to become family doctors with a special interest in substance misuse and so provide more specialist interventions up to tier four, including work in prisons.

It was suggested that in high income countries family doctors can play a role by working with secondary and tertiary care specialist providers to develop appropriate shared care protocols for the management of substance misuse. Well trained family doctors in high income countries who become family doctors with a special interest in substance misuse should also be able to provide care up to tier 4a, depending on membership of the team and the skill mix available.

The management of substance misuse within primary care provides challenges and also opportunities for further development. This editorial has described a treatment model developed in the USA and a commissioning framework developed in the UK, but there are other methodologies and models of care for both commissioning and treatment.

The journal *Mental Health in Family Medicine* welcomes contributions from all over the world that will enable us to move forward the knowledge and expertise in the field of primary care substance misuse so that we can learn from each other, share best practice and policy and reduce the frustrations suffered by family doctors, service users and their families when tackling this important problem.

REFERENCES

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2 NHS National Treatment Agency for Substance Misuse. *Models of care for the treatment of drug misuse*. London: DOH, 2002. www.nta.nhs.uk/uploads/nta_modelsofcare2_2002_moc2.pdf (accessed 1 August 2010).