

Clinical Guidelines on Drug Misuse and Dependence Update 2007
Independent Expert Working Group

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**Drug misuse and dependence –
guidelines on clinical
management:
update 2007**

CONSULTATION DRAFT
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The working group is aware that the draft Update still needs work on its balance of length and proportionality; references are to be inserted, completed or removed; the balance of depth for the appendices may need to be adjusted; and additional text may need to be included addressing variations in the different countries of the UK. However, the group is keen to receive expert commentary on the principal directions and recommendations before moving on to finalise the Update.

CONTENTS

MEMBERSHIP	6
FOREWORD	10
INTRODUCTION	16
1 Drug treatment is effective	18
2 The growth of drug misuse and drug treatment.....	18
2.1 Overview	18
2.2 Drug misusers presenting for treatment	20
2.3 Morbidity and mortality	21
3 Child protection.....	23
4 The impact of drug misuse on families and communities	23
5 The policy context.....	24
5.1 UK Drug Strategy	24
5.2 National initiatives	24
5.3 Models of drug treatment	24
CHAPTER 2 - CLINICAL GOVERNANCE.....	26
1 Principles of clinical governance	27
1.1 Introduction	27
1.2 Other relevant clinical governance frameworks.....	28
1.3 Policies and protocols	29
1.4 Policy and clinical governance issues for substance misuse treatment for those under 18 years of age	29
1.5 Competencies	31
2 Training	33
3 Non-medical prescribing	34
3.1 Mechanisms for non-medical prescribing	35
3.2 Requirements for training and continuing professional development.....	35
3.3 Clinical governance requirements for supplementary prescribing.....	36
3.4 Clinical governance requirements for independent prescribing.....	37
4 Information sharing, confidentiality, consent and child protection.....	40
4.1 Confidentiality and information sharing.....	40
4.2 Considering the needs of the children of drug using parents	40
4.3 Young people who misuse substances	41
5 Drugs and driving.....	42
5.1 Driving licence requirements.....	42
5.2 Driving under the influence of drugs	43
5.3 Risk assessment.....	43
5.4 Disclosure and breaching confidentiality	44
5.5 Action with patients	44
6 Involving carers	46

CHAPTER 3 ESSENTIAL ELEMENTS OF TREATMENT PROVISION.....47

1	Assessment, planning care and treatment	48
1.1	Introduction	48
1.2	Assessment.....	49
1.3	Care or treatment plan	51
1.4	Discharge from drug treatment and ensuring support to prevent relapse	52
2	Delivery of treatment.....	53
2.1	Care planning in other groups with externally co-ordinated care	54
3	Drug testing	55
3.1	Introduction	55
3.2	Uses of testing	56
3.3	Resources	56
3.4	Procedures.....	56
3.5	Contingency management	57
3.6	Approximate duration of detectability of selected drugs in urine	58
4	General health assessment at presentation and during treatment	59

CHAPTER 4 PSYCHOSOCIAL INTERVENTIONS.....64

1	Principles of psychosocial interventions	65
1.1	Psychosocial interventions and keyworking	65
1.2	Therapeutic alliance.....	65
1.3	Formal psychosocial interventions.....	66
1.4	Targeting formal psychosocial interventions.....	66
1.5	Individual versus group interventions	67
2	Models and evidence.....	68
2.1	Psychosocial interventions and techniques currently used by keyworkers	68
2.2	Formal psychosocial interventions to address drug misuse	69
2.3	Formal psychosocial intervention to address common mental disorders	72
3	Psychosocial interventions and different substances of misuse	74
3.1	Cocaine and other stimulants	74
3.2	Cannabis use	74
4	Competencies to deliver psychosocial interventions	75

CHAPTER 5 PHARMACOLOGICAL INTERVENTIONS.....76

1	Common issues.....	77
1.1	Prescribing	77
1.2	Induction onto methadone and buprenorphine treatment.....	81
1.3	Supervised consumption.....	91
1.4	Assessing and responding to progress and failure in treatment.....	93
1.5	Injectable opioid treatment (IOT)	97
2	Opioid maintenance prescribing.....	103
2.1	Introduction	103
2.2	NICE technology appraisal	104
2.3	Other opioids used for maintenance.....	106
3	Opioid detoxification	107
3.1	Introduction	107
3.2	Dosing regimen for detoxification.....	108
3.3	Symptomatic treatment of withdrawal.....	108
3.4	NICE guidelines	109

4	Naltrexone for relapse prevention	112
4.1	Introduction	112
4.2	Dose regimen.....	112
4.3	NICE technology appraisal	112
5	Benzodiazepines	114
5.1	Introduction	114
5.2	Prescribing regimen	114
6	Prescribing for users of stimulants and hallucinogens.....	118
6.1	General measures	118
6.2	Antidepressants	118
6.3	Substitute prescribing	118

CHAPTER 6 HEALTH CONSIDERATIONS 120

1	Blood-borne viruses.....	121
1.1	Introduction	121
1.2	Prevention and testing	121
1.3	Management issues for specific drug-related viral infections	122
1.4	Further information.....	124
2	Preventing drug-related deaths.....	125
2.1	Introduction	125
2.2	Reducing drug-related deaths.....	125
2.3	Dealing with overdose.....	126
3	Drinking and drug misuse	128
3.1	Treatment interventions	129
4	Tobacco.....	130

CHAPTER 7 CLINICAL SITUATIONS 132

1	Criminal justice	133
1.1	Introduction	133
1.2	Criminal justice intervention points and arrangements	133
1.3	The role of the clinician	136
2	Prisons	137
2.1	Introduction	137
2.2	Meeting the needs of drug dependent prisoners	137
2.3	Preparing for release	140
3	Pregnancy and neonatal care	142
3.1	Introduction	142
3.2	Management by a multidisciplinary team.....	142
3.3	Management of antenatal care	143
3.4	Effects of drugs on the foetus and baby	143
3.5	Maternal health problems	143
3.6	Management of labour	144
3.7	Neonatal withdrawal.....	144
3.8	Postnatal management.....	144
3.9	Prescribing drugs for pregnant drug misusers.....	145
3.10	Further reading.....	146

4	Mental health	147
4.1	Introduction	147
4.2	Prevalence	147
4.3	Mental health policy	147
4.4	The care programme approach	149
4.5	Treatment for mental health problems.....	149
5	Drug treatment for young people	150
5.1	Young people’s patterns of substance misuse are different from adults.....	150
5.2	Young people’s specialist drug treatment is different from adults	150
5.3	Research evidence on treatment effectiveness with those under 18 years	151
5.4	Assessment.....	152
5.5	Substance misuse treatment interventions.....	152
5.6	Pharmacological treatment for young substance misusers	153
5.7	The management of co-morbid disorders.....	156
6	Older current and ex-drug misusers.....	157
7	Pain management in drug misusers.....	160
7.1	Introduction	160
7.2	Acute pain	160
7.3	Chronic pain.....	161
8	Admission to and discharge from general hospital.....	162
8.1	Introduction	162
8.2	Opioid-dependent patients.....	162
8.3	Other drugs of misuse.....	166
8.4	Discharge	166
ANNEXES		168
1	Cardiac assessment and monitoring for methadone prescribing	169
2	Writing prescriptions	178
3	Interactions.....	190
4	Marketing authorisations.....	193
5	Licensing of medications: consideration for use with young people	195
6	Child protection in Scotland	199
7	Useful documents.....	201
8	Contacts	203
9	NICE summaries.....	208
REFERENCES.....		209

MEMBERSHIP OF THE CLINICAL GUIDELINES ON DRUG MISUSE AND DEPENDENCE UPDATE 2007 WORKING GROUP

Chair

Professor John Strang

Professor of psychiatry of addictions. Director of the National Addiction Centre, Institute of Psychiatry. Honorary consultant psychiatrist, South London and Maudsley NHS Foundation Trust

Members

Jayne Bridge

Nurse consultant, Drug & Alcohol Directorate, Mersey Care NHS Trust

Dr Dominic Connolly

Addiction psychiatrist, Community Addictions Services, Tyrone and Fermanagh Hospital

Dr Edward Day

Senior clinical lecturer in addiction psychiatry, Department of Psychiatry, University of Birmingham

Dr Michael Farrell (representing Royal College of Psychiatrists)

Senior lecturer, National Addiction Centre, Institute of Psychiatry and consultant psychiatrist, South London and Maudsley NHS Foundation Trust

Dr Clare Gerada (representing Royal College of General Practitioners)

General practitioner (London practice) and primary care lead for drug misuse.

Dr Eilish Gilvarry

Consultant psychiatrist, Northern Alcohol and Drug Service, Newcastle upon Tyne.

Simon J Greasley (representing Association of Nurses in Substance Abuse)

Clinical nurse specialist, The Kakoty Practice, Barnsley

Dr Linda Harris

Clinical director, Wakefield Integrated Substance Misuse Services

John Howard (representing service users)

Reading User Forum (RUF)

Dr Jenny Keen

Clinical director, Primary Care Clinic for Drug Dependence

Dr Brian Kidd

Consultant psychiatrist, NHS Tayside Substance Misuse Services and Clinical senior lecturer in addiction psychiatry, University of Dundee

Dr Judith Myles

Senior lecturer in addictions, St George's University of London, and consultant psychiatrist and clinical lead in addictions, South West London & St George's Mental Health NHS Trust

Dr Rossana Oretti

Consultant psychiatrist, Community Addiction Unit, Cardiff and the Vale NHS Trust

Dr Duncan Raistrick

Consultant psychiatrist, Leeds Addiction Centre

Dr Roy Robertson

Edinburgh GP and reader, Division of Community Health Sciences, University of Edinburgh

Neil Steventon (representing carers)

Assist 2000

Heather Walker (representing Royal Pharmaceutical Society of Great Britain)

Chief pharmacist, North East London Mental Health Trust

Ian Wardle

Chief executive, Lifeline Projects

Dr Nat Wright

Clinical director for substance misuse, HMP Leeds, Leeds Primary Care Trust

Dr Deborah Zador

Consultant physician in addictions, South London & Maudsley NHS Foundation Trust, and visiting senior lecturer, National Addiction Centre, Institute of Psychiatry

Service users and carer representative were supported and advised by national groups of users and carers respectively.

Service users:

Eliot Albert
Sharyn Charlton
Andy Cornish
James Grieve

Carers:

Pat Boydell
Dot Inger
Linda Moore
Teresa Seymour
Christine Tebano
Jane White

Observers

Yael Bradbury-Birrell

General Medical Council

Annette Dale-Perera

National Treatment Agency for Substance Misuse

Sherife Hasan

Drug Strategy Directorate, Home Office

Dr Sarah Watkins and John Lenaghan

Substance Misuse Policy Development Team, Welsh Assembly Government

Rob Phipps and Ian McMaster

Department of Health, Social Services and Public Safety, Northern Ireland

Dr Stephen Pilling

National Collaborating Centre for Mental Health / National Institute for Health and Clinical Excellence

Dr Mary Piper / David Marteau

Prison Health Policy Unit, Department of Health

Dr Mark Prunty

Department of Health, England

Deborah Smith

Public Health & Substance Misuse Division of Scottish Executive Health

Marion Walker

National Treatment Agency for Substance Misuse

Clinical director, Substance Misuse Services, Berkshire Healthcare NHS Foundation Trust

Secretariat

Dr Emily Finch – Clinical team lead and psychiatrist, National Treatment Agency for Substance Misuse (to November 2006), and consultant psychiatrist, South London and Maudsley NHS Foundation Trust

Steve Taylor – Project manager for the NTA

Conflict of interests

Members of the working group registered any potential conflict of interests with the National Treatment Agency.

Reviews

The NTA, with the advice of the chair and Department of Health, commissioned a series of reviews to advise the working group:

- Drug testing in treatment – Dr Neena Buntwal and Dr Sarah Welch, Countywide Specialist Substance Misuse Service (Gloucestershire).
- Methadone and buprenorphine dose induction – Dr James Bell, The Langton Centre, Surry Hills, Australia.
- Drug treatment for young people – Dr Eilish Gilvarry, Northern Regional Drugs and Alcohol Service.
- Drugs and driving – Dr Franjo Grotenhermen, nova-Institut, Huerth, Germany.
- Drug treatment in prisons – Sarah Larney, Benjamin Phillips, Effat Merghati Khoei, Bradley Mathers and Kate Dolan, Program of International Research and Training, National Drug and Alcohol Research Centre, University of New South Wales, Sydney.
- Cardiac assessment and monitoring – Dr Soraya Mayet, National Addiction Centre, London.
- Treatment of substance misuse in pregnancy – Dr Judith Myles, South West London & St George's Mental Health NHS Trust.
- Injectable opioid treatment – Dr Louise Sell, Bolton, Salford and Trafford Mental Health NHS Trust Substance Misuse Directorate and Dr Deborah Zador, National Addiction Centre, London.
- Drug testing technology – Dr Kim Wolff, King's College London, National Addiction Centre, Institute of Psychiatry.

FOREWORD

Who is the Update for?

Drug misuse and dependence – guidelines on clinical management: update 2007 (UK Health Departments, 2007) – hereafter referred to as the Update – is intended for all clinicians, especially those providing pharmacological interventions for drug misusers as a component of drug misuse treatment.

What is this Update?

This document updates and replaces *Drug misuse and dependence – guidelines on clinical management* (UK Health Departments 1999) – hereafter referred to as the Guidelines. It has the same status across the UK as the 1999 Guidelines.

The Update provides guidance on the treatment of drug misuse in the UK. It is based on current evidence and professional consensus on how to provide drug treatment for the majority of patients, in most instances.

This Update does not provide rigid protocols on how clinicians must provide drug treatment for all drug misusers. Neither does this guidance override the individual responsibility of clinicians to make appropriate decisions in the circumstances of the individual patient, in consultation with the patient and/or guardian or carer. In instances where clinicians operate outside the framework of this guidance, they may be expected to demonstrate the rationale for their decisions.

Why an update?

UK guidelines for the clinical management of drug misuse were last revised in 1999. There have been substantial developments in treatment – in particular, advances in knowledge and practice – that merit publication of an update. These include:

- greater recognition of and investment in the importance of drug treatment and a massive expansion in the numbers receiving treatment
- a much expanded evidence-base and resulting policy and practice guidance
- consensus on doctor competencies in substance misuse treatment (RCPsych and RCGP 2005).

- changes in contractual arrangements for general practitioners who provide drug treatment.

Also, in 2004 the National Institute for Health and Clinical Excellence (NICE) was charged with developing a suite of guidelines and technology appraisals on various aspects of the treatment and care of drug misusers. It was clear that, at the time of the Update's publication in 2007, there would be a considerable new body of evidence-based guidance on drug treatment.

An evidence-based Update

The 1999 Guidelines were based on a number of sources of evidence for effectiveness including research reviews, evidence from expert committee reports and the clinical experience of respected authorities. In updating the Guidelines, the working group commissioned a series of reviews of the evidence on specific aspects of drug misuse treatment. The working group then, by a process of consensus, came to a view of the best available evidence from whatever source. The 1999 Guidelines noted that “there is currently, with some exceptions, a limited amount of rigorous reviews in this area” and recommended “that systematic reviews be further developed along the lines of the Cochrane Collaboration, and ... incorporated in a future review of these Clinical Guidelines”. Although the evidence base for drug misuse treatment has improved, the working group again found that, in many areas of drug treatment, evidence was either lacking or that the research on which evidence was based came from countries other than the UK.

NICE and the Update

The Update was developed concurrently with the NICE suite of guidance on drug misuse treatment and NICE had observer status on the working group.

NICE will publish final guidelines in summer 2007 on:

- opiate detoxification
- psychosocial interventions for opiate users.

NICE published technology appraisals in spring 2007 on:

- methadone and buprenorphine maintenance
- naltrexone for relapse prevention.

The working group considered draft NICE guidelines and final NICE technology appraisals in drafting the Update. The Update interprets and incorporates the NICE suite of guidance as appropriate, but the Update covers the management and treatment of drug misusers in a more wide-ranging manner than the NICE suite of guidance. This Update and NICE guidance should be taken together with other key documents to provide a comprehensive picture of current clinical guidelines on the treatment of drug misuse.

NICE has also produced public health guidance on community-based interventions to reduce substance misuse among vulnerable and disadvantaged children and young people (NICE 2007).

It is important to note the different status of NICE in England and Wales, Northern Ireland and Scotland.

In England and Wales health professionals (and their organisations) are expected to take NICE guidance fully into account when exercising their clinical judgement. In relation to the two main types of guidance relating to drug misuse, NHS organisations are expected to do the following:

Type of NICE guidance	NHS organisations should
Clinical guidelines	Review current management of clinical conditions and consider the resources and time need to implement the guidelines
Technology appraisals	Fund and resource medicines and treatments recommended, usually within three months of NICE issuing guidance

NHS Quality Improvement Scotland (NHS QIS) provides advice to NHSScotland on the suitability for Scotland of NICE advice and the status of NICE advice in Scotland varies according to product type. For NHS QIS validated NICE multiple technology appraisals, NHS Scotland will take account of the advice and evidence from NHS QIS and ensure that recommended drugs and treatment are made available to meet clinical need. NICE single technology appraisals and clinical guidelines currently have no formal status in Scotland and are for information only in NHSScotland.

The Northern Ireland Executive reviews the applicability of NICE guidance to Northern Ireland.

The position of the Guidelines and Update

The 1999 Guidelines and this 2007 Update, which replaces it, have no specific statutory status. There are separate, defined legal obligations in relation to the prescribing of

controlled drugs. In addition Doctors need to ensure that they act within Home Office licensing arrangements for the prescription of diamorphine, dipipanone or cocaine for the management of drug misuse.

However, any doctor not fulfilling the standards and quality of care in the appropriate treatment of drug misusers as set out in this Update will have this taken into account if, for any reason, their performance in this clinical area is considered.

The General Medical Council states:

The investigations or treatment you provide or arrange must be based on the assessment you and the patient make of their needs and priorities, and on your clinical judgement about the likely effectiveness of the treatment options. You must not refuse or delay treatment because you believe that a patient's actions have contributed to their condition. You must treat your patients with respect whatever their life choices and beliefs. You must not unfairly discriminate against them by allowing your personal views [including your views about a patient's lifestyle] to adversely affect your professional relationship with them or the treatment you provide or arrange.

Regulation and inspection

In England, the Healthcare Commission (HC) uses guidance produced by the National Institute for Health and Clinical Excellence (NICE) for its annual health check, its programmes of review, and in audit and assessment work. The joint HC/NTA improvement reviews of drug treatment similarly use NICE guidance and the clinical guidelines.

Inspection and investigation of Welsh NHS bodies and private and voluntary provision rests with Healthcare Inspectorate Wales.

In Scotland independent healthcare services are regulated by the Scottish Commission for the Regulation of Care ('the Care Commission'). All independent healthcare service are expected to provide care and treatment that reflects the relevant NHS QIS standards and reflects good practice based on relevant research based studies, audit reports, standards, guidelines and evidence based treatments.

(Northern Ireland to be added)

The process for developing the Update

In 2006 the UK health departments tasked the National Treatment Agency for Substance Misuse (NTA) with supporting an independent working group to update *Drug misuse and dependence – guidelines on clinical management* (UK Health departments 1999). The chair of the 1999 (and 1991) guidelines working group, Professor John Strang, was invited to again chair the group.

The working group included members who brought a wide range of individual expertise, continuity with previous guidelines, and representation of key groups of stakeholders. These included addiction psychiatrists, general practitioners, nurses, pharmacists, service users and carers. The service user and carer representatives were, in turn, supported by their own advisory groups. Government departments, the NTA and others had observer status.

The terms of reference of the group were to produce an update in 2007, which is to replace the 1999 Guidelines and will incorporate key messages from NICE guidance and other relevant research and guidance.

Although the years since 1999 have seen considerable strengthening of the autonomy of the devolved administrations, it was agreed that it would still be sensible to issue a single set of guidelines for the whole of the UK. This would be a “skeleton” framework of best practice from which the devolved administrations could develop their own guidance on locally-appropriate variations in policy and practice.

Development of the update began with the commissioning of a series of reviews to advise the working group on the current evidence-base for a range of drug misuse treatment-related issues, including: prison drug treatment; drugs and driving; injectable opioid treatment; methadone and buprenorphine dose induction; drug testing and its use in practice; drug treatment for young people; treatment of substance misuse in pregnancy; cardiac assessment and monitoring for methadone prescribing.

The final distribution of the Update will include access for GPs, non-medical prescribers, accident and emergency consultants, NHS trusts and authorities, and specialist drug treatment providers.

They will also be available on the web sites of the UK health departments at:

- England www.dh.gov.uk
- Northern Ireland www.dhsspsni.gov.uk
- Scotland www.scottishexecutive.gov.uk
- Wales <http://new.wales.gov.uk/?lang=en>

The development of the Update was funded and supported by the National Treatment Agency. The finalised Update document will be published by the UK health departments in September 2007. Implementation plans for the separate countries will follow this.

CHAPTER 1

INTRODUCTION

Some key principles underlying appropriate care of drug misusers

- Drug misusers have the same entitlement as other patients to the services provided by the National Health Service.
- The General Medical Council has stated: “It is ... unethical for a doctor to withhold treatment from any patient on the basis of a moral judgement that the patient’s activities or lifestyle might have contributed to the condition for which treatment was being sought. Unethical behaviour of this kind may raise the question of serious professional misconduct.”
- It is the responsibility of general practitioners to provide general medical services for drug misusers. Health Authorities, Primary Care Trusts in England and Wales, and Health Boards in Northern Ireland and Scotland all have a duty to provide treatment for drug misusers, to meet local population needs. This should include interventions to reduce drug-related harm such as hepatitis B vaccinations and needle exchange provision, together with evidence-based drug treatment.
- Every doctor must provide medical care to a standard which could reasonably be expected of a clinician in his or her position. An increasing number of clinicians are trained and supported to provide drug treatment under the terms of a contract negotiated with their local commissioners.

Key points

- Drug misuse treatments work.
- Substantial numbers are affected by drug misuse across the UK who could benefit from interventions.
- Availability and engagement in treatment has been increasing substantially over the last decade.

- Patterns of use, referral patterns and the range of treatment interventions offered is well-documented.
- Current levels of mortality and morbidity are of concern (particularly due to overdose and blood-borne virus infections).
- Impact of drug misuse on the family and wider society is substantial and an important goal for treatment to address.
- A range of policy initiatives has been developed across the UK to address delivery of systems of care, which are responsive to identified need, based on partnership working, and the availability of a competent workforce that is supported by effective clinical governance arrangements, and that promote an increasing voice and role for service users and carers.

1 Drug treatment is effective

The effectiveness of well-delivered, evidence-based treatment for drug misuse is well established. UK and international evidence consistently shows that drug treatment impacts positively on levels of drug use, offending, overdose risk and the spread of blood borne viruses. Studies showing the effectiveness of drug misuse treatments have been conducted with clients with different types of drug problems, different treatment interventions, and in different treatment settings (e.g. Hubbard et al, 1989, 1997; Ward et al 1998; Institute of Medicine 1990; Simpson et al 1999; Sorensen and Copeland 2000; Gossop et al 2003; Hser et al 2005). In addition the National Treatment Outcomes Research Study (Gossop 2001) showed that for a significant proportion of those entering treatment (between a quarter and a third) drug treatment results in long-term sustained abstinence. The National Institute for Health and Clinical Excellence recently produced two technology appraisals (NICE 2007a and b) and two guidelines (NICE 2007c and d) on a range of drug treatment interventions, which endorse much of the mainstream drug treatment provided in the UK as evidence based and cost effective.

It now may be more appropriate to stop asking whether treatment for drug misuse is effective, and instead ask how treatment can be improved and how it can be tailored to the needs of different clients.

2 The growth of drug misuse and drug treatment

2.1 Overview

International comparisons of the prevalence of drug use and misuse are difficult due to differences in data collection and analysis. However, studies consistently show that the UK (Scotland and England in particular) has among the highest rates of recorded illegal drug use and misuse in the western world. In particular the UK has high rates of recorded problem drug users (PDUs) or problematic heroin and crack cocaine misusers.

Table 1 gives an overview of the prevalence of problem drug users in England, Scotland, Northern Ireland and Wales in 2005/6 in terms of numbers and percentage of the population and measures of treatment uptake.

Table 1: Overview of problem drug user (PDU) populations, treatment uptake and treatment capture rates 2005/6

Country	Popn.	Popn. aged 15-64	Prevalence of PDU	PDUs as % of popn.	Number of PDUs in treatment	Numbers in treatment as % of PDU popn.
England	52,041,916	32,292,156	287,670	0.55%	163,985	57.0%
Scotland	5,094,800	3,352,022	51,582*	1.01%	12,587	24.4%
Wales	3,000,000		16,513	0.55%	4,120	24.9%
N.I.	1,170,300	1,090,990	828*	0.07%	1,409	?

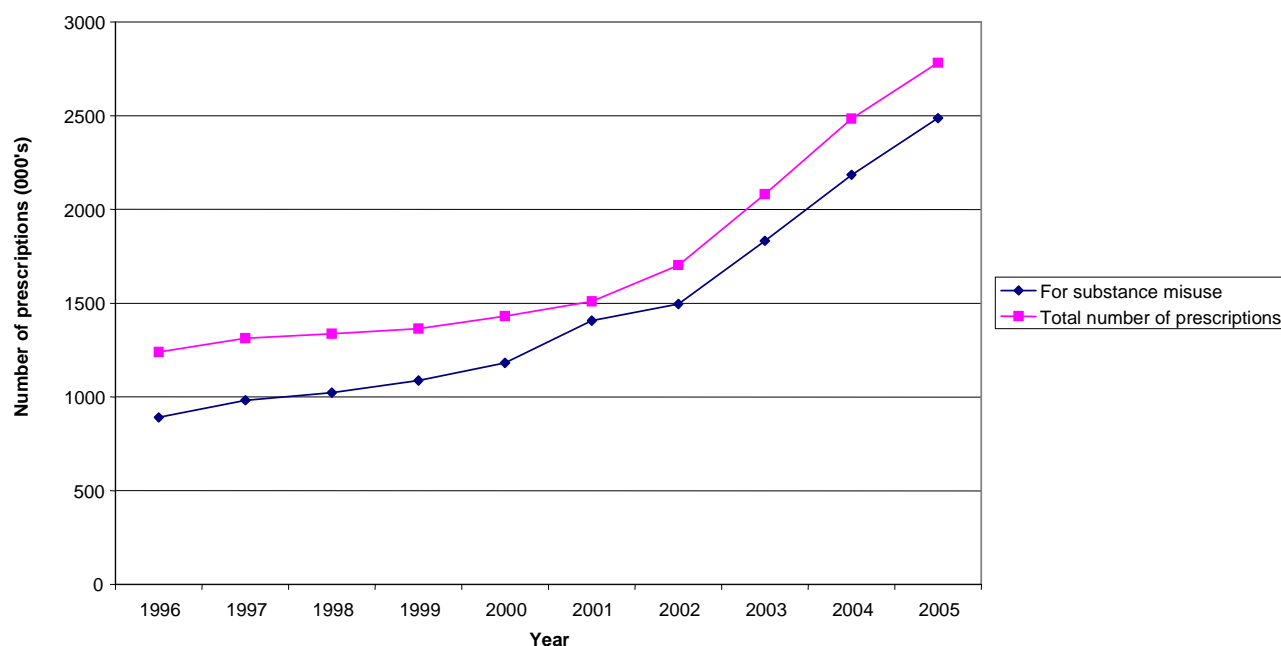
Figures from DAWN 2004, Home Office Online Report 2006, Drug Misuse Information Scotland, National Statistics

* Misusing opiates and benzodiazepines only in 2003

Table 1 also gives the recorded number of problem drug users in structured drug treatment over this time period and the rate of “treatment capture” for the year, i.e. the percentage of problem drug users who received treatment that year. It is worthy of note that England has among the highest rate of recorded problem drug users in community based treatment in the western world (second only to Portugal).

There is also evidence for increases in the provision of substitute prescriptions over the last decade. The Prescription Cost Analysis in figure 2 illustrates the increase in numbers of methadone and buprenorphine prescriptions issued for drug misuse in the past ten years.

Figure 2: Total number of prescriptions issued for methadone and buprenorphine in community settings in England, 1996-2005 (source: PCA, DH)



2.2 Drug misusers presenting for treatment

England

In 2004/05, around three quarters of those presenting for drug treatment reported opiates as their main problem with 64% reporting heroin as their main drug of misuse. 43% of heroin users reported currently injecting drugs. Of these heroin misusers, 21% also reported crack and 4% cocaine as adjunctive drugs of misuse. A further 10% of clients were reported to use either crack or cocaine and of this group 14% also reported heroin as an adjunctive drug of misuse. Heroin and crack or cocaine misuse is increasingly common among those presenting for treatment in England. Cannabis was the reported main drug of misuse for 11% of patients. For those aged younger than 18 years, 67% reported their main drug of misuse was cannabis (67%). Drug misusers who were under 18 years of age reported lower rates of class A drug use: heroin, crack and cocaine misuse accounted for 14%, 2% and 3% respectively.

The most frequent referral source in 2004/5 was self-referral (41%), with 15% of referrals from general practice. The criminal justice system provided 19% of episode referrals.

More than half (52%) of drug treatment in 2004/5 included pharmacological interventions (37% via drug treatment specialists and 15% via GPs). Residential treatment accounted for 4% of treatment including residential rehabilitation (2%) and inpatient detoxification (2%). The rest involved a range of psychosocial community interventions.

Scotland

In Scotland, the number of new clients accessing new treatment in 2005-6 was 13,791, an increase of 30% from 2000-1. In common with England, the main drug of misuse continues to be heroin (53%) with cannabis (12%), diazepam (5%) and cocaine (3%) being the next main drugs of misuse. Between 2004 and 2006 there was a significant decrease in prevalence of drug use in the last month in 13 and 15 year old males and females.

Prevalence of drug use among 15 year old boys declined from 21% to 14% and among 15 year old girls from 20% to 12%. Among 13 year old boys there was a decline from 7% to 4% and among 13 year old girls there was also a decline 6% to 3%. Use of cannabis in the last month was reported by 12% of 15 year old boys, 9% of 15 year old girls, 3% of 13 year old boys and 2% of 13 year old girls. Very few pupils reported using any other drug.

Wales

The Welsh National Database for Substance Misuse annual report for 2005/06 report presents data relating to cases referred to drug and alcohol treatment agencies in Wales. All treatment agencies in Wales contributed to the database.

Information was received on 19,407 referrals.

- Alcohol was specified as the main problem in just over 50% of cases; Other drugs were specified in just under 35% of cases; in 15% of cases the main problem was unspecified.
- Just over two thirds of referrals were male.
- 42% of referrals were aged under 30.
- Heroin was specified as a main or contributory problem in 3465 cases and cannabis in 2583 cases.
- Of the 19,407 cases referred, closure was recorded on 9582 occurrences with 9825 cases remaining open at the end of the year.

Northern Ireland

(Data to follow)

2.3 Morbidity and mortality

Drug misusers may have a range of health and social care problems, which may or may not be associated with their drug misuse. Although drug misuse exists in most areas in the UK, it is more prevalent in areas characterised by social deprivation, which in turn is associated with poorer health. The majority of drug misusers also smoke cigarettes and many have lifestyles which are not conducive to good health.

Drug misusers and injecting drug users are particularly vulnerable to contracting and spreading blood borne viruses and other infections. A long-term follow-up of heroin addicts showed they had a mortality risk nearly 12 times greater than the general population (Oppenheimer et al 1994). Another study of injecting drug users showed that they were 22 times more likely to die than their non-injecting peers (Frischer et al 1997). The high morbidity and mortality rates make it especially important that drug misusers are in contact with treatment services.

2.3.1 Blood borne viruses

Hepatitis B: Over a third (34%) of all cases of hepatitis B in England are associated with injecting drugs. A prevalence rate of 21% is thought to exist among injecting drug users (IDUs) in the UK, with wide variation between countries and regions. The rate of self reported hepatitis B vaccination doubled since 1998 from 25% to 59% in 2005 (HPA 2006).

Hepatitis C: Over 90% of hepatitis C diagnoses are associated with injecting drug use in England. The HPA (2006) reported that the current prevalence of hepatitis C among IDUs in England is 44%: and in the UK almost one in two IDUs are infected. There are wide geographic variations in prevalence, ranging from 58% in London to 20% in the North East. Almost half of IDUs in contact with drug services are unaware of their status. Recent research indicates that those injecting crack have a much higher prevalence of hepatitis C infection (67%) and cohort studies indicate the incidence has recently increased.

HIV: Injecting drugs accounted for 5.6% of HIV diagnosis reported in England (HPA 2005) and 6.7% in Scotland. The overall prevalence of HIV among injecting drug users (IDUs) in England and Wales remains relatively low at 1 in 50 infected but the prevalence in London is much higher at 1 in 25 infected. Of great concern is the recent increase in HIV among IDUs outside London which has seen a six fold increase in two years from one in 400 IDUs in 2003 to one in 65 in 2005. New studies looking at HIV incidence (new cases per year) found evidence of a recent increase in transmission to as much as 3.4% per annum in London and 6% of those injecting crack.

From 2002-2004, the prevalence of newly diagnosed HIV infection among IDUs tested in Scotland remained steady at between 0.47% and 0.62% (about 1 in 200 IDUs tested). In 2005 this figure rose to 0.93%. However, nine of the 21 cases who received an HIV antibody test are presumed to have become infected outside Scotland (Health Protection Scotland 2005).

Trends in sharing injecting equipment and risk behaviour: Injecting is a key factor in the transmission of blood borne viruses (BBV) in drug misusers and in many overdose deaths. Tackling risky injecting behaviour lies at the heart of combating BBV and overdose deaths in drug misusers. The rate of reports of sharing injecting equipment rose in the late 1990s and remains high. In 2005 28% of IDUs reported directly sharing needles and syringes and 48% reported sharing other injecting paraphernalia. Other trends in injecting identified by research during 2006 included an increase in injecting heroin with crack; particularly risky injecting

behaviour among those who are homeless; a trend to earlier high risk groin injecting and poor injecting hygiene (HPA 2006).

2.3.2 Drug-related overdose

Recorded rates of drug-related death due to overdose in the UK are among the highest in Europe. In the UK, acute drug-related deaths accounted for more than 7% of all deaths among those aged 15-39 years in 2004 (EMCCDA 2006). Following steep increases in the rate of drug-related deaths in the 1990s, just over 1500 drug-related overdose deaths were recorded in England alone in 2005. The vast majority of these deaths are associated with injecting heroin misuse in combination with alcohol, benzodiazepines or other depressants. A significant proportion of deaths also occurs among drug misusers who have just left prison. Deaths associated with methadone has significantly reduced over the past five years, probably reflecting implementation of supervised consumption of methadone prescriptions in the initial stages of drug treatment.

3 Child protection

Protecting children from the potential impact of drug misuse is an important issue across the UK and a policy priority in Scotland. For example, Scotland has recognised and promoted the need to provide better outcomes for children, especially for those in need of care and protection and the importance of joined-up working for those agencies involved with children. There is guidance on preventing harm, a framework of standards, and a three-year programme to reform child protection services strengthened Multi-Agency Child Protection Committees to ensure that all relevant partners play their part in identifying and responding to child protection concerns. There is additional information at annex #6.

4 The impact of drug misuse on families and communities

Drug misuse can place an enormous strain on the families of drug misusers including the children of drug using parents, and have a serious negative impact on the long-term health and well being of family members.

The *Hidden harm* report by the Advisory Council on the Misuse of Drugs (2003) estimated that there were between 250,000 and 350,000 children of problem drug misusers in the UK. The report stated that parental problem drug use can and does cause serious harm to children at every age and that reducing harm to children from parental problem drug misuse should become a main objective of policy and practice. It concluded that effective treatment

of the parent can have major benefits for the child and services and clinicians needs to work together to protect and improve the health and well being of affected children. Drug treatment can also have a positive impact in improving the quality of life for families and carers.

Drug-related crime has been estimated to inflict a major cost on local communities and the national economy. The evidence that drug treatment significantly reduces drug-related crime has been one of the main drivers behind the 1998-2008 UK drug strategy and the subsequent priority accorded to expanding drug treatment.

5 The policy context

5.1 UK Drug Strategy

(To follow in final version)

5.2 National initiatives

(To follow in final version)

5.3 Models of drug treatment

There are major changes likely in the delivery of healthcare over the coming years. The trend to devolution of responsibility to regional and local levels will present risks and opportunities for drug treatment. A single “shared care” model, as described in the 1999 Guidelines, as partnerships between primary and secondary/specialist providers has actually developed into a range of different models, often driven by local circumstances and including a wider range of providers.

Whatever the local treatment system model, the following principles are still key:

Local drug treatment systems based on local need

Local partnerships (and clinicians) will need to work together to ensure local drug treatment systems are commissioned and provided that meet the changing needs of local drug misusing populations within defined resources. In England *Models of care for treatment of adult drug misusers: update 2006* (NTA 2006) provides a basic commissioning framework for the range of drug treatment recommended within each local area, depending on local need. Wales has the *Substance Misuse Treatment Framework for Wales*. Drug misuse trends and potential treatment populations can change rapidly, and local partnerships and providers will need to work together to ensure local systems keep abreast of locally changing needs.

Partnership

Many drug misusers have a myriad of health and social problems which require interventions from a range of providers. Joint working across health and social care is therefore a key feature of effective treatment. It is seldom that one clinician will be able to meet these needs in isolation. One of the special features and strengths of drug treatment in the UK is the valuable partnership between statutory NHS drug treatment services and non-statutory or voluntary sector drug treatment providers which comprise up to half of service provision in some local areas.

Doctors with a range of competencies

Each local system will need to have a cohort of doctors providing treatment for drug misusers, ranging from those able to provide general medical services to those with specialist competencies in treating drug dependence.

Clinical governance

Ensuring good clinical governance systems within and between different providers will enable the provision of quality drug treatment.

Involving patients

Involving patients as active partners in their drug treatment is good practice and is associated with good outcomes (NTA 2006). Patients should be fully involved in the development of their care or treatment plan, in setting appropriate treatment goals and reviewing progress in treatment. It is also good practice to involve patients in the design, planning, development and evaluation of services, and in advocacy and support groups linked to local drug treatment systems. Patients may also be involved in peer education schemes to reduce the risk of overdose and blood borne viruses.

Involving carers

The families and other carers of drug misusing patients are a valuable resource in drug treatment and can be involved wherever possible and agreed by the (adult) patient. However, they are often in need of information and support for themselves, and their needs should not be overlooked.

CHAPTER 2

CLINICAL GOVERNANCE

Key points

- Staff working with drug misusers must be appropriately competent, trained and supervised.
- Services should be provided according to national guidance and principles, and in line with the evidence base.
- Policy and statutory frameworks for providing substance misuse treatment to those under 18 years of age are often different from adults and different approaches are required from clinicians.
- The expansion of non-medical prescribing will have implications for drug misuse treatment and care and clinical governance.
- Drug treatment can now utilise a range of non-medical prescribing mechanisms, for which good clinical governance should be in place.
- A timely and regular audit and review cycle should be in place.
- Information governance policies and practice are critical, including confidentiality and information sharing.
- Families and carers of drug misusers are both an important resource in treating drug misusers and often in need of support for themselves. Carers of adults can be involved with the patient's consent and there may be an obligation to involve the carers of young people.

1 Principles of clinical governance

1.1 Introduction

Clinical governance is a term used to describe a systematic approach to monitoring and continuously improving the quality of clinical interventions (DH 1998). Both substance misuse provider organisations and individual clinicians working in them have to take account of both formal and informal clinical governance structures.

Underpinning clinical governance implementation are a series of components including some pertinent to the individual clinicians responsible for providing treatment for drug misusers. These components are a mixture of organisational responsibilities and responsibilities of the individual health or social care professional, who has a responsibility to ensure the systems necessary to meet those standards are in place. This list is not exhaustive and just includes those which are relevant elements of clinical governance particularly relevant to the provision of clinical services.

Clinical effectiveness – Clinicians should use evidence-based interventions and monitor their implementation and effectiveness using clinical audit. Protocols may be useful to ensure consistent provision and share good practice. For some clinicians, carrying out research to establish the evidence base is a priority.

Competence and continuous professional development – Clinicians need to have appropriate competencies for their clinical role and training to achieve those competencies. They need to have appropriate certification, e.g. specialist registration or other, and take account of professional revalidation. Non-clinical skills such as leadership and management development are also important. Clinicians may benefit from individual or peer supervision, mentoring or other forms of professional support. Clinicians have an obligation to update their knowledge and skills base according to emerging evidence and developments in professional practice. Appraisal is mandatory for all clinicians and needs to be carried out according to current regulation.

Working in a team – Clinicians need to work with a range of other professionals and may work as part of a wider organisation or in a multi-disciplinary teams. Clinical governance of a team may have different best practice requirements depending on the setting and nature of the organisation, e.g. a community drug service within a mental health trust, a primary care led drug service, a voluntary sector drug service working in partnership with primary care clinicians etc. Whatever the team arrangements clinicians should be aware of the clinical

governance arrangements that are required and that are best practice and work in accordance.

Information management – Clinicians need to keep patient records, ensure appropriate information sharing, confidentiality and data protection, data collection and analysis and effective use of information and data. Information sharing can be of great value to the direct care of individual service users and may also contribute indirectly to the delivery and effectiveness of the drug treatment system. Information sharing protocols should be consistent with guidance from the local Caldecott Guardian and any national guidance, and acknowledge that patient consent is key in most situations where identifiable information is shared. Doctors must be satisfied that local information sharing is consistent with GMC guidance.

Patient, public and carer involvement – A clinician must take account of the needs and views of patient and their carers in planning the delivery of care. They may also have to take into account the views of the local community.

Risk management – Incident reporting, investigation and review, risk assessment, risk prevention and control and infection control normally constitute a duty of both an individual clinician and the organisation in which they work.

Public health – Clinicians should take account of disease prevention, health promotion and addressing health inequalities. This is particularly pertinent when working with drug misusers who are at high risk of blood borne viruses, other infections and drug-related death due to overdose.

1.2 Other relevant clinical governance frameworks

The General Medical Council's guidance, *Good medical practice* (2006), sets out the principles and values on which good medical practice is founded. They cover many of the areas described above and provide an example of another framework for good practice in doctors.

Other standards may be relevant to a doctor such as guidance from the Royal College of Psychiatrists, the Department of Health and the National Treatment Agency, *Clinical governance and risk management* standards in Scotland.

Prescribing governance and an adequate understanding of the law relating to prescribing for substance misusers is important. Prescribers have a responsibility to keep up to date on

changes in the law and guidance on prescribing controlled drugs. An example of this is changes following the Shipman enquiry.

1.3 Policies and protocols

It is usually good practice to ensure that practice is standardised by the use of local area or agency policies and protocols. It is important to note that the individual clinician may need to vary and deviate from protocols in some clinical situations. This should only be done within the limits of a clinician's competence and recorded as a matter of course.

1.4 Policy and clinical governance issues for substance misuse treatment for those under 18 years of age

- Consent must be gained from the appropriate person: either a competent young person or a parental responsibility holder.
- While a child or young person has a right to confidentiality they should be encouraged to involve significant others in their care.
- Confidentiality must be balanced against the duty to protect a child from significant harm, so in some cases confidentiality may need to be breached.
- Doctors have specific additional responsibilities in relation to prescribing for the treatment of substance misuse in children and young people (see annex #5). These responsibilities **cannot** be delegated.
- In the pharmacological management of substance misuse the use of medicines outside of their license is often unavoidable. In this case proper precautions must be taken.

Policy framework for working with those under 18 years

The legislative and policy framework for those under 18 years of age is different to that for adults. Inter-agency collaboration is often required to assess and respond to the needs of vulnerable children and young people. Partnership working is a fundamental principle and is encompassed in the Children Act 1989 and 2004, and *Working together to safeguard children: a guide to inter-agency working to safeguard and promote the welfare of children* (1999).

National service framework for children, young people and maternity services (DH 2004).

This states that: drug education should be provided for young people in schools and pupil

referral units; primary care trusts (PCTs) should provide information and services on substance use to children and parents; and staff from all agencies should identify young people at risk of misusing drugs or alcohol and provide them with access to prevention and treatment services.

Every child matters (HM Government 2003) and related documents (HM Government 2004 and DfES 2004b) state that: all professionals working with children should be trained to identify, assess and respond to those with drug use problems; PCTs, local authorities and drug and alcohol action teams (DAATs) should work together to identify vulnerable young people through the common assessment framework (CAF); local behaviour and education support teams (BEST) should work with children and young people, families and schools to intervene early and prevent problems developing further.

National specification for substance misuse for juveniles in custody (Youth Justice Board 2004) requires that drug use needs are assessed and identified as part of the reception into a facility; that drug education and prevention programmes are provided; and that support programmes acknowledge the needs of young people.

Northern Ireland

(To follow)

Scotland

(To follow)

Wales

The Welsh Assembly Government's strategic policy with respect to children and young people is governed by the 2004 Children Act, section 25 which creates a statutory framework for local co-operation between local authorities, key partner agencies and other relevant bodies, including the voluntary and community sectors, in order to improve the well-being of children in the area.

The Act requires local authorities in Wales to work with their partners to prepare and publish a single Children and Young People's Plan setting out their agreed strategy for discharging their functions in relation to all children and young people. Current statutory duties and responsibilities for the delivery of services remain.

Implementation of the 2004 Act is supported by the development and piloting of a Common Assessment Framework (CAF). The Welsh CAF is being developed for use by all agencies working with children, including those whose primary focus is on adults. It is intended for use with children and young people who have additional needs and those at risk of poor outcomes.

The Welsh Assembly Government published its *National service framework for children, young people and maternity services in Wales* in September 2005. As in England, this is a ten-year strategy that sets national standards to improve services for children and young people.

1.5 Competencies

Individual clinicians will have different fields of expertise and their professional background and training will predict, to a large extent, their competence to work in a particular type of service. Individual clinicians and employing organisations have a duty to ensure they have the right competencies and continuing professional development and appraisal to allow them to practice in their positions.

Competencies of clinicians may be viewed across the following domains: advice, identification, assessment, patient management, training supervision and teaching, research and audit and management and service development. Training assists clinicians to acquire and maintain the required competencies. The document *Roles and responsibilities of doctors in the provision of treatment for drug and alcohol misusers* (RCPsych and RCGP 2005) sets out the competencies for doctors in detail.

Doctors' job titles and competencies

Specialists	
Consultant in addiction psychiatry	A doctor on the specialist register in psychiatry, with endorsement in substance misuse working exclusively to provide a full range of services to substance misusers.
Substance misuse specialist (primary care)	A doctor with a general practice background with an extensive postgraduate training in substance misuse working as a specialist GP lead/director employed by a PCT or mental health trust.
Substance misuse specialist (other professional backgrounds)	Doctors from a range of professional backgrounds particularly public health. They may have a specialist qualification in their own field. They will be on the specialist register.
Associate specialists, senior clinical medical officers, staff grades and other doctors	Doctors working in specialist services under the supervision of a consultant in addiction psychiatry.
Doctors with a special interest	
Consultant in general psychiatry with a special interest in addiction	A doctor on the specialist register in psychiatry with some training in substance misuse, who spends a proportion of their time providing services to substance users in specialist services.
GPs with special clinical interest (GPwSI) providing enhanced services	GPwSIs have received specific higher-level training in the management of substance misusers in primary care, usually the GP Certificate in Management of Drug Use Part 2. GPwSIs delivering locally enhanced services or nationally enhanced services are able to work more autonomously and take responsibility for more complex cases in substance misuse than other GPs.
GPs providing enhanced services	Doctor providing basic medical care plus care to substance misusers, in accordance with local enhanced service agreements.
Other doctors caring for substance users	
GPs providing core services	Doctor providing general medical care only to substance users.
Consultant in general psychiatry	A doctor on the specialist register in psychiatry, who provides non-specialist services to substance misusers attending general adult psychiatry services (usually alcohol).

2 Training

Clinicians need to ensure that they have been trained to gain the appropriate competencies to treat drug misusers.

Medical students receive a very limited amount of training in drug misuse issues in their medical training.

Addiction psychiatrists have a formal training route now reformed by MMC (modernising medical careers) which provides a six year run-through training leading to a certificate of completion of training and entry to the specialist register. During this training period individuals can elect to spend time in addiction services and gain an endorsement in addiction psychiatry. The curriculum and examination of the training are delivered by the Royal College of Psychiatrists and results in gaining the MRCPsych. Following training they need to be registered for CPD with the appropriate Royal College. CPD can be monitored through the appraisal process.

General practitioners increasingly have formal training in substance misuse as part of the RCGP curriculum. Increasing numbers take the Certificate in the Management of Drug Misuse Parts 1 and 2, which may be taken by nurses, pharmacists and other professionals. Part 1 combines e-learning and some local training. Part 2 combines large and small group teaching and is designed to teach the competencies needed to provide tier 3 interventions at a special interest level. After completing part 2 the doctor undertakes CPD and appraisal specific to their work with drug misusers. This can be monitored formally through the GP appraisal process.

The White Paper, *Trust, assurance and safety – the regulation of health professionals* (DH 2007), published in 2007 sets out plans for recertification and revalidation. Recertification will ensure that a doctor is registered to practice and recertification ensures that they are qualified to remain on the specialist or the GP register. The exact nature of these processes has yet to be determined. Revalidation will be the responsibility of the regulatory body, i.e. General Medical Council. The medical royal colleges are involved in setting standards for recertification for specialist registers (hospital and GP) which will be one part of the criteria necessary for revalidation.

3 Non-medical prescribing

There are a number of mechanisms for the prescribing, supply and administration of medicines. Services can utilise a mixture of patient group directions, independent and supplementary prescribing. The decision to adopt one or more processes will be influenced by different clinical situations.

Patient group directions

Patient group directions (PGD) are a mechanism for supply and administration only. They are not a form of non-medical prescribing. PGDs are written instructions for the supply or administration of particular medicines to patients with a defined diagnosis, condition or need, who are not individually identified before presentation for treatment. The directions should be drawn up by multidisciplinary groups and must be authorised by the NHS trust or PCT and signed by a senior doctor and a pharmacist. PGDs can be utilised by a range of healthcare professionals, including nurses, pharmacists and occupational therapists. There are no specific training programmes for PGDs but individual organisations must ensure that people using them are competent to do so.

Non-medical prescribing

The term 'non-medical prescribing' refers to the prescription of medication by health professionals other than doctors. It is part of a range of NHS reforms designed to improve patients' access to medicines, develop workforce capability, utilise skills more effectively and ensure provision of more accessible and effective patient care. In practice this means prescribing by nurses and pharmacists although the list of professions that can train to undertake supplementary prescribing responsibilities has been expanded to include physiotherapists, radiographers and podiatrists.

In drug misuse treatment Nurse Independent Prescribers can prescribe a limited range of controlled drugs for specific medical conditions but this does not yet extend to the independent prescribing of controlled drugs for the treatment of opiate dependency. In these cases, however, all appropriate non-medical prescribers can prescribe controlled drugs as supplementary prescribers, working according to parameters set out in a clinical management plan agreed with a doctor and the patient. Proposed changes in legislation mean that these restrictions are likely to be removed later in 2007 so that nurses and pharmacists will be able to prescribe from the full Formulary.

3.1 Mechanisms for non-medical prescribing

3.1.1 Supplementary prescribing

Supplementary prescribing is a voluntary partnership between an independent prescriber (in practice, a doctor) and a supplementary prescriber (a non-medical health professional) to implement an agreed patient-specific clinical management plan (CMP) with the patient's agreement. It involves diagnosis by the doctor, agreement by the patient to be managed by the prescribing partnership, and preparation of a CMP signed by both prescribers. The patient's prescriptions are then managed by the supplementary prescriber within the terms of the CMP, with regular clinical reviews of the arrangement by the independent prescriber. At the time of writing (April 2007), supplementary prescribing by nurses and pharmacists is only legally required for controlled drugs, since all other medication can be independently prescribed. In the future, nurse and pharmacist independent prescribing may be extended to include all drugs.

3.1.2 Independent prescribing by nurses and pharmacists

Independent prescribing means that the prescriber takes responsibility for the clinical assessment of the patient, for establishing a diagnosis and the clinical management required, as well as for prescribing where necessary and for the appropriateness of any prescription. All doctors and dentists are independent prescribers. Currently appropriately trained and qualified nurses and pharmacists can also independently prescribe all medications in the British National Formulary, except all controlled drugs in the case of pharmacists and controlled drugs for the treatment of substance misuse problems in the case of nurses.

3.2 Requirements for training and continuing professional development

To become a nurse independent prescriber, a nurse must have completed basic nurse training and be UK registered, a UK registered midwife or a UK-registered specialist community public health nurse, with an annotation on the register signifying that the nurse has successfully completed an approved programme of preparation and training for nurse independent prescribing.

A pharmacist independent prescriber must be a UK-registered pharmacist with an annotation signifying that the pharmacist is qualified as an independent prescriber.

All nurses and pharmacists who are selected to train as independent prescribers must have the opportunity to prescribe in the post that they will occupy on completion of their training

and the area in which they will prescribe should have been identified before they begin their prescribing training. This will almost always be in the field in which they already hold considerable expertise.

Nurses should be able to study at level 3 (degree level), have three years post registration experience – the last of those three being in the clinical area in which they intend to prescribe – and they must be able to carry out a comprehensive assessment.

Pharmacists should have at least two years' experience in a clinical environment following their pre-registration year after their graduation. Their employing organisation should be satisfied that the pharmacist is competent to prescribe in the area in which they will prescribe following training.

All non-medical prescribers must ensure via PDP/CPD processes that they maintain and develop their competencies in relation to prescribing activity. The KSF outlines for the postholder must include an overview of prescribing knowledge and skills that must be evidenced against a review.

The non-medical prescriber is responsible for their ongoing professional development but organisations will facilitate and enable the development as appropriate.

3.3 Clinical governance requirements for supplementary prescribing

- Clear lines of responsibility and accountability for overall quality of clinical care – supplementary non-medical prescribers agree in advance with the independent prescriber how to maintain continuity of service user care when they are not available
- Clinical audit – clinical audit units include non-medical prescribing in their audit programmes and non-medical prescribing is monitored as part of overall prescribing monitoring. Supplementary prescribing should be monitored to ensure it stays within clinical management plans.
- For supplementary non-medical prescribing the clinical management plans should be patient specific and up to date.
- Supplementary non-medical prescribers will meet regularly (at least annually) with the independent prescriber.

- Prescribe according to the clinical management plan agreed with the independent prescriber.
- Refer all patient circumstances that fall outside the clinical management plan, or outside their competency, to the independent prescriber.
- Develop an effective relationship with the independent prescriber.

3.4 Clinical governance requirements for independent prescribing

Non-medical prescribers must have in place comprehensive professional indemnity insurance which may be obtained from their professional organisation or trades union. The indemnity choice must provide adequate cover for prescribing practice.

Each qualified non-medical prescriber is individually and professionally accountable for their prescribing decisions including actions and admissions and cannot delegate this accountability to any other person. Each non-medical prescriber is also expected to work within the standards and code of professional conduct as set out by their own regulatory body as well as their policies and guidelines ratified by their employing organisation. They must be able to recognise and deal with pressures, e.g. from the pharmaceutical industry or colleagues, that might result in inappropriate prescribing (DH 2006).

Other pertinent principles of clinical governance for independent non-medical prescribing can be broken down into those relating to employing health organisations and those relating to individual non-medical prescribers, as follows:

For employing organisations:

- Clear lines of responsibility and accountability for overall quality of clinical care – non-medical prescribing is included in reports on quality of clinical care to local clinical governance committee or equivalent.
- Clinical audit – clinical audit units include non-medical prescribing in their audit programmes and non-medical prescribing is monitored as part of overall prescribing monitoring.
- Evidence based practice – ensure that national guidelines, local guidelines, local agreements and formularies are disseminated to all non-medical prescribers.

- Monitoring of clinical care – patients' experience of non-medical prescribing is included in surveys of patients' experience of substance misuse services and non-medical prescribers are supported to be able to participate in clinical governance programmes.
- Workforce planning and development is integrated in organisations' service planning – ensure CPD (which may include peer review and support and mentoring), is built into planning, that succession and contingency plans are in place and that service users are involved and their opinions taken into account.
- Risk management programmes – non-medical prescribing should be included in clinical risk management, patient safety, confidentiality, handling complaints and controls assurance programmes.
- The Trust will accept vicarious liability for non-medical prescribers who adhere to the Trust non-medical prescribing policy.
- Management of poor performance – all organisations employing non-medical prescribers should have systems in place for identifying poor professional performance, as for other prescribers. Prescribing responsibilities need to be considered as part of this process.

For individual non-medical prescribers:

- Clear lines of responsibility and accountability for overall quality of clinical care – supplementary non-medical prescribers agree in advance with the independent prescriber how to maintain continuity of service user care when they are not available, and all non-medical prescribers comply with local, national and professional standards relating to dealing with the pharmaceuticals industry.
- Clinical audit – non-medical prescribers participate in local clinical audit activity relating to their scope and quality of prescribing practices.
- Clinical guidelines and evidence based practice – non-medical prescribers keep up to date with and prescribe according to local or national standards and guidelines, with reference to best evidence-based practice.
- Continuing professional development – non-medical prescribers are expected to keep a CPD portfolio which includes a review of prescribing, related critical incidents and any learning (critical incidents may be recorded in a separate log). Non-medical prescribers will be expected to participate in local prescriber learning sets or peer groups; with their

managers, identify training needs in relation to prescribing and develop ways of meeting them.

- Monitoring of clinical care – non-medical prescribers will take part in audits of clinical record keeping and medicines monitoring information, audits of the communications pathways they use and audits of whether service users have received appropriate information about their prescribed medication.
- Risk management – non-medical prescribers will participate in local clinical risk assessment and management programmes, report any relevant adverse drug reactions or critical incidents according to local and national procedures. They will be aware of service patient complaints procedures and use complaints to identify learning needs and areas for development. They will ensure they have an appropriate level of professional indemnity insurance.

4 Information sharing, confidentiality, consent and child protection

4.1 Confidentiality and information sharing

Clinicians must be satisfied that local decisions concerning information sharing are consistent with GMC guidance and guidance from the local Caldecott Guardian. Patient consent is required in most situations where identifiable information is shared and information will be shared on a “need to know” basis only. Whenever a confidential relationship is entered into the boundaries of this confidentiality must be discussed with the patient so that they understand what it means and how and when information is likely to be shared.

Information sharing can be of great value to the direct care of individual service users and may also contribute indirectly to the more effective delivery of the drug treatment system. Many patients, including those involved in drug treatment through the criminal justice system, will, following appropriate discussion, be quite willing to consent to share appropriate personal information with others on a need-to-know basis. It is important to maintain public confidence in the confidential nature of personal health information, while at the same time optimising use of such information. Local protocols on information sharing arrangements between the criminal justice system and health and social care providers of drug treatment can be particularly useful to describe and facilitate suitable information sharing arrangements that are both consistent with legal and ethical obligations and avoid unnecessary barriers or delays.

4.2 Considering the needs of the children of drug using parents

Hidden harm (ACMD 2003) estimates that there are between 250,000 and 350,000 children of problem drug users in the UK: about one child for every problem drug user, and that parental problem drug use may cause serious harm to children at every age from conception to adulthood. Importantly the report acknowledges that effective treatment of the parent can have major benefits for the child. The report set out expectations that a local treatment system should work together to ensure that adequate steps are taken to protect and improve the health and well-being of affected children. Clinicians and services need to take account of local frameworks, which are now in place in most areas.

Clinicians have an individual responsibility to the children of their patients. They need to take systematic steps to ensure that they assess risk to children (such as making sure that

detailed knowledge of a patient's children and risks to them are ascertained as part of all assessments. If a clinician suspects a child may be at risk they must take steps, if necessary immediately, to deal with that risk. This may require referral to involve others such as social services (according to relevant frameworks and protocols). This must be done with the patient's knowledge if possible but not necessarily with their consent.

4.3 Young people who misuse substances

The boundaries around confidentiality and information sharing for young people may be different from adults in two respects: a) if a young person is deemed at risk of significant harm, and b) where involvement of those with parental responsibility is required or agreed. As with adults, confidentiality agreements for offenders may be different than other clients (see *The National Specification for Substance Misuse for Juveniles in Custody* (2004) which states that interventions must be undertaken within clear confidentiality arrangements, and that information about a young person's medical needs and interventions should be used to inform substance misuse care plans).

4.3.1 Information sharing and child protection

Confidential information will be disclosed to others if a clinician thinks the child is suffering, or likely to suffer, significant harm and if such disclosure might be of value; for example to promote and safeguard the welfare of a child. In these instances the clinician should operate in accordance with local guidelines.

4.3.2 Informed consent and competence to consent

Issues around consent for treatment and competence to consent are different for young people than for adults. Informed consent is a legal requirement for adults and young people. With those under 18 informed consent requires an individual to be 'competent' or have the capacity to consent.

There are different legal and statutory requirements required in England and Wales to Scotland and Northern Ireland, of which clinicians should be aware.

If a child, or a young person under 18 years old, is **not** competent to consent to his or her own treatment, consent should be sought from a person with '**parental responsibility**'. Legally, consent is needed from one person with parental responsibility, although it is good practice to involve all those close to the child in the decision making process.

5 Drugs and driving

5.1 Driving licence requirements

The Driver and Vehicle Licensing Agency (DVLA) regularly publishes new editions of its *At a glance guide* (DVLA 2007) which sets out the medical standards required for the holding of driving licences. This document outlines the regulations on persistent misuse of drugs.

Under the terms of the Road Traffic Act, holders of a driving licence are required to inform the Driver and Vehicle Licensing Agency (DVLA) in Great Britain or Driver and Vehicle Agency (DVA) in Northern Ireland of "... any disability likely to affect safe driving".

Drug misuse, whether or not amounting to dependency, is regarded as a disability in this context. However the focus and emphasis is on dependent and persistent misuse that is likely to impair driving. If dependent, then the use of prescribed medication to treat drug/substance misuse constitutes a relevant disability and is subject to specific rules in order to obtain permission to continue to retain their licence.

The responsibility to inform the licensing agency of their current medical status lies with the licence holder, not the prescribing clinician or drug service.

A patient with a Group 1 driving licence will be required to undergo a short independent medical examination which will include a urine screen for drugs. If there are only methadone metabolites in the urine, a licence will usually be issued for one year at a time, until three years have elapsed since the cessation of treatment. The issue of a licence is subject to the conditions that the person is on a supervised methadone maintenance course, has been stable for the past year and is supported by a favourable medical report.

On re-application, the patient will have to undergo a medical. This will include a urine screen for drugs. They will be called back for another medical every year until three years after methadone treatment has finished.

The driver licensing agencies will not issue a Group 2 (HGV/PSV) to anyone receiving methadone treatment. A patient with a Group 2 (HGV/PSV) licence, who informs one of the agencies that they are receiving methadone on prescription, will have that licence withdrawn for a minimum of three years.

If a urine screen carried out for an agency medical examination shows persistent misuse of cannabis, the licence will be withdrawn for one year. If it shows positive for any other drug,

they will withdraw the licence for a minimum of one year, but this may be up to three years in cases of persistent misuse. There will be another medical on re-application and every year for the first three years after the licence has been returned.

5.2 Driving under the influence of drugs

It is an offence to be in charge of a vehicle if “unfit to drive through drink or drugs”.

A patient taking a prescribed drug like methadone would not automatically be considered by the courts to be unfit to drive.

The General Medical Council’s code states that doctors “should explain to patients that they have a legal duty to inform the DVLA about their condition. If patients refuse to accept the diagnosis or the effect of the condition on their ability to drive, you can suggest that the patients seek a second opinion, and make appropriate arrangements for the patients to do so. You should advise patients not to drive until the second opinion has been obtained. If patients continue to drive when they may not be fit to do so, you should make every reasonable effort to persuade them to stop. This may include telling their next of kin, if they agree you may do so. If you do not manage to persuade patients to stop driving, or you are given or find evidence that a patient is continuing to drive contrary to advice, you should disclose relevant medical information immediately, in confidence, to the medical adviser at the DVLA. Before giving information to the DVLA you should try to inform the patient of your decision to do so. Once the DVLA has been informed, you should also write to the patient, to confirm that a disclosure has been made.” (GMC 2007)

5.3 Risk assessment

The responsibility for determining whether or not a patient’s driving is putting the public at risk is not a clinician’s alone but also that of the treatment service, although a prescriber cannot deflect their responsibility.

A review (Tunbridge et al 2000) for the European Union categorised the overall risk to traffic safety caused by different drugs and combinations as follows:

- high risk: alcohol, benzodiazepines, cannabis + alcohol
- high-moderate risk: cocaine
- moderate risk: cannabis, amphetamines

- low-moderate risk: opiates, methadone, antihistamines
- low risk: antidepressants.

There are also stages in treatment when a patient may be at greater risk of their driving being impaired. These include:

- dose induction and dose adjustment
- detoxification
- change to injectable opioid treatment.

5.4 Disclosure and breaching confidentiality

Whether or not clinicians should take the step of breaching confidence and informing the driver licensing agency without their patient's consent, if they are concerned about their patient's ability to drive or if the patient is driving passenger or heavy goods vehicles, is a complex but real ethical issue.

Clinicians should make, and document, an assessment of risk assessment before deciding whether to break confidentiality in the public interest.

5.5 Action with patients

Some services find it helpful to issue patients with an information leaflet on their rights and responsibilities in relation to driving (and other issues). It may also be appropriate to record the fact that this information has been given (especially where there are concerns).

Patients should be advised that they:

- should not drive for 4-5 days after beginning an opioid treatment or after a dose increase
- should not drive if they ever feel sedated
- should report sedation/unsteadiness/cognitive decline immediately to the physician so that reduction in dosage can be initiated
- should not use alcohol or other drugs that impair performance, such as cannabis and antihistamines, and drive

- should not make any changes in their medication regimens without consulting with the prescribing service.

Further information can be obtained from:

The Senior Medical Adviser
DVLA
Driver Medical Unit
Longview Road
Morrison
Swansea
SA99 1TU
www.dvla.gov.uk

or the Driver and Vehicle Agency in Northern Ireland
www.dvni.gov.uk

6 Involving carers

Families and carers of drug misusers are both an important resource in treating the drug misuser and often in need of support for themselves. Depending upon the relationships between patients and their carers, and bearing in mind the patient's right to confidentiality, in as far as it is possible and practicable, information should be exchanged both ways between clinicians and carers, and carers should be active partners in drug misuse treatment.

Carers should be offered specific information and advice on:

- the risks from blood-borne viruses and overdose and, if appropriate, should be offered vaccination
- safe storage of medicines.

It is recommended that clinicians:

- make themselves accessible to family members and carers with the consent of the patient
- assess and take account of the needs of family members and carers, including the welfare of dependent children, siblings and vulnerable adults
- provide verbal and written information and advice on the impact of drug use and about treatment and the settings in which it may take place
- provide information about self-help and support groups for families and carers
- consider family or couples-based interventions.

If families and carers have been offered but not benefited from guided self-help and/or support groups and continue to have significant family problems, consideration should be given to providing formal psychosocial interventions.

National Institute for Health and Clinical Excellence (NICE) guidelines on detoxification (NICE 2007a) and on the psychosocial management of drug misuse (NICE 2007b) (see section #3, chapter #5 and section #5, chapter 4) detail the general and specific interventions that healthcare professionals should offer to carers.

CHAPTER 3

ESSENTIAL ELEMENTS OF TREATMENT PROVISION

Key points

- All drug misusers should be appropriately assessed.
- All drug misusers entering structured treatment should have a care or treatment plan which is regularly reviewed.
- Drug misuse treatment involves a range of appropriate interventions, not just prescribing.
- A named individual should manage and deliver aspects of care or treatment planning to patients.
- Appropriate drug testing is useful.

1 Assessment, planning care and treatment

Good assessment is essential to the continuing care of the patient. Not only can it enable the patient to become engaged in treatment but it can begin a process of change even before a full assessment is complete. Assessment skills are vital for all clinicians and members of a multidisciplinary team, including drugs workers, psychologists, nurses and doctors. Clinicians need sufficient competencies to be able to assess client need.

1.1 Introduction

Patients present, or are referred, to drug treatment services for a variety of reasons. Patients may consult a clinician for a medical problem without mentioning any drug use or misuse. By maintaining an empathic, non-judgemental attitude, the clinician may encourage appropriate disclosure.

Irrespective of the drug of misuse with which the patient presents, the same fundamental aims of assessment apply.

In most circumstances assessment may take more than one consultation, and may be done by more than one clinician. The nature of the first consultation will depend upon whether or not the clinician is aware that the patient is seeking advice about a drug-related problem. If this is the first contact, it may be helpful to offer a longer appointment which allows enough time for a full diagnostic interview and physical examination. It may be appropriate for concerned relatives or professionals already involved to attend with the patient. With patients under 16 years, this may be required. Doctors should have a significant role in health education regarding drug misuse, and will find value in giving accurate information to minimise the harm of more persistent drug taking and the risks of developing significant dependence.

Treatment goals

For some years now, a range, or hierarchy, of goals of drug treatment has been identified in the UK (ACMD 1988, 1989; DH 1996). These are:

- reducing health, social, crime and other problems directly related to drug misuse
- reducing harmful or risky behaviours associated with the misuse of drugs (e.g. sharing injecting equipment)

- reducing health, social or other problems not directly attributable to drug misuse
- attaining controlled, non-dependent or non-problematic drug use
- abstinence from main problem drugs
- abstinence from all drugs.

In their broadest sense, "...harm reduction policies, programmes, services and actions work to reduce the health, social and economic harms to individuals, communities and society that are associated with the use of drugs" (UKHRA 2005).

Reducing harm from an individual's drug use will be an important element of care, especially during the engagement phase of treatment. The principle of a hierarchy of goals is a useful one in helping patients look at any of their treatment objectives in a systematic manner.

1.2 Assessment

Assessment should be seen as a process that may need to be conducted over several sessions or consultations.

After a brief initial assessment involving a risk assessment, clinicians may find it useful to develop a brief initial plan of care with the patient to address immediate concerns (e.g. access to clean injecting equipment for drug injectors together with advice to reduce risk of overdose and contracting blood borne viruses).

For drug misusers with severe problems, the assessment process may involve a number of professionals as patients may have treatment and care needs in the domains of drug and alcohol misuse, health (physical and psychological), social functioning including housing and employment, and criminal involvement (particularly if the clinician is working closely with the criminal justice system or providing drug treatment in prison).

Assessment of risk

Assessing risk is an important part of assessment. Substance misuse specific risks that may need to be prioritised could include risks related to overdose, poly drug and alcohol use or unsafe injecting practices. Wider risks may include self-harm or harm to others, especially children living with the patient.

1.2.1 Aims of full assessment

A substance misuse assessment should include:

- treating any emergency or acute problem.
- confirming the patient is taking drugs (history, examination and drug testing).
- assessing degree of dependence.
- identifying complications of drug misuse and assess risk behaviour.
- identifying other medical, social and mental health problems.
- determining the patient's expectations of treatment and the degree of motivation..
- determining the need for substitute medication – with advice from a doctor with more competencies in the treatment of drug misuse (if appropriate, see section #1, chapter #2).
- with young people, assessing competency to consent to treatment (if required) and involving those with parental responsibility as appropriate. If risk of significant harm to the young person is found, involve other professionals according to local child protection requirements. Local assessment proformas or processes specifically designed for young people may also need to be used and different professional competencies may be required.
- in private practice, establishing that the patient is able to pay for treatment through legitimate means

The assessment process also provides an excellent opportunity for clinician to provide brief interventions to reduce immediate harm from drug misuse including, if appropriate, access to sterile needles and syringes, testing for hepatitis and HIV, and immunisation against hepatitis B.

It is also important to assess the most appropriate level of expertise required to manage the patient (this may alter over time), and refer/liaise appropriately (e.g. to a clinician with more competencies in treating drug misuse and/or psychosocial interventions). Clinicians will also need to notify the patient to the relevant national drug monitoring system using the appropriate local reporting form or system.

The assessment process should result in a written document that can be referred to and used as a basis for discussing care planning, goals and objectives with the patient.

Assessment is discussed in:

- *Models of care: update 2006* (NTA 2006)
- *Care planning practice guide: update 2007* (NTA 2007a)
- *Needs assessment: a practical guide to assessing local needs for services for drug users* (Scottish Effective Interventions Unit 2004)
- forthcoming In-depth Integrated Specialist Assessment Toolkit In Wales.

1.3 Care or treatment plan

Following taking a full history and completing an assessment, a care or treatment plan should be agreed with the patient. It should normally cover patient need as identified in one or more of the following domains:

Drug and alcohol use

- drug use, including types of drugs, quantity and frequency of use, pattern of use, route of administration, source of drug (including preparation) and prescribed medication
- alcohol use, including quantity and frequency of use, pattern of use, whether in excess of “safe” levels and alcohol dependence symptoms.

Physical and psychological health

- physical problems, including complications of drugs and alcohol use, blood-borne infections and risk behaviours, liver disease, abscesses, overdose and enduring severe physical disabilities. Pregnancy may also be an issue
- psychological problems include personality problems or disorders, self-harm, history of abuse or trauma, depression and anxiety and severe psychiatric co-morbidity. Contact with mental health services will need to be recorded.

Criminal involvement and offending

- legal issues including arrests, fines, outstanding charges and warrants, probation, imprisonment, violent offences and criminal activity. Involvement with workers in the criminal justice system, for example probation workers.

Social functioning

- social issues, including childcare issues, partners, domestic violence, family, housing, education, employment, benefits and financial problems.

It will be rare that a clinician will be able to meet patient need if they have a serious substance misuse problem or unmet need in a range of domains. A patient may have need for prescribing interventions plus a need for psychosocial interventions, help with housing or benefits etc. This often requires clinicians to have input from or facilitate referral to a range of other professionals.

The assessment of young people will require additional components, e.g. comprehensive educational needs and development needs (NTA 2007b).

Clinicians will need to be able to track progress with patients around their range of needs and record progress in the plan of care or care plan. It may be useful to have named clinicians for aspects of a patient's treatment, with a lead clinician named in the treatment or care plan.

1.4 Discharge from drug treatment and ensuring support to prevent relapse

If a patient has successfully completed drug treatment, they still may have ongoing needs to prevent relapse into drug and alcohol misuse. Drug misuse is a chronic relapsing condition and patient may require psychosocial support for some time. This may be provided through organisations such as Narcotics Anonymous (NICE 2007). Ongoing support and help to maintain health and well-being from a GP may also be vital to success, together with support from social care providers (housing, education or employment access schemes, etc). It is also important that patients can gain speedy access back to drug treatment if they relapse.

2 Delivery of treatment

The delivery of treatment is normally through a key individual or clinician sometimes known as the keyworker. This may be a doctor, a nurse, a voluntary sector drugs worker, etc. The clinician in most regular contact with the patient is normally the keyworker and, if the patient has complex needs, it is important that this is a single named individual. Keyworking helps to ensure the delivery and ongoing review of the care or treatment plan. This would normally involve regular sessions or consultations with the patient in which progress against the care plan would be discussed and goals revised as appropriate. As good practice, keywork involves building a therapeutic relationship with the patient (see section #1.2, chapter #4). The content of keywork sessions is dependent on individual patient needs but would normally include the following:

- developing and agreeing the care or treatment plan with the patient, implementation of the plan and checking progress against its milestones
- information and advice on drug and alcohol misuse
- interventions to prevent relapse
- harm reduction work and motivational interventions
- other psychosocial and medical interventions depending on the competency of the keyworker
- helping to address social needs, for example benefits
- taking responsibility for child protection if relevant.

In primary care, the keyworker may be the GP or drugs worker supporting the GP in a shared care arrangement. In this setting, the keyworker will still work within a care and treatment planning framework that adheres to the principles described above. Therefore, the care or treatment plan will describe how the specific roles and responsibilities of the GP, the shared care worker and any others involved will be shared in delivering co-ordinated care. Shared responsibilities will include monitoring of compliance and continuity of care. The GP is likely to lead on prescribing interventions, changes and additions to medication, and addressing health care needs. The shared care worker is likely to lead on monitoring progress against treatment goals, developing a holistic treatment plan and in ensuring multidisciplinary discussion when appropriate. For GPs working at a more specialist level (e.g. GP with

special interest) the roles may be different but in all cases this should be clear in the care plan.

In secondary care the keyworker may be a nurse or drugs worker but doctors may also keywork some patients and have an advisory or supervisory role for others, depending on local arrangements. In specialist drug treatment services, the keyworker is often part of a multi-disciplinary team and responsible for co-ordinating patient care when more than one clinician or service is delivering treatment to a patient, e.g. a patient who is receiving psychosocial interventions from a psychologist to address specific issues in addition to being on a methadone programme and having regular keyworking sessions.

2.1 Care planning in other groups with externally co-ordinated care

Individuals with severe mental health problems whose care is co-ordinated under the care programme approach (CPA), particularly those on the current “enhanced” CPA, will have a named mental healthcare co-ordinator. The structured drug treatment providers usually contribute to elements of the mental health CPA plan of care.

Those who are under supervision or treatment orders from the criminal justice system will need careful integration of planning of their structured treatment to optimise outcomes (e.g. in the case of those on community sentences requiring drug treatment). The probation service (or Criminal Justice Social Work in Scotland) may have information (particularly regarding risk issues and offending behaviour) that may need to be incorporated into the care plan.

Patients receiving community care funding (e.g. someone in residential rehabilitation) may have the co-ordination of their care and case management provided by a community care manager (sometimes drug-specific).

Young substance misusers (those under 18 and those under 16) may have the primary responsibility for delivery of a holistic treatment and care plan located with child and adolescent mental health services, social services team or young offenders team, etc. In these situations drug treatment clinicians may need to work closely with other professionals and participate in multi-disciplinary meetings which focus on all the young person’s needs and which co-ordinate care.

3 Drug testing

3.1 Introduction

Illicit and prescribed drugs can be tested for in a range of biological samples using different testing methods. These combinations are able to detect different drugs and their metabolites. A test may be specific, i.e. provide information on the target drug and may or may not also be sensitive, i.e. test for varying amounts of drugs. An example of a specific test is one that can test for a range of particular opiate drugs rather than just the opiate group. A sensitive test can provide information on a very small concentration of the drug within the sample. This may depend on the cut-off level for a positive result set by the manufacturer of the test. Hair testing has the longest window of detection (as long as 90 days after substance ingestion) and oral fluid the shortest (most drugs are only detectable within 12-24 hours of use). No routine drug test provides information about amounts consumed.

Urinalysis remains the most versatile biological fluid for drug screening and has the advantage of indicating drug use during the previous few days (longer with cannabis, methadone and diazepam). Random intermittent interval urine drug screening is probably the most practical and cost effective option for providing sensitive, specific and reliable information about an individual's drug misuse.

Oral fluid testing has the advantage of being easier to collect and less easy to adulterate. However, the detection windows are shorter than for urine and the evidence base for their sensitivity and specificity is less good.

Tests of urine or oral fluid can either be for screening or confirmatory purposes. Screening tests are usually immunoassay and often point-of-care tests (dipsticks). Confirmation tests provide greater specificity and sensitivity and usually involve GC-MS or LC-MS (gas or liquid chromatography – mass spectrometry) done in a laboratory. Confirmatory tests may be required where greater certainty is required about a result.

Staff administering tests should be competent in taking samples and, if appropriate, in reading results. Laboratory testing should be done in appropriately accredited laboratories.

3.2 Uses of testing

Drug testing can be used for:

- initial assessment and confirmation of drug use (although testing does not confirm dependence or tolerance and should be used alongside other methods of assessment)
- confirming treatment compliance, i.e. that a patient is taking prescribed medication
- monitoring illicit drug use
- contingency management.

The rationale for testing and the use made of drug test results is important and must be clearly delineated to those responsible for patient care, in order to be cost effective and efficacious.

Drug testing to confirm drug use when a patient has admitted to it and is already in treatment is generally not cost-effective.

3.3 Resources

Resource implications for performing biological tests need to be taken into consideration.

The “gold standard” of drug testing is still gas or liquid chromatography with mass spectrometry (GC/MS or LC/MS). In addition to being commonly used for confirmatory testing this “gold standard” must be used when testing is for forensic purposes or may otherwise have serious consequences for on a patient or their family, e.g. child protection cases.

However, alternative forms of testing may be quicker, cheaper, easier and suitable for other purposes. Qualitative non-specific screening tests (for urine or saliva) such as those employed in point of collection test kits (immunoassay tests) report either a positive or a negative result for a group of drugs. These types of tests are unable to identify a specific compound.

3.4 Procedures

It is normal practice to have written procedures for the collection, storage and dispatch of biological samples to the laboratory and for the discussion and management of reporting

results. The time of sample collection should always be noted and related to the consumption over the last few days of both prescribed and illicit substances. In addition, standard operating procedures should include, where relevant, storage of test strips, calibration of equipment, infection control procedures, disposal of biological fluids and clean areas for testing.

Collection procedures should aim to ensure the integrity of specimens. In routine clinical practice strict supervision of specimen collection is not necessary. If necessary, steps which may be taken to limit the opportunities to tamper with specimens include checking toilets (or other specimen collecting areas) for previously hidden specimens or adulterants; requesting that the patient takes no bags, coats, other people, etc. into the toilets with them; general observation of the specimen for colour or possible additives; measurement of the temperature of the specimen, e.g. through the use of temperature strips on urine pots; testing for methadone metabolites (to ensure methadone has not been added to a specimen); use of dipsticks to ensure specimen is urine by the measurement of creatinine; use of dipsticks to check for the possible presence of adulterants (e.g. by measurement of pH, specific gravity, presence of bleach etc.).

In cases where serious consequences might follow a positive (or negative) test, the procedure should be more rigorous and, in addition to the above, might include greater security of the specimen collection site; steps to reduce tampering or adulteration; clear identification of the specimen and secure packaging for delivery to the testing site.

It will only be very occasionally be necessary to directly observe a specimen, and then only with full patient consent.

3.5 Contingency management

The issue of contingency management is discussed in more detail in chapter #4. There is evidence supporting contingency management approaches using negative urine tests as the behaviour to be rewarded. However, rewarding other treatment-related behaviours may be more powerful. It is likely that effective contingency management programmes will be those that do not only reward negative urine tests.

3.6 Approximate duration of detectability of selected drugs in urine

Substance	Duration of detectability
Amphetamines/amfetamines	48 hours
Methamphetamine/methamfetamine	48 hours
Barbiturates	
short-acting	24 hours
intermediate-acting	48–72 hours
long-acting	7 days or more
Benzodiazepines	3 days (therapeutic dose)
ultra-short-acting (half-life 2hrs) (e.g. Midazolam)	12 hours
– short-acting (half-life 2–6hrs) (e.g. Triazolam)	24hrs
– intermediate-acting (half-life 6–24hrs) (e.g. Temazepam/Chlordiazepoxide)	40–80hrs
– long-acting (half-life 24hrs)(e.g. Diazepam/Nitrazepam)	7 days
Cocaine metabolites	2–3 days
Methadone (maintenance dosing)	7–9 days (approximate)
Codeine/Morphine/Propoxyphene (Heroin is detected in urine as the metabolite morphine)	48 hours
Norpropoxyphene	6–48 hours
Cannabinoids (Marijuana)	
– single use	3 days
– moderate use (4 times per week)	4 days
– heavy use (daily)	10 days
– chronic heavy use	21–27 days
Methaqualone	7 days or more
Phencyclidine (PCP)	8 days (approximate)

4 General health assessment at presentation and during treatment

Early assessment of the general health status of an individual revealing a drug problem is important and may be best carried out by the person conducting the initial assessment of the problem. This is not always the GP or a specialist drug service worker. Increasingly the entry point into treatment or the route by which individuals are directed into specialist care begins with a non-specialist worker such as a generic counsellor, a pharmacist, a non-statutory care agency, a midwife or a community or practice nurse. Presentation may be directly connected with drug taking, a complication of drug use or drug use lifestyle, or as an incidental finding.

The prescriber should ensure that health care assessment, screening and management are being provided for each patient – especially where specialist prescribing may be occurring for patients who are not registered with a GP.

As a general principle it is good practice to do a general health assessment, within the clinician's competency, and to decide whether or not an intervention is appropriate or inevitable, and whether this is urgent or can wait. Sometimes it will be obvious that there is a requirement for further and more detailed examination and perhaps laboratory or clinical testing and the most appropriate action is to refer to a medically qualified practitioner such as a GP or from primary care to a specialist clinic. The specialist clinic may be a drug or alcohol service or a clinic dealing with, for example, liver problems, cardiac and vascular abnormalities or respiratory diseases.

The aim of a health assessment is to identify unmet healthcare needs as well as to consider the presenting symptoms and to take account of health problems that could interact with drug treatment. There is also a need to take advantage of an opportunity to attract a patient into contact with health services and to improve the outcome of drug treatment by also improving general health and wellbeing.

Inevitably there are some conditions which commonly affect drug users; questions (Box 1) and examinations (Box 2) that might help to identify these are listed below. There are then tests that should be discussed and carried out on selected individuals according to need and decisions of the patient (Box 3). There are, in addition, possible health hazards connected with drug taking which might be important but which do not occur frequently and there is always the need for the clinician to keep an open mind about other, more unusual, health issues. The clinician might like to consider covering these areas over a series of consultations rather than attempting to unearth complex and sometimes longstanding

problems in a short consultation. One of the advantages of having patients in treatment is the ongoing contact and opportunities for medical and social interventions.

Box 1: Early assessment

Health-related questions to be considered addressed early in assessment

There is an overlap between the questions asked specifically in relation to health needs and those addressed as part of a comprehensive drug assessment (see section #1, chapter #3).

History taking should include questions about:

- presenting symptoms and perceptions of why the meeting is taking place
- past history of drug use and injecting drug use and alcohol use
- time spent in prison – any drug use and “homemade” tattoos
- current prescribed and non prescribed medication including cigarette, cannabis and alcohol consumption
- any allergies or sensitivities
- other past medical issues such as operations, injuries and periods in hospital
- history of overdose
- drug-related complications such as constipation, venous thrombosis, septicaemia and endocarditis
- presence of current or past infection with blood borne viruses and immunisations for hepatitis B and tests for hepatitis B and C or HIV carried out in the past
- psychiatric history and current symptoms
- contraception history past and present and cervical screening, menstrual and pregnancy history in women
- sexual health and sexually transmitted infections history
- dental health
- current contacts with statutory and non-statutory agencies.

Box 2: Relevant examinations early in assessment process

Examinations which may be relevant at an early assessment of the patient include:

- assessment of injection sites in all limbs and inguinal areas
- measurement of weight and height
- mental health assessment
- urine testing for common conditions such as diabetes and infection
- blood pressure measurement
- general impression of respiratory, cardiovascular and other systems, paying attention to symptoms offered and complaints given.

Box 3: Examinations and testing that may be required

Examinations and testing which may be required depending upon presence of risks, symptoms and physical signs:

- examination of respiratory system and, if necessary, simple pulmonary function tests such as peak flow and FEV/FVC
- examination of gastrointestinal system including liver
- pregnancy testing
- urinalysis for protein and sugar
- testing for the presence of blood borne virus infection in the past and hepatitis B immunisation
- hepatitis C antibody testing and PCR testing (for the presence of HCV RNA)
- other blood tests to assess liver function, thyroid function, renal function and haematological indices
- ECG if the patient is on a methadone dose greater than 100mg per day, has evidence of heart or liver disease, is being treated with CYP 3A4 inhibitors, using other QTc prolonging drugs, shows electrolyte abnormalities.

Initial management of general health and drug-related problems

Within their level of experience and competence the following tasks and interventions might be commenced or discussed with a drug misusing patient. This might be a single, an ongoing task or preparatory to referral to a specialist worker or colleague. There are occasions when an opportunity should not be missed to initiate a health care intervention as contact can be transitory and interrupted by events in a patient's disorganised life.

- treatment of acute episodes of illness
- information and advice about, and immunisation against, hepatitis B (and possibly hepatitis A)
- counselling and advice about testing for a blood-borne virus infection
- testing for a blood-borne virus infection
- cervical cancer screening
- family planning advice
- point of contact for general health information
- treatment of direct complications of injecting, including deep vein thrombosis and abscesses
- safer injecting and provision of injecting paraphernalia
- safer sex advice and referral to sexual health service.

It should be remembered that drug users, like others, are at risk from all diseases and should be included in screening programmes and health assessments. They are, in addition, susceptible to an increased range of problems and perhaps early onset of some degenerative diseases because of their lifestyle and risk activities. Consideration needs to be given to repeating the tests and investigations in those who continue to inject or to be uncontrolled in their drug use.

Drug misusers may suffer from poor nutrition but should only receive oral nutrition support if there are clear medical reasons to do so. They should be given advice on diet and nutrition, especially if drinking heavily.

Patients who are known to have injected in the past should be considered as at risk from drug-related complications and counselled and invited to be tested accordingly.

CHAPTER 4

PSYCHOSOCIAL INTERVENTIONS

Key points

- Treatment for drug misuse always involves a psychosocial component.
- Keyworking is a basic delivery mechanism for a range of key components including: the provision of drug-related advice and information, harm reduction interventions, interventions to increase motivation and prevent relapse and, help to address social problems.
- A good therapeutic alliance is crucial to the delivery of any treatment intervention, especially a psychosocial one: this may also be enhanced by interventions to increase retention in drug treatment.
- Discrete evidenced-based formal psychological interventions may be provided in addition to keyworking. These should be targeted to addressing assessed need.
- Discrete formal psychological interventions may be provided either to treat drug misuse related problems, e.g. cocaine misuse, or to address common associated or co-occurring mental disorders such as depression or anxiety.
- Psychosocial interventions can be delivered alongside a pharmacological intervention or alone, depending on assessed need and the goals of treatment.
- Psychosocial interventions are the mainstay of treatment for the misuse of cocaine and other stimulants, and for cannabis and hallucinogens.
- Self-help and mutual aid approaches, especially 12-step, have been found to be highly effective for some individuals and should be offered to patients seeking abstinence.
- The strongest scientific evidence base is for contingency management (CM). However CM is not widely provided in the UK and clinicians and services will need to be provided with appropriate guidance, training and support before it can be implemented.

1 Principles of psychosocial interventions

1.1 Psychosocial interventions and keyworking

Treatment for drug misuse should always involve a psychosocial component. Psychosocial interventions encompass a wide range of actions from “talking therapies”, such as cognitive behavioural or family therapy, to supportive work such as help with benefits.

Keyworking is a basic delivery mechanism for a range of psychosocial components including:

- regular reviews of care plans and treatment goals with the patient
- provision of substance misuse related advice and information
- interventions to reduce drug-related harm (especially risk of overdose and infections such as blood borne virus infections)
- psychosocial interventions to increase motivation
- psychosocial interventions to prevent relapse
- help to address social problems.

The keyworker is the dedicated and named clinician, usually in most regular contact with the patient, who is responsible for ensuring the patient’s care or treatment plan is delivered and reviewed. This is discussed in chapter #3. This individual may also deliver some or all of the psychosocial elements of care. Keyworking usually involves regular contact between the clinician and the patient and the development of a formal or informal treatment agreement. This may range from an agreement with a drug worker to have a series of one hour sessions to discuss cocaine problems, to the sustained relationship made during regular contact a patient may have with a GP who is treating a drug-related health problem. The strength of therapeutic alliance predicts early treatment engagement and treatment retention.

1.2 Therapeutic alliance

A good therapeutic alliance is crucial to the delivery of any treatment intervention, especially a psychosocial one. The competencies of the clinician or keyworker in building and maintaining any psychological intervention are important in patient outcomes. A recent Department of Health review (Roth and Pilling 2007) cites some of the key competencies as:

- the ability to engage a patient appropriately while demonstrating satisfactory levels of warmth
- the ability to build trust, and to be able to adopt a personal style that is consistent with and meshes with that of the patient
- an ability to adjust the nature of the intervention according to the capacities of the patient
- an ability to deal with difficult emotions, understand and work with a patient's emotional context including patient motivation.

1.3 Formal psychosocial interventions

In addition to the basic keyworking outlined above, discrete “formal” psychosocial interventions may be provided in addition. These may be either:

- to treat drug misuse related problems, e.g. where a formal contingency management programme is used to address persistent cocaine misuse in primary cocaine users or to address crack misuse among those on methadone maintenance programmes

or

- to address common associated or co-occurring mental disorders, e.g. cognitive behavioural treatment to address depression.

Formal psychosocial interventions or discrete packages of psychosocial interventions may be delivered alongside basic keyworking (and pharmacological interventions if appropriate). They may be delivered by a keyworker who has the required competencies or may be provided by other competent workers, e.g. in a primary care setting the GP may be the keyworker, while a formal package of psychosocial interventions may be delivered by a drug worker or psychologist. Individual clinicians may or may not have the time or competencies to deliver a full range of psychosocial interventions. Whatever the local arrangements, keyworkers need to have a basic understanding of what psychosocial interventions may be required and how to access them for their patients.

1.4 Targeting formal psychosocial interventions

Clinical decisions to provide formal psychosocial interventions, like other interventions, depend on an assessment of need. Evidence from research can also provide indications about which populations are likely to benefit from specific psychosocial interventions.

For example, where patients are resistant to engaging in programmes to prevent or address physical healthcare problems such as hepatitis B vaccination, contingency management may be a useful tool (NICE 2007a). Deciding whether an individual should be offered a formal psychosocial intervention should be made in careful discussion with the individual and the wider clinical team, and the keyworker should seek advice from specialists in the field as and when necessary. It is likely that the large majority of individuals may not be in receipt of formal psychosocial interventions at any one time. For example, perhaps around 30% of people in a methadone maintenance programme may benefit from a formal psychosocial intervention to address entrenched injecting behaviour or crack misuse, at particular points in their care. In contrast, formal psychosocial interventions might be considered as a first option for all individuals considering abstinence from cocaine. Similarly, a minority of drug misusers may require psychosocial interventions focused on couples or families.

Self-help and mutual aid groups and (such as Narcotics Anonymous) should be recommended for all drug misusers seeking to achieve and maintain abstinence. The patient then has a clear choice as to whether they participate in these groups outside formal treatment settings.

Psychosocial interventions may be targeted to address different substances of misuse. With some substances, psychosocial interventions are the only treatment available. This is discussed later in this section.

1.5 Individual versus group interventions

Many interventions can be provided either in groups or on an individual basis. Group interventions can be helpful and a good way of delivering effective care to a larger number of patients. However they are not popular with all patients.

2 Models and evidence

2.1 Psychosocial interventions and techniques currently used by keyworkers

Advice and information: the keyworker will provide the patient with appropriate advice and information about their drug misuse, its consequences and the treatments available. This will assist patients in making informed choices about what their treatment goals should be and which type of treatment and support is likely to help them.

Harm reduction: specific advice and techniques for reducing the harm from drug misuse should be provided, e.g. advice on safer injecting techniques and on minimising the risk of overdose.

Motivational interviewing and other motivational enhancement techniques: these include a collection of therapeutic principles, a set of counselling techniques, and more generally, a style of interaction in which the therapist takes the position of a collaborative partner in discussions with the patient about their drug use. Therapists use a set of specific skills, such as asking open questions, listening, and summarising the ideas the patient has expressed, and reflecting these back to them and providing affirmation. Underlying this approach is the principle that patients persuade themselves that change is desirable, achievable and will bring benefit. Motivational enhancement may be used to improve patient engagement in, and adherence to, treatment.

Relapse prevention: is an individual or group-based cognitive behavioural approach. A relapse prevention programme usually includes the following (Wanigaratne 2003): identifying high-risk situations and triggers for craving; developing strategies to limit exposure to high-risk situations; developing skills to manage cravings and other painful emotions without using substances; learning to cope with lapses; learning how to recognise, challenge and manage unhelpful or dysfunctional thoughts about substance use; developing an emergency plan for coping with high-risk situations when other skills are not working; learning to recognise how one is “setting oneself up” to use substances; generating pleasurable sober activities and relationships, improving quality of life and attaining a lifestyle balance.

Mapping techniques, e.g. node–link mapping: record interactions between a patient and a clinician, based on cognitive behavioural principles. The clinician and patient work together to produce visual maps of behaviours, relationships, emotions, coping strategies, etc. which assist in planning and executing treatment. These have been found to enhance both the

therapeutic relationship and treatment engagement, and to improve the patient's memory and understanding of the therapeutic session.

Other non-treatment interventions: include sport, exercise, skills-based interventions (such as programmes teaching computer skills) and similar activities, provided as part of a structured treatment programme which can be useful both to increase engagement in treatment and to improve physical health and well being. They may be recommended in conjunction with skills-based interventions such as programmes teaching computer skills.

Complementary and alternative therapies: may aid the building of a therapeutic alliance and enable patients to learn relaxation techniques. There is little evidence that they have a significant specific impact on drug treatment outcomes although they may increase treatment retention, which has itself been linked with improved patient outcomes. Complementary and alternative therapies should therefore be seen as an adjunct to drug treatment but are not a mainstay of treatment itself.

2.2 Formal psychosocial interventions to address drug misuse

The current draft NICE guideline on psychosocial interventions in drug misuse (NICE 2007a) identified a number of formal psychological treatments as having a high quality evidence base. It is important to remember that the absence of empirical evidence for the effectiveness of a particular intervention is not the same as evidence for ineffectiveness. Although the evidence base is rapidly expanding there are a number of gaps. These treatments are highlighted below because the evidence would suggest, on average, that they are more likely to have a significant clinical benefit. Clinicians should refer to the full NICE guideline for the detailed findings and recommendations, noting the caveats in the introduction to this update about their status outside England.

Brief motivational interventions: are brief opportunistic interventions focused on motivation that should be offered to people in limited contact with services if they have identified concerns about their drug misuse (e.g. attendees at a needle exchange or in primary care). They normally consist of one or two brief sessions between 10 and 45 minutes, which often focus on exploring ambivalence about changing behaviour and are offered in a non-judgemental way. For people not in contact with drug services (e.g. those in primary care, educational or occupational health settings), such interventions are likely to produce real benefit. However, they would not routinely be offered as the main intervention by a keyworker once there was a care plan for structured treatment.

Contingency management: operates by providing a variety of incentives in the form of vouchers, privileges, prizes or modest financial incentives, to modify a person's drug misuse or to increase health promoting behaviours. Contingency management is effective for people engaged in methadone maintenance programmes who are continuing to use illicit drugs and it is effective in promoting abstinence of people who are misusing stimulants. Contingency management can also have an important impact on a person's physical health care and the use of simple one-off incentives has proved to be effective in promoting engagement with and concordance with hepatitis B, hepatitis C and HIV testing, and hepatitis B vaccination programmes. It would normally be provided as part of a structured care or treatment plan in combination with other interventions provided by the keyworker.

This approach has been identified in the NICE guideline as having the strongest scientific evidence base for the most effective outcomes. However, contingency management is not commonly used formally in the UK and clinicians and services will need to identify and evaluate appropriate rewards and the behaviours upon which rewards are contingent. Guidance on the implementation of contingency management will be made available by NICE and the National Treatment Agency.

Behavioural couples therapy: is for patients who have an established relationship and a drug free partner who is willing to engage in treatment. There is good evidence that behavioural couples therapy focused on drug misuse can be of benefit to individuals with a range of drug misuse problems.

Family therapy: Family members may also benefit from self-help or support groups specifically focused on addressing carer needs. Support for families engaging with these groups can be a vital and important role for keyworkers. However, some families may not benefit either from guided self help or support for families. In these cases a rather more formal structured family therapy intervention should be provided which again focuses on drug misuse, discusses with families the sources of stress associated with drug misuse and tries to support and promote the family in developing more effective coping behaviours.

Mutual aid (self-help) approaches: are typically provided outside formal treatment agencies, but are nevertheless one of the most commonly travelled pathways to recovery. They come in different types, with the most widely provided being mutual aid groups based on 12 step principles, for example Narcotics Anonymous and Cocaine Anonymous. The benefits of these groups can be further enhanced if keyworkers and other staff in services facilitate contact with them, for example by making an initial appointment, arranging transport

or possibly accompanying patients to the first meeting and dealing with any subsequent concerns. These interventions can be of benefit to a wide range of people at different levels of the care and treatment system.

The 12 steps

1. We admitted that we were powerless over our addiction, that our lives had become unmanageable.
2. We came to believe that a Power greater than ourselves could restore us to sanity.
3. We made a decision to turn our will and our lives over to the care of God as we understood Him.
4. We made a searching and fearless moral inventory of ourselves.
5. We admitted to God, to ourselves, and to another human being the exact nature of our wrongs.
6. We were entirely ready to have God remove all these defects of character.
7. We humbly asked Him to remove our shortcomings.
8. We made a list of all persons we had harmed, and became willing to make amends to them all.
9. We made direct amends to such people wherever possible, except when to do so would injure them or others.
10. We continued to take personal inventory and when we were wrong promptly admitted it.
11. We sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out.
12. Having had a spiritual awakening as a result of these steps, we tried to carry this message to addicts, and to practice these principles in all our affairs.

Other self help approaches: include user support and advocacy, self-help manuals and websites, techniques such as relaxation, guided imagery, etc.

2.2.1 Other psychological therapies

Community reinforcement approach (CRA): is a cognitive behavioural approach originally developed for alcohol dependence. It involves specific types of counselling and skills training, tailored to the treatment goals of the patient, and is based on the principle that individuals will have their own reinforcers in the community, which maintain their behaviour (both substance using and non-substance using behaviours). The outcome of altering these reinforcement contingencies (and involving the patient's social network in this process) is that the individual will make changes in their lifestyle that will support the patient's goal of abstinence from substance use.

Social behaviour network therapy (SBNT): uses between four and eight treatment sessions to explore and build social network support for changing drug using and other behaviour. It is based on the community reinforcement approach, marital therapy, relapse prevention and social skills training approaches, and aims to develop positive social support for change in substance use and diminish support for continuing use.

Other psychological therapies: have been used in substance misuse services and these have been covered in the Wanigaratne et al (2005) review. Careful analysis in the NICE guideline did not suggest that there was good evidence that these should normally be offered as first line psychosocial treatments. However, they may be reserved for individuals who have not benefited from first line treatments such as brief interventions, contingency management and self help groups described above, or in cases where clinical judgement suggests this may be appropriate in the particular circumstances of the case. These other interventions include cognitive behavioural relapse prevention based therapy or psychodynamic therapy. Where treatments have a more limited evidence base it is important for those providing the therapy to make this clear to the patient and to regularly monitor the outcomes of these treatments.

2.3 Formal psychosocial intervention to address common mental disorders

Many drug users also have considerable co-morbid problems, particularly common mental health problems such as anxiety and depression. There is evidence that a range of evidence based psychosocial interventions (as described in relevant NICE guidelines) can be beneficial. Relevant guidelines include that for depression (NICE 2007b) which recommends a stepped approach to treatment which ranges from watchful waiting to short packages of CBT treatment or guided self help and in more severe cases to medication and CBT for a longer time. Similarly the NICE guideline on anxiety (NICE 2007c) recommends a stepped

approach using various CBT, self help and pharmacological interventions for general anxiety disorder and panic disorder of variable severity. Psychological approaches for other disorders such as post traumatic stress disorder (NICE 2005a), eating disorders (NICE 2004) and obsessive compulsive disorder (NICE 2005b) and for some patient groups, e.g. antenatal and post natal mental health (NICE 2007d) are also available.

Refer to section #4, chapter #7 for further advice on working with mental health problems in drug misusers.

3 Psychosocial interventions and different substances of misuse

For opioid and polydrug and alcohol misusers, psychosocial interventions may be provided in combination with a pharmacological intervention. There is evidence (Amato et al 2004) that the effectiveness of methadone maintenance is enhanced by the provision of psychosocial interventions.

For stimulant misuse, including for cocaine, and for cannabis misuse, there is no effective substitution agent. Hence, the mainstay of treatment is evidence based psychosocial intervention.

3.1 Cocaine and other stimulants

The mainstay of treatment for cocaine and other stimulant misuse is psychosocial therapy. Cocaine and other stimulant misusers are a heterogeneous group whose problems have a wide range of severity. Most severe are usually those engaged in polydrug misuse, especially combining heroin and cocaine but also cocaine and alcohol, and cocaine and benzodiazepines.

A primary cocaine user with a short history of use may benefit from a brief motivational intervention. A secondary crack cocaine user who is using the drug in combination with opiates is more likely to benefit from keyworking in combination with contingency management.

There is evidence of the effectiveness of self-help approaches (such as Cocaine Anonymous in cocaine misusers) and contingency management.

A range of accompanying physical and psychological problems such as weight loss or cocaine-related psychiatric problems may require appropriate medical or psychiatric interventions.

3.2 Cannabis use

GPs and other medical professionals may be faced with patients seeking help for their cannabis misuse or the side-effects of such use. In part, this may be a result of increasing availability and use of stronger forms of cannabis, usually known as “skunk”. High rates of consumption of any form of cannabis may cause physical and mental health problems.

Cannabis use can lead to significant dependence requiring appropriate treatment interventions, even though there may not be a prominent physical withdrawal syndrome.

Cannabis smokers are at risk from health-related problems. If they smoke cannabis with tobacco they are also risking all the same dependence and health problems as cigarette smokers.

Heavy cannabis users may experience symptoms such as depression, lethargy, paranoia and memory loss. Cannabis may also trigger symptoms of psychosis and may contribute to the development of longer-term problems in some individuals.

Cannabis may only be one of a range of drugs used by a patient and, like alcohol, its use may be increased by patients trying to reduce or stop using other drugs.

There are no medications suitable for treating cannabis misuse. Clinicians should consider psychosocial interventions, especially brief motivational interventions and cognitive behavioural therapies in more severe cases.

There is an online self-assessment and self-help programme at www.knowcannabis.org.

4 Competencies to deliver psychosocial interventions

Developing and supporting competencies in delivering effective planned care and in the role of the keyworker will underpin delivery of more specific interventions. Evidence suggests that a number of factors may have an impact on the performance of therapists in delivering specific interventions. These include adequate training in the delivery of the intervention and building training programmes around the identified competencies associated with evidence based interventions is one way to address this (Roth and Pilling 2007). In addition it is essential that effective supervision is delivered. Clinical trials of effective treatments are also often associated with the provision of effective and competent supervision (Roth et al 2007). This itself requires competencies in supervision and the associated activity of quality assurance in psychological treatment programmes. Services providing psychosocial interventions therefore need staff of sufficient seniority and competencies to provide effective supervision and to monitor the overall quality of treatment. There is also good evidence (Lambert et al 2001) that the routine monitoring of outcomes and appropriate feedback to individual clinicians can lead to significant benefits and improvements in outcome.

CHAPTER 5

PHARMACOLOGICAL INTERVENTIONS

Key points

- Dose induction should aim to achieve an effective dose while also exercising caution about the inherent risks of too rapid dose increase.
- Supervised consumption should be available for all clients for a length of time appropriate to their needs and risks.
- Clinicians should optimise opportunities for clients to be retained in and benefit from pharmacological treatments.
- Methadone or buprenorphine at optimal dose range are effective drugs for maintenance treatment.
- Opioid detoxification, using the medication the patient has been maintained on and in an appropriate setting, should be offered to patients ready for and committed to abstinence.
- Methadone, buprenorphine and lofexidine are all effective in detoxification regimens.
- Opioid detoxification should be offered as part of a package including preparation and post-detoxification support to prevent relapse.
- Where required, benzodiazepines should be prescribed at the lowest possible dose to control dependence and doses reduced as soon as possible.
- Psychosocial interventions are the mainstay of treatment for misusers of cocaine.
- Injectable opioid treatment may be suitable for a small minority of patients who have failed in optimised oral treatment.
- Patients should be made fully aware of the risks of their medication and their responsibilities to protect children and others.

1 Common issues

1.1 Prescribing

1.1.1 The responsibility of prescribing

Prescribing is the particular responsibility of the person signing the prescription. This includes non-medical prescribers whether working as a supplementary or independent prescriber. The responsibility cannot be delegated.

A decision to prescribe, what and how much to prescribe will depend upon:

- the overall treatment plan for the individual patient
- clinical guidelines
- locally agreed protocols
- the clinician's experience and competencies
- discussion with other members of a multidisciplinary team
- advice, where necessary, from a specialist in drug misuse.

In the context of prescribing, it is important to note that the British National Formulary (BNF) is a key reference. The dosages stated in this Update and in the BNF are intended for general guidance and represent (unless otherwise stated) the range of dosages that are generally regarded as being suitable for prescribing in the context of treating adults who have become dependent.

1.1.2 Deciding whether to prescribe

Before deciding whether to prescribe, the clinician should be clear as to the desired outcomes for the patient. These could be:

- reduce or prevent withdrawal symptoms
- offer an opportunity to stabilise drug intake and lifestyle while breaking with previous illicit drug use and associated unhealthy risky behaviours
- promote a process of change in drug taking and risk behaviour

- help to maintain contact and offer an opportunity to work with the patient.

A prescription for substitute medication should only be considered if:

- the opiate(s) is/are being taken on a regular basis – usually daily
- there is convincing evidence of current dependence (including objective signs of withdrawal symptoms wherever possible)
- the patient is motivated to change at least some aspects of their drug use
- the assessment (including history, examination and toxicology, drug diary) clearly substantiates the need for treatment
- the clinician is satisfied that the patient has the capacity to comply with the prescribing regimen.

Before prescribing substitute drugs the clinician should conduct a full assessment and agree a care or treatment plan with the patient. This process is described in more detail in section #1, chapter #3.

1.1.3 Prescriptions

There are strict rules governing the writing of prescriptions for medicines controlled under the Misuse of Drugs legislation. Detailed requirements are described in the British National Formulary and annex #2.

1.1.4 Communication between prescriber and dispensing pharmacist

The relationship between the prescriber and the pharmacist dispensing – and often supervising the consumption of – prescribed medicines is important. In many cases the pharmacist will also be supervising the consumption of the medication.

Prescribers should liaise with the pharmacist when first prescribing controlled drugs for a patient:

- to ensure the pharmacy has sufficient capacity to take on a new patient
- to introduce the pharmacist to a new patient; e.g. by offering a brief description / history, letter of introduction, shared care agreement (in some schemes the patient may be asked

to introduce themselves to the pharmacy themselves prior to starting a prescription which can help facilitate smoother initiation of treatment)

- to ensure the pharmacist is part of a suitable local scheme (e.g. a Locally Enhanced Service) and can provide supervised consumption of the prescribed medicine if requested by the prescriber
- to ensure the pharmacist is able to confirm the prescriber and prescription are genuine.

It is good practice that pharmacists will share relevant information with prescribers and other health care professionals and agencies in line with locally determined confidentiality agreements:

- when the pharmacist is aware that a patient is failing to comply with their treatment, for example when the patient has missed scheduled pick-ups
- when there are concerns about the patient's health or well-being.

Note: Pharmacists who are also operating a needle exchange scheme will not usually share information with the prescriber that a patient receiving prescribed medication is also obtaining supplies of injecting equipment from the pharmacy except where the pharmacist has the permission of the patient to do so.

1.1.5 Notification of substance misusers

In the past, all doctors in the UK were legally required to notify the Chief Medical Officer at the Home Office if they suspected that a patient was addicted to certain controlled drugs. The Addicts Index was closed in 1997 although Northern Ireland still maintains a Drug Addicts Index.

Prescribers are now expected to report details of substance misusers by returning special reporting forms to their regional or national drug misuse database. Details of national and regional centres can be found in annex #8 and in the British National Formulary.

1.1.6 Travelling abroad with controlled prescription drugs

When travelling abroad for any length of time, controlled drugs are carried at the risk of the individual, who is subject to legal requirements and restrictions of the country/ countries of transit and destination. These can be checked with the relevant embassies/consulate to

enquire about any restrictions in the country to be visited (contact details can be found at www.drugs.gov.uk). In general drugs should:

- be carried in original packaging
- be carried with a letter from the prescriber confirming the patient's name, destination, drug details / amounts
- meet carriers' requirements for hand and hold luggage.

Travelling for 28 days or less

Drug misusers in receipt of a prescription for a controlled drug can travel abroad with their supply. A Home Office licence is not necessary for planned stays of 28 days or less. The requirements listed above still apply.

Travelling for more than 28 days (but less than three months)

A Home Office personal export licence is required for planned stays of more than 28 days. The patient should download and complete the form available from www.drugs.gov.uk/publication-search/drug-licences/Personal and return it to Home Office Drugs Licensing with a letter from the prescriber stating:

- the name and address of the person
- their date of birth
- the strength
- the form
- the quantity of the drug
- the daily dose prescribed
- the person's date of departure and return.
- the country(ies) being visited.

There is nothing laid down about the maximum amounts that individuals may travel with and the Home Office advises that each case is treated on its merits.

The export licence is to allow the carriage of the drug out of the UK and any surplus back in. It does not mean that the holder of the licence has the right to take the drug into the country to be visited. Therefore, it is important that the user checks with the embassy or consulate before departure, to establish that the country/countries to be visited will accept the Home Office licence.

Anyone applying for a licence should allow at least two weeks, assuming all the information needed is contained in the letter from the prescriber, for the processing of the application.

A licence is obtainable from:

Home Office Drugs Licensing
6th Floor, Peel Building
2 Marsham Street
London SW1H 9AT
Tel: 020 7035 0467

<http://www.drugs.gov.uk/drugs-laws/licensing/contact-us/>

The requirements laid out above are similar for all/most prescribed drugs contained in Schedules 2, 3 and 4 of the Misuse of Drugs Regulations 2001.

Travelling for more than three months

Patients are advised to register with a doctor in the country they are visiting for the purpose of receiving further prescriptions.

1.2 Induction onto methadone and buprenorphine treatment

1.2.1 Introduction

Induction onto methadone and buprenorphine treatment is the process of starting a patient on a suitable dose of a substitute opioid and optimising the dose. It may take two to four weeks to achieve an optimal dose.

There is considerable research evidence (Capelhorn and Drummer 1999, Zador and Sunjic 2000) that the first two weeks of methadone treatment is a time of increased risk of death due to methadone toxicity. After the first two weeks, the risk of death due to opioid overdose during maintenance treatment falls to very low levels.

Healthcare professionals need to balance three competing pressures in prescribing for opioid-dependent drug misusers:

- to prescribe an effective and appropriate dose
- to minimise the risks of overdose during induction onto appropriate medication
- to rapidly respond to the patient's need for appropriate treatment in order to retain them in treatment and prevent harm from illicit drug misuse.

1.2.1.1 Dose optimisation

Buprenorphine and methadone are long-acting drugs. One key aim of maintenance treatment is to keep blood concentrations of these drugs within a narrow range, within which patients experience minimal intoxication and minimal withdrawal. During induction with methadone or buprenorphine, signs and symptoms of intoxication and withdrawal fall progressively, reducing the subjective sensations that drive drug seeking and drug use. This is the process of dose optimisation. If doses administered during induction are too high, intoxication will result. If doses are too low, they may not prevent the emergence of withdrawal symptoms and drug cravings for the full 24 hours between doses.

1.2.1.2 Managing risk

Death during induction remains a rare event but induction protocols should continue to be designed to minimise the risk of adverse events. This is the basis of the recommendations made in these guidelines.

1.2.1.3 Competencies of the professional

A healthcare professional who is experienced in the treatment of drug misuse (see section #1.5, chapter #2), and in the use of a particular medication, may feel more able to operate at the outer limits of, or even to depart from, these guidelines than an inexperienced clinician. Clinicians should work within a clinical governance framework and be prepared to justify their clinical decisions, and – especially when operating outside guidelines – should keep comprehensive notes to support their decisions.

1.2.1.4 Assessment

Appropriate assessment of the patient is critical – see section #1, chapter #3 on assessment, planning care and treatment.

1.2.1.5 Risk factors

Methadone

The risk factors for overdose during induction are:

- low opioid tolerance
- use of CNS depressant drugs, including alcohol
- too high initial dose
- too rapid dose increases
- slow methadone clearance.

There is an increased risk of death during induction into methadone treatment and a consistent finding is that multiple drugs, particularly benzodiazepines and alcohol, are usually involved. Opioids induce respiratory depression and hypoventilation, and sedative drugs potentiate this effect.

With methadone, toxicity is delayed, at least several hours after exposure, and often after several days of treatment. The reason for the delayed toxicity is that methadone has a long but variable half-life, measured at between 13 and 50 hours with chronic administration. Variation can occur between individuals and within an individual. The half-life can be affected by other factors such as alcohol consumption or other drugs taken. It takes five half-lives, or 3-10 days, for patients on a stable dose of methadone to reach steady state blood levels. The slower methadone is cleared, the longer it takes to reach steady state and the higher the steady state blood levels. During those 3-10 days, blood levels progressively rise even if patients remain on the same daily dose. A dose tolerated on day one may become a toxic dose on day three. Patients must therefore be carefully monitored and, if necessary, the dosage adjusted during the accumulation period.

There are many factors affecting methadone metabolism and action, and most are not currently predictable on history and examination. They mean that patients can have markedly different responses to the same dose of methadone and their response can vary over time.

Drug interactions can slow or speed methadone metabolism, or can potentiate toxicity. See annex #3 for more information.

However, the critical factor in response to methadone is the degree of tolerance to opioids. It is in individuals with low tolerance that a starting dose that would be safe in the majority of patients can become a toxic dose.

Minimising the risks of toxicity

Risks can be minimised by:

- initial assessment
- identification of high-risk patients
- low starting doses
- slow increments
- monitoring during induction
- supervised consumption (see chapter #1.3, chapter #5)
- alerting patients and carers to the early signs of overdose.

High risk cases require greater supervision.

Buprenorphine

The risk factors for overdose during induction are:

- low opioid tolerance
- use of CNS depressant drugs, including alcohol

At low doses, buprenorphine is a potent opioid agonist, producing morphine-like effects. However, due to its mixed agonist/antagonist properties, increasing doses become self-limiting and do not produce more intense opioid effects. It is generally agreed that there is less risk of opioid overdose associated with the use of buprenorphine than with oral methadone, although the former has greater potential for misuse by injection.

However, as with methadone, concomitant use of buprenorphine with benzodiazepines, alcohol and other CNS depressant drugs can produce fatal opioid overdose, probably in individuals who lack opioid tolerance. Therefore, there is a risk of toxicity and the need for caution when initiating treatment with buprenorphine in someone misusing CNS depressant drugs.

1.2.2 Assessment

1.2.2.1 Introduction

Drug-misusing patients typically present at a time of crisis in their lives and may not respond well to an exhaustive interview. At the same time, professionals need to gather sufficient information to properly and safely assess presenting problems. It is important to find a balance that obtains the necessary information without risking losing the patient from treatment.

Further assessment can take place over the coming weeks during treatment.

1.2.2.2 Diagnosis of opioid dependence and assessment of tolerance

It is not appropriate to offer methadone or buprenorphine maintenance treatment to patients who do not meet the diagnostic criteria for opioid dependence.

Establishing the diagnosis requires a history of the patient's drug use, including duration of use, frequency (i.e daily), route of administration, periods of abstinence, and past treatment. Applicants should be asked to give an account of their daily activities and social functioning, and forensic history.

Corroborative evidence of opioid dependence should be sought, by physical examination, investigations, or information from other people.

Collecting a urine or oral fluid specimen for toxicological analysis is essential to confirm (or refute) drug use history, and perhaps to improve the accuracy of self-reported recent drug use. However, a positive test for opioids does not establish the diagnosis of dependence, nor does a negative test exclude the diagnosis (see section #3, chapter #3). In situations of doubt it may be useful to repeat a screening test, or to conduct a confirmatory test.

The major risk factor for toxicity during induction is use of CNS depressants, especially benzodiazepines and alcohol. Each patient should be asked about all drugs used (including prescribed and over-the-counter medication) in the three days prior to the assessment interview.

1.2.2.3 Medical and psychiatric factors

At assessment, many applicants report depressed mood and disturbed sleep. However, mood usually improves after stabilisation on methadone or buprenorphine, and it is not normally appropriate to initiate antidepressant treatment during induction. Review of mental state should be part of ongoing assessment. Patients already on antidepressants, particularly

tricyclic antidepressants or fluvoxamine, may need care during induction as these drugs may interact with methadone.

Antipsychotic drugs may potentiate methadone, and perhaps increase the risk of toxicity.

A high proportion of injecting drug users are infected with hepatitis B or C, but this seldom poses problems during induction unless they have advanced liver disease, detectable at clinical examination. Patients with end stage liver disease should only be commenced on methadone or buprenorphine with extreme care and should be referred for a specialist opinion. Many HIV medications interact with methadone and buprenorphine, and dose adjustments may need to be made. Consultation with the person prescribing for HIV medications is recommended.

1.2.2.4 Provision of information

At the initial visit patients should be informed of the rationale for treatment, the expectations placed on them (such as daily attendance for supervised doses), and what they can expect. They should be told what will happen in treatment, the risks during induction, and the dangers of using benzodiazepines and other CNS depressant drugs. Many patients are anxious that they will not get enough methadone or buprenorphine to feel comfortable; the planned rate of increase should be explained, and the fact that blood levels of methadone rise during the first week of treatment.

Risks to children of ingesting prescribed medication and the importance of safe storage must be emphasised at the first appointment and repeatedly thereafter. Assessment of compliance with these safety measures should form part of the decision-making concerning dispensing and supervision arrangements.

1.2.3 Using supervised consumption to minimise risk

Supervised consumption of methadone and buprenorphine during induction should be normal practice in most cases. However, healthcare professionals should weigh the need for supervision against the risks of not engaging patients in treatment. There is further information on supervised consumption in section #1.3, chapter #5.

The precise nature of the supervision to be conducted should be clearly specified, including the circumstances in which a dose might be withheld and the patient referred back to the prescriber.

1.2.4 Choosing an appropriate opiate substitute

1.2.4.1 Choices

Methadone and buprenorphine are both approved for the treatment and prevention of withdrawals from opioids. Both are recommended by NICE for maintenance programmes. Some clinicians also have experience of using medicines outside their marketing approval.

Other medications, and treatment for non-opioid drug misuse, are covered in sections #2.3 and #6, chapter #5.

1.2.4.2 Factors in choosing medication

A number of factors should be taken into account when selecting an appropriate medication:

- level of opioid use
- patient's views and experience, treatment history and response

The patient's preferences and previous experience with both illicit and prescribed medications should be taken into account.

- prescriber's experience with different medications
- safety
- retention

Methadone is more likely to retain patients in treatment.

1.2.5 Converting from other opioids

For patients who are using other opioids it is sometimes necessary to stabilise onto methadone or buprenorphine. It is not possible to accurately predict equivalent doses in most cases. This is especially true for street drugs where purity is notoriously variable. It is also problematic to convert from one drug to another when the half lives are not equivalent.

However some useful conversions include 15mg of codeine phosphate being equivalent to 1mg of methadone and 30mg dihydrocodeine being equivalent to 3mg of methadone.

Safe conversion from another opiate involves carefully following the dose induction process.

1.2.6 Dosing

1.2.6.1 General

The guidance given here applies to patients within normal ranges of body weight and body mass index. Patients outside the normal ranges may need to have their dose adjusted up or down accordingly, although with methadone a low initial dose and slow increase will usually take care of any necessary variation.

1.2.6.2 Methadone

1.2.6.2.1 Commencement dose

Methadone should normally be prescribed as the 1mg in 1ml oral solution. [Oral concentrates, containing methadone hydrochloride 10 mg/ml or 20mg/ml, should be dispensed only after dilution as appropriate (BNF 2007).]

Methadone tablets should not normally be prescribed due to the increased potential for diversion

The commencement dose should aim to achieve an effective level of comfort, both physical and psychological, while minimising the likelihood of overdose.

Inappropriate dosing can result in overdosing in the first few days: as cumulative toxicity develops to methadone, this can lead to death. There is no uniquely fatal dose of methadone. Deaths have occurred following doses of as little as 20mg methadone.

In general, the initial daily dose will be in the range of 10-30mg.

If tolerance is low or uncertain then 10-20mg is more appropriate.

With heavily dependent misusers, i.e. those who are tolerant, and an experienced/competent clinician, a first dose can be up to 40mg but it is unwise to exceed this dose.

A supplementary dose on the same day may be considered where there is evidence of persistent opioid withdrawal. These cases need to be assessed by a prescriber with appropriate competencies.

In general more caution should be taken with high risk patients. More caution should be applied if the patient cannot be well supervised, e.g. seen only weekly.

The process of dose induction requires clinical judgement on behalf of the prescriber. Clearly those prescribers with more experience may feel able to take more and proportionate risks following thorough assessment.

1.2.6.2.2 Optimal dose

First seven days

If managing the opioid dependant in the community, it is recommended that patients attend daily during the first few days in order that their dose can be titrated against withdrawal symptoms and for assessment by the prescriber.

With patients who can only attend infrequently, dose induction will take longer.

Where doses need to be increased during the first seven days, the increment should be no more than 5mg to 10mg on one day.

In any event, a total weekly increase should not usually exceed 30mg above the starting day's dose.

Steady state plasma levels should be reached five days after the last dose increase.

Subsequent optimisation

Following the first week doses can continue to be increased incrementally up to a total of between 60 and 120mg a day or when the patients reports no longer using illicit heroin. Caution needs to be exercised and it may take several weeks to reach the desired dose. There should be a few days between each dose increase.

It is critically important to provide adequate information regarding the recognition of methadone toxicity and management to patients and accompanying carers (with consent).

1.2.6.3 Buprenorphine

Most dosing regimens involve starting with a low dose (4-8mg), and rapidly increasing

The two identified problems during buprenorphine induction are:

- the risk of precipitated withdrawal
- the risk of premature dropping out of treatment.

1.2.6.3.1 Precipitated withdrawal

Precipitated withdrawal occurs when buprenorphine is first administered to an opioid-dependent person with circulating opioid agonist drugs present. In that situation, buprenorphine can inhibit the agonist, leading to the appearance of withdrawal signs and symptoms. Precipitated withdrawal is unpleasant, and may deter patients from continuing participation in treatment. There are three measures to minimise precipitated withdrawal:

- Administer the first dose of buprenorphine when the patient is exhibiting signs of withdrawal. The pharmacist needs to emphasise this point when supervising medication.
- If this is logistically difficult, delay the administration of buprenorphine until at least 6 hours after the last use of heroin (or other short-acting opioid), or 24-48 hours after the last dose of low-dose methadone.
- In all cases, patients should be provided with information about precipitated withdrawal.

1.2.6.3.2 Premature dropping out

Some clinical trials have reported poor retention in buprenorphine treatment, and attributed high rates of early attrition from treatment to the use of low doses during induction. However, all trials, whether using high initial doses or low doses, tend to have quite similar retention, and at this time there is no evidence that one regimen is more effective than any other.

1.2.6.3.3 Starting dose and increments

Effective maintenance treatment with buprenorphine involves doses in the range of 12-16mg for most patients. Some patients may need up to 32mg. It makes sense to work towards this dose rapidly, so long as this does not produce side effects or precipitated withdrawal.

A cautious approach is to initiate treatment with 4mg on day one, then 8-16 mg on day two and thereafter. An experienced and confident clinician may increase this to 8mg on day one, then 16mg on day two and thereafter increase the dose more slowly if necessary. The patient should be warned that the tablets have a bitter taste and have to be taken sublingually. Many patients also find that buprenorphine gives them clarity of thought compared to the “clouding” effect commonly felt with methadone or heroin. Some patients find this desirable whereas others do not.

Ongoing assessment, monitoring, regular clinical review and reassurance are likely to improve retention.

1.2.6.3.4 Symptomatic prescribing

There is a limited evidence base for the effect of adjunctive medications for withdrawal. The prescribing of other opioids, or any respiratory depressant drugs, during induction onto buprenorphine treatment is therefore not recommended.

1.3 Supervised consumption

Supervised consumption with an appropriate professional provides the best guarantee that the drug is being taken as directed. Since the advent of supervised consumption in England the number of drug-related deaths involving methadone has reduced, during a period when more methadone is being prescribed, providing indirect evidence that supervising the consumption of the medication may reduce diversion.

Other guidance, such as the ACMD report on drug-related deaths (ACMD 2000), the NICE technology appraisal on methadone and buprenorphine (NICE 2007) and the 1999 Clinical guidelines (Departments of Health 1999) have recommended different approaches to supervised consumption. For this Update the working group has agreed the following recommendations.

In most cases, all new patients being prescribed methadone should be required to take their daily dose under the direct supervision of a professional for a period of time which may be around three months, subject to assessment of the patient's compliance and individual circumstances. A range of durations of supervised consumption is likely to be seen for different patients: ranging from just a couple of weeks in highly-compliant working patients to many years in patients who fail to respond to conventional treatment. The decision on when to relax the requirement for supervised consumption is one for the individual clinician.

Long-term, daily supervised consumption would probably not be appropriate for a patient in regular, full time work where supervision would be a clear barrier to engagement in treatment.

When a patient restarts methadone after a break, or receives a significant increase in the methadone dose, daily dispensing – ideally with supervised consumption – should be reinstated for a period of time agreed in local guidelines and protocols.

In patients who are failing in treatment a period in supervised consumption can improve observation of progress and increase interventions to improve outcome. A good example is

to enable daily breathalyser readings in patients who are drinking heavily while taking methadone.

Supervised consumption may have a role in contingency management. Relaxation of supervision can be regarded as a reward if progress such as drug free urines can be demonstrated.

Supervised consumption is often a situation in which therapeutic relationships can be built with patients and efforts should be made to stop it being viewed as a punishment.

In the majority of cases, the person supervising will be a community pharmacist though some specialist services and dispensing doctors may employ their own pharmacy or nursing staff to provide on-site supervised consumption. There should be multi-agency protocols in place to ensure a consistent high standard service is provided. As part of the service, there should be systems in place to ensure information about patients can be fed back to the prescriber/ keyworker as well as agreement from the patient that the pharmacist can share confidential information with named members of the multi-disciplinary team.

1.3.1 Stopping supervision

Relaxation should be a stepped process in which a patient first stops taking doses observed by a professional but remains on daily dispensing. Later, after further progress, they are given take-home doses. The relaxation of supervision can be seen as an important component of rehabilitation and re-establishing acceptable, responsible behaviour.

Supervised consumption should only be relaxed if the prescriber is reasonably confident that compliance will be maintained. The assessment of compliance and clinical progress is covered in section #1.4, chapter #5. In general the prescriber needs to assess the following: changes in drug taking behaviours (e.g. injecting), compliance with prescribed drug treatment, abstinence from or significant change in illicit drug use and compliance with other elements of a care plan, e.g. attendance at appointments. Arrangements for daily consumption through instalment prescribing and, where appropriate, supervised consumption of other drugs should also be made.

Take-home doses should not normally be prescribed where:

- a patient has not reached a stable dose

- the patient shows a continued and unstable pattern of drug misuse, including a significant increase in alcohol intake, the use of illicit drugs, benzodiazepines or other tranquillisers
- the patient has a significant, unstable psychiatric illness or is threatening self-harm
- there is continuing concern that the prescribed drug is being diverted or used inappropriately
- there are concerns about the safety of medicines stored in the home and possible risk to children.

1.3.2 Issues

A range of different medications can be supervised. Oral methadone mixture consumption can most easily be observed. Buprenorphine, as a sublingual tablet, can be more difficult to supervise because of the length of time taken for the tablet to dissolve. Some pharmacists have been crushing buprenorphine tablets before consumption to make the supervision process more straightforward. This practice, while technically off-licence, can be undertaken with appropriate clinical governance approval and protocols (also see annex #2).

Other medication can be observed being consumed such as benzodiazepines, antidepressants, antipsychotics and medication for medical conditions such as antituberculous medication and antiretrovirals.

Patients' privacy and dignity should be taken into account when making arrangements for supervised consumption.

1.3.3 Competencies

Supervised consumption can take place either in a pharmacy or a specialist drug service or other clinical environment. In either case staff supervising medication need to be competent to do so.

1.4 Assessing and responding to progress and failure in treatment

1.4.1 Principles

It is clear from the available evidence that drug treatment offers protection against a range of harms including risk of contracting or spreading blood borne viruses, risk of overdose, risk of offending etc.

Treatment should seek to maximise treatment outcomes across a range of domains including drug and alcohol misuse, health, crime and social functioning.

While drug treatment has been shown to be effective in reducing substance misuse, drug misusers may not cease all illicit drug use immediately on entering treatment and eliminating all illicit drug misuse and alcohol misuse may take months or years. Clinicians will frequently be faced with decisions concerning what action to take if a patient is not fully complying with a treatment programme. Such assessments should be based on the assessment of relative risks to the patients while maintaining the integrity of the treatment programme.

In principle, if a patient is not succeeding in treatment, clinicians should consider optimising treatment by increasing the intensity of the treatment programme rather than reducing it. Optimising treatment may include: ensuring medication is provided within evidence-based optimal levels, changing to another substitute medication, increasing keyworking or psychosocial interventions and increasing supervised consumption.

Use of illicit drugs or alcohol misuse may indicate the patient requires discrete treatment for these substances. Relapse or lapse into illicit use may provide an opportunity for discussion and for the patient to learn about what triggers a relapse and how they can develop techniques to avoid such situations.

A good therapeutic relationship between the clinician and the patient should allow for discussion about substance misuse without fear of expulsion from treatment. A clinician should ensure a patient is fully aware of their roles and responsibilities while in drug treatment including correct use of medication.

A decision to temporarily or permanently exclude a patient from a drug treatment service or provide coerced detoxification should not be taken lightly. This course of action may put the patient at an increased risk of fatal overdose, contracting a blood borne virus or offending. In these cases, if at all possible, these patients should be offered treatment at another local service or setting in a way that minimises risks and maximises opportunities for patients to be retained in treatment.

Care planning and regular review should provide a vehicle to check patient progress and agree a course of action in partnership with the patient.

Clinicians are encouraged to chart progress in treatment systematically under the four domains of care planning: drug and alcohol misuse; physical and mental health; social functioning and criminal justice.

1.4.2 What constitutes failure to benefit

A number of different scenarios may constitute failure to benefit, each of which may require a different response. It will be beneficial for clinicians to be aware of the pre drug treatment behaviour of the patients in order to assess whether improvements (albeit slow) are being made. A good therapeutic relationship will enable illicit drug use to be discussed and interventions agreed accordingly. If this does not exist or if a clinician or service is perceived as rigid or having a punitive response to illicit use, a patient may not disclose use and may not be able to elicit the help they require.

Common scenarios in failure to benefit are outlined below together with some proposed solutions and risks.

1.4.2.1 Opiate misuse in addition to an opiate prescription

Risks: risk of overdose; if injecting, risk of blood borne viruses and other infections; risk of continued offending and involvement in drug misusing lifestyle; risk of impaired engagement.

Reasons	Solutions
inadequate dose	dose assessment, increase dose, give injecting equipment
medication unsuitable	change medication regime
patient on reducing regime	swap patient to maintenance regime
patient using heroin and/or cocaine for "high" on high dose opioids	increase psychosocial interventions, e.g. contingency management plus urine tests and supervised consumption, provide injecting equipment and address negative social problems such as housing if applicable

1.4.2.2 Cocaine/crack misuse including that in addition to an opiate prescription

Risks: greatly increased risk of blood borne viruses and infections if injecting; substance misuse may become more chaotic; increased crime; psychological problems.

Reasons	Solutions
patient using for "high"	increase keywork/psychosocial interventions, provide injecting equipment if injecting drug misuser
patient dependent on cocaine/crack	increase keywork/psychosocial interventions, provide injecting equipment if injecting drug misuser

1.4.2.3 Alcohol or benzodiazepine misuse in addition to an opiate prescription

Risks: alteration of methadone metabolism; deterioration of hepatic functioning in those with hepatitis C; street drinking; intoxicated presentations; overdose or near misses; drug interactions.

Reasons	Solutions
patient using to get intoxicated	increased keywork/psychosocial interventions plus supervised consumption of opioid prescriptions with breathalyser test
patient dependent	alcohol/benzo detoxification and/or reduction regime plus increased keywork/psychosocial interventions and supervised consumption of opioid prescriptions with breathalyser test

1.4.2.4 Patient misses appointments

In instances where a patient is collecting methadone every day but failing to attend appointments as arranged with the clinician in line with the agreed care or treatment plan, the clinician will be unable to monitor progress against identified needs including feedback on drug tests. If this situation persists and the patient does not respond to requests to contact the clinician the patient may be offered incentives to attend or evening appointments. An urgent review needs to take place to enable the prescriber to review the patient and satisfy themselves that the medication is optimised and safe.

1.4.2.5 Patient misses pick up of drugs for more than three days

In these instances a pharmacist is normally (under the terms of local agreements) unable to dispense unless they contact the prescriber. Normally this will trigger urgent reassessment by prescriber. Efforts should be made to limit the impact of being out of prescribing until new prescriptions can be established. The patient should be asked about pick up details and the clinician should check this aligns with the patient's lifestyle.

1.4.3 Clinical responses to patient “failing in treatment”

Where patients are not progressing or are failing in drug treatment it is important that clinicians demonstrate and actively participate in regular monitoring, which should include:

Repeated risk assessment using a consistent and validated approach – careful record keeping that accurately details responses to treatment details the risks and benchmarks progress across the four care planning domains informs clinical decision making and provides a clear audit trail for individual service user and practitioner clinician alike.

Information and feedback on risks – service users who may be struggling in treatment are informed of the risks and consequences of continued chaotic drug use while established on a substitute opiate prescription.

Informed drug testing regimes – drug testing (e.g. once/twice weekly as part of a care plan) provides an opportunity to reflect back to the individual real evidence of poor progress

and share the risks and concerns as a prescriber (e.g. of the negative consequences of use on top and/or polydrug misuse and/or missed pick ups etc).

Application of safe prescribing boundaries – prescribers have a responsibility to make individuals aware of the criteria that they as healthcare professionals are applying when deciding whether or not it is safe to continue to prescribe or when it is necessary to make a change to a prescription in order to manage documented risk.

Suspension – it may be necessary on the basis of a careful risk assessment to come to the conclusion that a prescription must be suspended or in rare cases withdrawn. Such decisions must involve the prescribing clinician *and* other members of the multidisciplinary team. Service users themselves must be “forewarned” of the potential actions and consequences that the prescriber and the team may take where there is a failure to optimise treatment and be offered the opportunity to set new goals or identify contingencies that might influence their progress from this point.

A decision to temporarily or permanently exclude a patient from a drug treatment service or provide coerced detoxification should not be taken lightly. Such a course of action can put the patient at an increased risk of overdose death, contracting a blood borne virus or offending. In these cases, if at all possible, these patients should be offered treatment at another local service or setting in a way that minimises risks and maximises opportunities for patients to be retained in treatment.

1.5 Injectable opioid treatment (IOT)

1.5.1 Introduction

There is a small section of the treatment population who, despite treatment with oral opioid maintenance, fail to make adequate progress and continue to be involved in high levels of injecting drug misuse and other risk-taking behaviour. These patients may benefit from specialist assessment: in some instances, clinical benefit can be improved by correcting sub-optimal dosing, although for other patients specialists could decide to initiate a trial of injectable maintenance treatment.

Injectable opioid maintenance treatment is a less established and less accepted form of treatment, which requires greater commitment of time and resources from the patient, the clinician and the service. It is a second line treatment that should only be considered when optimised oral methadone and buprenorphine maintenance treatment are available and are found not to be suitable or, after proper trial, fails to deliver the expected benefit. Provision of

optimised treatments using oral methadone and buprenorphine can be expected to be the more appropriate form of maintenance treatment for the majority of patients, and should remain the major clinical approach.

The situation in the UK with regard to injectable prescribing is complex. A number of long-term patients are still receiving injectable opioids under what is often called “the British System”. There are also some areas of England where a new form of IOT is being introduced, modelled on the recent Swiss and Dutch supervised injectable maintenance clinics which have been established to treat heroin dependent patients who have failed to benefit from orthodox treatments. The trials in Europe have shown very promising results and these models do have advantages as a result of the higher levels of supervision and safety; however results from the UK are not yet available. IOT is not currently available in all specialist services and in all parts of the country.

1.5.2 Principles of injectable opiate prescribing

Patients being considered for injectable prescribing should be considered for this only in line with the eight key principles outlined below. These were established through an expert consensus process and described in the NTA guidance “Injectable heroin (and injectable methadone): potential roles in drug treatment” (NTA 2003). Applying these principles in practice sets a high standard for delivery of this treatment intervention in recognition of the risks involved in providing injectable treatments. In addition to these principles evidence from research in this area should be considered in development of new services.

1. Drug treatment comprises a range of treatment modalities which should be woven together to form integrated packages of care for individual patients.
2. Substitute prescribing alone does not constitute drug treatment. Substitute prescribing requires assessment and planned care, usually with other interventions such as psychosocial interventions. It should be seen as one element or pathway within wider packages of planned and integrated drug treatment.
3. Within the substitute prescribing modality, a range of prescribing options are required for heroin misusers requiring opioid maintenance. Some options may carry more inherent risks than others (e.g. injectable versus oral options, frequency of injecting etc). Patients who do not respond to oral maintenance drug treatment should be offered other options in a series of steps. This would normally include:

- oral methadone and buprenorphine maintenance, specifically optimised higher dose oral methadone or buprenorphine maintenance treatment, then
 - injectable methadone or injectable diamorphine maintenance treatment (perhaps in combination with oral preparations).
4. Before considering injectable maintenance, a local area should be able to offer optimised oral methadone maintenance treatment including adequate doses, supervised consumption and psychosocial interventions. This is essential to ensure oral drug treatment options have been fully explored prior to a trial of injectable maintenance treatment and to ensure smooth transition back to oral treatment if required.
 5. Injectable and oral substitute prescribing must be supported by locally commissioned and provided mechanisms for supervised consumption. Injectable drugs may present more risk of overdose than oral preparations and have a greater value on illicit markets and hence may require greater levels of supervision.
 6. All maintenance treatment is likely to be long-term treatment with long-term resource implications. This may be especially true of injectable maintenance. Clinicians should consider the move from oral to a trial of injectable preparations carefully, including long-term implications for the patient and drug treatment systems and involvement of services.
 7. Specialist levels of clinical competence are required to prescribe injectable substitute drugs. Diamorphine prescribing also requires a Home Office licence.
 8. The skills of the clinician should be matched with good local systems of clinical governance, supervised consumption and access to a range of other drug treatment modalities.

Both injectable diamorphine and injectable methadone are effective and, at present, our guidance is that selection of one or the other should be on the basis of assessment of the individual patient, rather than there being any specified hierarchy. More research evidence is required to compare injectable diamorphine and methadone treatments.

Clinicians providing IOT should encourage patients not to regard it as a lifelong treatment option and should regularly review their patients and the continuing necessity for this unusual and expensive treatment, particularly in view of the significant inherent risks.

Suggested eligibility criteria are outlined in the NTA guidance (NTA 2003).

1.5.3 Models for delivery of IOT

1.5.3.1 The nature of new IOT

The current evidence for successful injectable opioid treatment programmes comes from Swiss and Dutch programmes. These differ in several crucial ways from how injectable opioids have been prescribed in the past in the UK. They include the absolute requirements that the patient must:

- attend in person for their prescribed injectable opiate maintenance treatment – daily or more frequently, according to the treatment plan
- inject their dose under the direct supervision of a member of staff who is competent to do so
- be given no take-away medication.

On occasions and in circumstances where it is not feasible to provide this close supervision, patients may be issued with a take-home alternative supply of oral opioid medication. These occasions and circumstances might include rural areas where it is not feasible to supervise consumption every day, and days when the patient cannot come into the service.

Advantages and disadvantages of supervised injectable opioid treatment

Advantages:

- supervised environment permits prescription of higher doses with less concern about potential acute hazards
- supervised environment permits higher doses to be prescribed without concern about potential abuse or diversion
- structured setting and supervised environment permit treatment of higher risk and more complicated patients.
- removes any potential for prescribed injectable medication to be diverted into the 'black market'
- patients can be taught better injecting technique, safer areas for injecting, e.g. moving away from groin or neck injecting to safer sites.

- provides opportunities for building therapeutic relationships, brief interventions and for daily observation and monitoring.
- the restrictive nature of supervised IOT may encourage patients to work towards other treatments which give them more freedom – for example, encouraging the return to oral maintenance.

Disadvantages:

- inconvenience to patients of the necessity for daily (or more frequent) attendance
- limited compatibility with workplace requirements if the patient secures gainful employment
- challenges around child care if the patient is the sole carer for a child or children and does not have any support
- financial and human resources costs to the service provider of establishing, maintaining and delivering such a special facility and service
- difficult to provide in rural areas, especially as patients on injectable medication are typically considered not fit to drive.

1.5.3.2 Patients already receiving unsupervised injectable opioid treatment

There are a small but significant number of patients who are already in receipt of injectable maintenance prescriptions, on an unsupervised basis – the number who receive such treatment is a steadily dwindling number – having been about 10% of prescribing to this group in the mid 1990s, it now represents about 2% of all maintenance prescribing (Strang, Sheridan et al 1996, Strang, Manning et al 2007). They usually receive a prescription regularly and pick up sometimes very large doses of drugs from community pharmacists. There is some evidence that quality of care planning and treatment for many of these patients is variable and often poor (Metrebian et al 2006). Many have long-term chronic health problems.

The quality of care for such patients is often in need of renewed attention, and should be reviewed regularly. Where there is clear evidence of benefit, then treatment should continue and be improved for these patients.

There may be some difficulty for service providers in continuing to provide for such “old system” patients while, within another part of local development, the service is moving to supervised-only IOT for new patients. “Old system” patients should not have their treatment withdrawn but should be reviewed to consider whether their current treatment optimally meets their needs.

2 Opioid maintenance prescribing

2.1 Introduction

While a few patients can achieve abstinence rapidly, most require the support of the prescribed drugs for longer than just a few months. Longer-term prescribing should be reviewed at regular intervals (at least three-monthly) and should be part of a broader programme of care planned social and psychological support.

Maintenance treatment

Opiate maintenance treatment is increasingly recognised to be an effective management strategy and oral methadone remains the most commonly used drug. However, there is an increasing body of work on the effectiveness of buprenorphine and a NICE technology appraisal (NICE 2007), which compared the two drugs in 2007, is summarised below.

Maintenance treatment should be provided in the context of high quality, care planned, well supervised and well organised treatment services.

Any doctor or treatment service prescribing for opiate users must be competent to provide maintenance treatment and local protocols and guidelines should be provided to assist in this.

If a decision to provide a long-term maintenance prescription is being considered, a number of factors which assist treatment effectiveness need to be incorporated:

- Patients may need to be seen at least fortnightly initially and then, if stable, at least monthly or less frequently if very stable.
- Random urine or oral fluid tests may be helpful, e.g. at least twice a year.
- Co-existing physical, emotional, social and legal problems, as well as drug and alcohol use, should be addressed as far as possible.
- A more thorough review every three months may be useful to consider what has been achieved and to set new goals.

Dosing regimen for maintenance treatment

After careful dose induction (see section #1.2, chapter #5) and dose stabilisation, there is a consistent finding of greater benefit from maintaining individuals on a daily dose between 60mg and 120mg. In some instances, due to a patient's high tolerance, higher doses may be required but this is exceptional. Plasma methadone monitoring can be helpful in determining the adequacy of dosage. The clinician may need to ensure that there is good compliance through supervised consumption. High doses can reduce heroin and other opiate consumption, but caution needs to be observed about high doses if there is associated alcohol or benzodiazepine dependence. If patients miss methadone doses for three or more days, for whatever reason, they need to be reassessed for intoxication and withdrawal before methadone administration is recommenced. It may be appropriate to reduce the dose and titrate back up to the original dose if the patient has not had methadone for more than three days, as their tolerance may be reduced. If a patient has abstained from methadone for five days or more, they will require an assessment of their tolerance before they are re-inducted onto methadone.

There is less consensus about the effective dose levels of buprenorphine required to optimise outcome once dose induction and stabilisation has taken place. Trials have shown that higher doses result in lower levels of opiate use and higher treatment retention. In general, daily doses of between 12 and 16mg (and up to 32mg in some cases) would seem appropriate for long-term prescribing. Alternate day dosing may suit some patients. Like methadone, if a patient misses more than three days of buprenorphine the dose may need to be reduced and retitrated. If missed for five days the patient may need an assessment of their tolerance before they are re-inducted onto buprenorphine to minimise the risk of precipitating withdrawal.

2.2 NICE technology appraisal

The National Institute for Health and Clinical Excellence (NICE) completed a technology appraisal in January 2007 on the use of methadone and buprenorphine for managing opioid dependence (NICE 2007). Clinicians should refer to the full appraisals for the detailed findings and recommendations. What follows is a brief summary and the recommendations of the clinical guidelines update working group.

NICE's summary of its guidance is as follows:

Methadone and buprenorphine (given as a tablet or a liquid) are recommended as treatment options for people who are opioid dependent.

A decision about which is the better treatment should be made on an individual basis, in consultation with the person, taking into account the possible benefits and risks of each treatment for that particular person. If both drugs are likely to have the same benefits and risks, methadone should be given as the first choice.

Different people will need different doses of methadone or buprenorphine. People should take methadone or buprenorphine daily in the presence of their doctor, nurse or community pharmacist for at least the first 3 months of treatment and until they are able to continue their treatment correctly without supervision.

Treatment with methadone or buprenorphine should be given as part of a support programme to help the person manage their opioid dependence.

In addition to its status in England and Wales as NICE guidance, this technology appraisal has been validated by NHS QIS for Scotland.

The clinical guidelines update working group supports the key messages contained in the guidance. The following points are supplementary to NICE's guidance:

- The process of and factors involved in setting and reviewing periods of supervised consumption are covered in detail in section #1.3, chapter 5. The thrust of the working group's recommendation is that the majority of patients will benefit from a period of supervised consumption but that this period should be determined according to clinical need rather than any fixed timescale. Some patients will not require three months of supervised consumption, others may need more and all should be reviewed regularly and, if necessary, returned to supervised consumption.
- The importance of programmes of support and other interventions alongside prescribing is described in chapter #4.

2.3 Other opioids used for maintenance

Codeine preparations

Codeine preparations are not licensed in the UK for the treatment of opiate dependence but have been used for opiate substitution, often in the situation where a doctor is unwilling to prescribe methadone or buprenorphine. There is a small evidence base that codeine can be used effectively for maintenance although none that it is superior to other drugs (Robertson et al, 2007). The problems with codeine are that the tablets can be injected, it is difficult to supervise, it is short acting so needs frequent dosing, and it can be easily diverted. However, it may on occasions be prescribed, with care, by clinicians with appropriate specialist competencies.

Slow release oral morphine

Slow release oral morphine (SROM) preparations are also not licensed for the treatment of opiate dependence. Research has shown them to be useful in treating patients who fail to tolerate methadone. Several studies have show SROM to be effective in maintaining patients. There is also some evidence that the drug may be useful in patients who are “not held” on methadone.

Currently SROM needs further clinical evaluation before its effectiveness can be established.

Buprenorphine with naloxone (Suboxone®)

A new form of buprenorphine has been developed which includes a dose of the opiate antagonist naloxone (buprenorphine: naloxone 4:1) in a combined sublingual tablet. This new form is for use at the same buprenorphine dose (i.e. the current 8mg sublingual buprenorphine being considered as the same therapeutic dose as the new combination of 8mg buprenorphine plus 2mg naloxone). It has been presented as a new product, under the tradename Suboxone, and received product approval for addiction treatment in many European countries in 2007. The rationale is that, when taken sublingually as intended, the naloxone is inactivated or is only absorbed at a dose which is insufficient to provoke withdrawal symptoms, but that if it is abused – by intravenous injection for example – opiate withdrawal effects results The combination tablet is therefore expected to provide the same therapeutic benefit while preventing or reducing the liability for abuse. Clinical experience with this new combination product is, so far, extremely limited in the UK, and it is too early to indicate the relative positions of these two versions of buprenorphine.

3 Opioid detoxification

3.1 Introduction

Detoxification from opiates can be defined as the process by which the effects of opiate drugs are eliminated from dependent opiate users in a safe and effective manner, such that withdrawal symptoms are minimised (WHO 2006). It is usually thought of as being a clear defined process lasting about 28 days as an inpatient or 12 weeks as an outpatient.

The assessment process can establish whether a patient is suitable for detoxification. It should be remembered that detoxification is rarely successful especially at the first attempt.

The following factors can guide the clinician and the patient's decision about whether they are suitable for a detoxification:

- The patient is fully committed to and informed about the process.
- The patient is fully aware of the high risk of relapse.
- The patient is either in a stable and supportive social situation or able to go into one following detoxification.
- Plans for continuing support and treatment are in place.

There is clear evidence that coerced detoxification against a patient's express will leads to relapse and increased risk of overdose, blood borne viruses, etc.

A full programme of psychosocial support needs to be in place during detoxification. Access to a range of drug-free support services is vital following detoxification.

Some patients and prescribers agree to reduce doses slowly over many months or years. This is not really detoxification but can be useful as a way to work towards a formal detoxification. It reduces the dose at which the detoxification process is started and can improve a patient's confidence in their ability to manage on lower opioid doses.

Alpha agonists are not useful in detoxification for patients with substantial dependence but may be helpful in relieving symptoms of withdrawal in those who are using small amounts of opioids and are keen to achieve abstinence. NICE found that there was no evidence for any superiority of clonidine over lofexidine and, because of its greater side effect profile, suggest that clonidine is not used in routine practice.

3.2 Dosing regimen for detoxification

Methadone

Following stabilisation on methadone the dose can be reduced at a rate which will result in reaching zero in around 12 weeks. This is usually a reduction of around 5mg every one or two weeks. Patients often prefer a faster reduction at the beginning although there is no research evidence to indicate the superiority of a linear or exponential dose reduction.

Buprenorphine

Buprenorphine doses can be reduced initially by 2mg every two weeks or so with final reductions being of between 200 and 400 micrograms. Anecdotally patients report being able to reduce buprenorphine doses more quickly than methadone ones.

NICE guidelines found that there was no drug which was more effective in achieving good outcomes from detoxification. They concluded that detoxification should be carried out with the drug on which the patient had stabilised.

3.3 Symptomatic treatment of withdrawal

Lofexidine

Lofexidine is a non-opioid alpha-adrenergic agonist and is not a controlled drug.

The treatment course is between 7–10 days with doses starting at 800 micrograms daily and rising to a maximum of 2.4g. The dose is then reduced over subsequent days. It is probably most likely to be successful for patients with uncertain dependence, young people and shorter drug and treatment histories.

Reported side effects are a dry mouth and mild drowsiness. Sedation is increased with concomitant use of alcohol or central nervous system depressants. Hypotension and bradycardia can be clinically significant.

The patient should be seen daily in the early stages of treatment to check for withdrawal symptoms, for blood pressure monitoring and to provide general encouragement. Additional short-term medication for symptoms such as stomach cramps and diarrhoea may be required; one of the disadvantages of lofexidine is that adjunctive medications may be needed to control side-effects.

The patient should be advised to take at least part of their dose at bedtime to offset insomnia associated with opiate withdrawal.

Others

Prescribing symptomatically can reduce some of the physical effects of withdrawal. There is no systematic evidence that any of these drugs work to improve outcome but they may be useful for the clinician in situations where it is not possible to prescribe effective opiate substitution. Particular care is needed concerning the risks of polypharmacy and ensuring appropriate supervision and support in such cases.

- Loperamide (diarrhoea) 4mg immediately followed by 2mg after each loose stool for up to five days; usual dose 6-8mg daily, maximum 16mg daily.
- Metoclopramide (nausea, vomiting, may also be useful for stomach cramps) 10mg eight-hourly or prochlorperazine 5mg three times a day or 12.5mg intramuscularly 12-hourly.
- Mebeverine (stomach cramps) 135mg three times a day.
- Diazepam (oral) (agitation and anxiety, sleep) up to 5-10 mg four times daily when required or zopiclone 7.5mg at bedtime. In severe cases of anxiety/agitation, contact the on call duty psychiatrist.
- Non-steroidal anti-inflammatory drugs (muscular pains and headaches); paracetamol, aspirin and other non-steroidal anti-inflammatory drugs. Topical rubefacients, e.g. "Deep Heat", can be helpful for relieving muscle pain associated with methadone withdrawal.

3.4 NICE guidelines

The National Institute for Health and Clinical Excellence (NICE) will publish its final guideline in July 2007 on opiate detoxification for drug misuse (NICE 2007). Clinicians should refer to the full guidance for the detailed findings and recommendations. What follows is a brief summary and the recommendations of the clinical guidelines update working group.

NICE's summary of its guideline is as follows:

Key priorities for implementation are:

Providing information, advice and support

- *Detoxification should be a readily available treatment option for people who are opiate dependent and have expressed an informed and appropriate choice to become abstinent.*
- *In order to obtain informed consent, healthcare professionals should provide accurate and detailed information about the components of detoxification and the associated risks and benefits, including:*
 - *the physical and psychological aspects of opiate withdrawal symptoms, including the length and intensity of symptoms, and how these may be managed*
 - *the use of non-pharmacological approaches, where appropriate, to manage or cope with opiate withdrawal symptoms*
 - *the potential medical risks inherent in detoxification*
 - *the loss of opiate tolerance that follows detoxification and the ensuing risks, including overdose, because there is a potential risk of an increase in illicit drug and/or alcohol use as a response to opiate withdrawal symptoms*
 - *the importance of continued psychosocial interventions and support, and appropriate pharmacological treatments, to maintain abstinence, and where necessary to treat comorbid mental health problems.*

The use of opiate agonists

- *Buprenorphine or methadone should be considered the first-line treatments in opiate detoxification. When deciding between these medications, healthcare professionals should take into account the following factors:*
 - *if the service user is currently maintained on methadone or buprenorphine, opiate detoxification should normally be started on the same medication*
 - *the informed preference of the service user.*

Rapid and ultra-rapid detoxification

- *Ultra-rapid detoxification under general anaesthesia or heavy sedation (where the airway needs to be supported) must not be offered. This is because of the risk of serious adverse events, including death.*

Community detoxification

- *Community detoxification should normally include:*
 - *prior stabilisation of opiate drug use through appropriate pharmacological treatment*
 - *effective co-ordination of care by competent primary or specialist practitioners*
 - *the provision of psychosocial interventions, where appropriate, during the stabilisation and maintenance phases.*

Inpatient detoxification

- *Inpatient detoxification should be considered for people who have had at least one previous unsuccessful detoxification attempt within a community setting and who:*
 - *require a high level of medical and nursing support because of significant comorbid physical and/or psychiatric problems, or*
 - *are polydrug users and require concurrent detoxification from alcohol.*

In addition to its status in England and Wales as NICE guidance, this technology appraisal has been validated by NHS QIS for Scotland.

The clinical guidelines update working group supports the key messages contained in the guideline. The following point is supplementary to NICE's guideline:

- There are cases in which detoxification in an inpatient or residential rehabilitation service might benefit a patient who has not previously been unsuccessfully detoxified in the community.

4 Naltrexone for relapse prevention

4.1 Introduction

Naltrexone is an opiate antagonist which, when taken regularly, stops an opiate user experiencing the effects of opiates. It can be helpful following detoxification in enabling a patient to maintain abstinence.

In the UK naltrexone is only licensed for use orally. A depot formulation, licensed for use in alcohol dependence, may soon become available.

4.2 Dose regimen

Due to the potentially hepatotoxic nature of naltrexone, liver function tests should be conducted before and after a patient is commenced on a naltrexone dosing regimen.

If not certain that the patient has not used opiates, it may be necessary to conduct a naloxone dose challenge before administering naltrexone. If opiates have been used then severe and prolonged withdrawal symptoms will result if naltrexone is administered.

Following a negative urine or oral fluid test for opiates the patient is given a single dose of naltrexone (25mg) orally or naloxone (400micrograms) intramuscularly or subcutaneously. If the patient does not experience any withdrawal symptoms after a few hours a 50mg tablet of naltrexone can be given. Patients can be commenced on naltrexone within a few days of finishing a buprenorphine detoxification. The usual maintenance dose is then 50mg a day.

It is good practice to give patients a card indicating that they are maintained on naltrexone.

The outcome of naltrexone treatment is improved by a programme of supervision, which can involve carers, to ensure compliance with the regimen.

4.3 NICE technology appraisal

The National Institute for Health and Clinical Excellence (NICE) completed a technology appraisal in January 2007 on the use of naltrexone for the management of opioid dependence (NICE 2007). Clinicians should refer to the full guidance for the detailed findings and recommendations. What follows is a brief summary and the recommendations of the clinical guidelines update working group.

NICE's summary of its guidance is as follows:

- *Naltrexone is recommended as a treatment option for people who have been opioid dependent but who have stopped using opioids, and who are highly motivated to stay free from the drugs in an abstinence programme.*
- *It should only be given to people who have been told about the problems associated with treatment, and with proper supervision. Treatment with naltrexone should be given as part of a support programme to help the person manage their opioid dependence.*
- *Healthcare professionals should regularly review how well naltrexone is working to help people stay off opioids. If there is evidence that the person has been using the drugs again then healthcare professionals should consider stopping naltrexone treatment.*

In addition to its status in England and Wales as NICE guidance, this technology appraisal has been validated by NHS QIS for Scotland.

The clinical guidelines update working group supports the key messages contained in the guidance. The following point is supplementary to NICE's guidance:

- The importance of programmes of support and other interventions alongside prescribing is described in chapter #4.

5 Benzodiazepines

5.1 Introduction

These drugs have their own potential for misuse and dependence and are often taken in combination with opiates or stimulants.

Many drug users misuse benzodiazepines but the majority do not require long-term replacement prescribing or high dosages.

For those who are benzodiazepine dependent, sudden cessation in their use can lead to a recognised withdrawal state. {17, 18}

Good assessment and care planning – and adherence to local protocols – are pre-requisites for considering prescribing benzodiazepines. Prescribing benzodiazepines to drug misusers requires competencies in this form of treatment and appropriate supervision. It is therefore more likely to be considered an appropriate approach in secondary rather than in primary care.

5.2 Prescribing regimen

There is little evidence to suggest that long-term substitute prescribing of benzodiazepines reduces the harm associated with benzodiazepine use and there is increasing evidence that long-term prescribing (especially of more than 30mg diazepam equivalent per day) may cause harm. Clinicians may be faced with requests to continue a prescription for maintenance benzodiazepines. To prevent symptoms of benzodiazepine withdrawal the clinician should continue the prescription but the dose should be gradually reduced to stop.

Only very rarely should doses of more than 30mg diazepam equivalent per day be prescribed.

Prescribing to assist withdrawal should only be initiated where there is clear evidence of benzodiazepine dependency from the patient's history, observed symptoms and drug testing. The aim should be to prescribe a reducing regime for a limited period of time.

Longer-term prescribing of benzodiazepines should adhere to the general principles of management, including clear indications of benzodiazepine dependence, clear intermediate treatment goals and milestones, regular review and methods to prevent diversion. {20}

If the patient is also receiving a long-term prescription of methadone for concomitant opiate dependency, the methadone dose should be kept stable throughout the benzodiazepine reduction period. Concurrent detoxification from both drugs is not recommended in a community setting. More research is needed in this area of practice.

A short course of benzodiazepines lasting only a few days may help alleviate anxiety and insomnia in cases of acute psychological distress. However, clinicians should guard against longer prescribing regimens that might induce dependence and inadvertently become maintenance prescribing.

Insomnia in patients receiving prescribed methadone may be best alleviated by a modest increase in methadone dose, cessation of stimulant use and guidance on management of sleep disturbance.

NICE guidance (NICE 2004) is that the choice of shorter-acting benzodiazepine or “Z-drug” (zaleplon, zolpidem and zopiclone) for the short-term “management of severe insomnia interfering with normal daily life” should be determined by cost. Patients who have not responded to one of these hypnotic drugs should not be prescribed any of the others.

There is no evidence that intermittent, “pulse” regimens (e.g. one week on and one week off) prevent dependence and these should be avoided.

5.2.1 Reduction of sedative hypnotics (including benzodiazepine and “Z-drugs”)

Dose regimen

The following guidelines are suitable for a long-term sedative hypnotics withdrawal regimen in the community.

It is good practice initially to convert all sedative hypnotics to an appropriate dose of diazepam. The conversion chart below can be used for selected drugs.

Diazepam has several advantages over other benzodiazepines. It has a relatively long half-life and is available in different strength tablets. It can be given as a once a day dose which may need to be adjusted against withdrawal symptoms.

The clinician should aim for the lowest dose of diazepam that will prevent withdrawal symptoms.

In cases of non-prescribed high-dose benzodiazepine abuse, the amount prescribed should be substantially less than the equivalent amount of diazepam the patient claims to be taking.^{2}

The rate of withdrawal is often determined by an individual's capacity to tolerate symptoms. Benzodiazepines, including diazepam, can be withdrawn in proportions of about one-eighth (range one-tenth to one-quarter) of daily dose every fortnight. In dependence on therapeutic doses, the dose can be reduced initially by 2 to 2.5mg and if withdrawal symptoms occur then the dose can be maintained until symptoms improve. If the patient is not coping and is experiencing severe withdrawal symptoms, it may be necessary to increase the dose to alleviate the symptoms.

If very high dose prescribing is required the patient should be referred for specialist assessment. The specialist practitioner then needs to exercise caution in their assessment and prescribing. If the patient is stable and free of withdrawal symptoms, at for example 50mg a day, the dose should be gradually reduced at a faster rate than suggested above, for example by half over six weeks and then the planned rate of reduction should be again reviewed in line with above. This faster rate of reduction from very high doses led to no convulsions even in a group who had a high incidence of these during previous benzodiazepine withdrawals.^{3}

Appropriate dosages of common benzodiazepines and Z-drugs equivalent to 5mg of diazepam

Drug	Dose
Chlordiazepoxide	15mg
Diazepam	5mg
Loprazolam	500 microgram
Lorazepam	500 microgram
Nitrazepam	5mg
Oxazepam	15mg
Temazepam	10mg
Zaleplon	10mg
Zopiclone	7.5mg
Zolpidem	10mg

Adjunctive therapies

While reducing the dose, counselling, support groups and relaxation techniques can be helpful.

5.2.2 Monitoring

It is important to note that, because of long-term effects, all patients on a benzodiazepine prescription must be regularly reviewed, on at least a three-monthly basis.

5.2.3 Dispensing and supervision

Where practicable, this should follow a schedule similar to that for other drugs of dependence, including daily dispensing and supervised consumption where appropriate.

6 Prescribing for users of stimulants and hallucinogens

Clinicians will have to advise and treat stimulant users with a wide range of severity of problems. The mainstay of treatment is psychosocial i.e. non-pharmacological. These approaches are discussed in chapter 4. Many pharmacological agents have been tested to assess their utility in treating withdrawal from stimulants, particularly cocaine, and none have been found to be useful in promoting abstinence.

6.1 General measures

General principles of management, such as giving preventive advice about safer injecting practice, must be applied. Psychiatric complications need to be treated on a symptomatic basis. Studies have found that an abstinence-based psychosocial treatment approach, linking counselling and social support, had the greatest impact on cocaine misuse. Where a patient exhibits persistent anxiety and agitation, the clinician should attempt to focus on stress reduction procedures. Patients who display persistent and severe psychotic symptoms require admission and treatment in a psychiatric unit. Other stimulant users who are chaotic may benefit from a period of inpatient assessment with support. Complementary therapies, such as acupuncture, are being more widely used for cocaine misuse, although there is only limited evidence to support their effectiveness. Such interventions in some settings are clearly capable of attracting a hard to reach population into treatment and should be explored specifically for this purpose.

6.2 Antidepressants

Antidepressants, such as fluoxetine, can be effective in the management of major depressive episodes associated with stimulant use. There is no evidence that antidepressants have any effect on the withdrawal symptoms from stimulants. Care should be taken if selective serotonin re-uptake inhibitors are prescribed while cocaine or amphetamines continue to be taken, as toxic reactions have been described.

6.3 Substitute prescribing

In polydrug users there is no indication for the prescription of cocaine or methylamphetamine in the treatment of stimulant withdrawal, and it is not recommended that other stimulants, such as methylphenidate or phentermine, are prescribed. However, there is evidence that adequate opiate substitution also reduces stimulant use. If not, an appropriate response is to increase psychosocial interventions.

There may be a limited place for the prescription of dexamfetamine sulphate 5mg (five) in the treatment of amphetamine misuse. There is evidence that some treatment is being undertaken in England and Wales and there are a number of reports of its use from clinicians. However, to date there is only limited evidence to prove its effectiveness and no evidence that the practice is increasing.

Dexamfetamine prescribing should only be initiated by specialists with specific competencies in the area. The aim is not to give an equivalent dose to that used illegally but to minimise withdrawal symptoms and craving. For those patients stabilised on a prescription of dexamfetamine, reduction can take place fairly rapidly. Withdrawal may be associated with significant depression: the patient's mood should be monitored and the risk of suicide assessed.

Dexamfetamine is not licensed for the treatment of drug dependence. Experienced clinicians limit dexamfetamine prescribing to primary amphetamine users, injecting users, heavy, dependent use for more than three months (i.e. more than 1g daily or on more than three days a week) and evidence of escalating use and increasing tolerance and craving.

It is important that dexamfetamine is not prescribed in cases of poly-drug use, a history of mental illness, hypotension or heart disease or pregnancy.

There is little research to guide clinicians. The risk of paranoid symptoms should deter the use of high doses. Doses are usually given once a day in the morning. Daily dispensing is recommended and supervised consumption may be necessary. Avoid long-term prescribing – a strict time limit is preferable.

Injecting behaviour, illicit drug use, mental state, blood pressure, weight and urine, should all be monitored regularly.

If there is no progress towards any of the goals of treatment the prescription should be reviewed and stopped if necessary. There is as yet no international consensus or endorsement of this practice.

CHAPTER 6 HEALTH CONSIDERATIONS

Key points

- Reducing potential harm due to overdose, blood-borne viruses and other infections should be a part of all patient care.
- All drug misusers should be offered vaccination against hepatitis B, and hepatitis A where indicated.
- All drug misusers should be offered testing and, if required, treatment for hepatitis C and HIV.
- Retaining patients in high quality treatment is protective against overdose, and may be enhanced by other interventions including training drug misusers and their families/carers in the risks of overdose, its prevention and how to respond in an emergency.
- Drug misusers who are also misusing alcohol should be offered alcohol treatments.
- Drug misusers should be offered smoking cessation interventions.

1 Blood-borne viruses

1.1 Introduction

Four viruses are currently of particular concern in the context of drug misuse: hepatitis C, B and A viruses and HIV.

There have been recent increases in the levels of blood borne viruses among drug misusers (particularly those who inject). This increase is more marked in certain groups, including those injecting crack with heroin and homeless drug users. Blood borne virus incidence has also increased among new (predominantly younger) injectors and there has been a rise in the rate of sharing of injecting equipment.

Overall, approaching one in two injecting drug users in the UK have been infected with hepatitis C but there are marked regional variations. The overall prevalence of hepatitis C infection among injecting drug users has probably increased in recent years and levels of hepatitis C transmission remain elevated (HPA 2006).

Risks can be reduced by providing an optimised range of drug services, including access to:

- needle exchange services
- adequate doses of opiate substitution treatments
- structured psychosocial interventions including contingency management.

1.2 Prevention and testing

In addition to the virus-specific recommendation below, there are some general measures that clinicians working with drug misusers should take:

- Injecting equipment and education to reduce equipment sharing should be made available to all injecting drug users.
- Opiate-dependent patients, whether injecting or not, should be encouraged to have access to relevant advice and information or counselling which includes strategies for avoiding exposure to blood borne virus infection and contamination.
- Sexual partners and household contacts should be supported and tested where appropriate.

- All injecting drug users and their partners should be offered testing for hepatitis C and hepatitis B infection even if they regard themselves as unlikely to have acquired these infections.
- Testing may have to be repeated when the risk of exposure continues.

1.3 Management issues for specific drug-related viral infections

The main route of transmission in this context is the blood-borne route, through the sharing of injecting equipment or paraphernalia. However, hepatitis A is commonly transmitted through the oral-faecal route and hepatitis B and C, and HIV infections can spread through sexual contact.

Vaccination is currently available against hepatitis A and hepatitis B viruses but not against hepatitis C virus and HIV.

Hepatitis B and C viral infections may be followed by complete recovery without treatment or may develop into longer-term infection and illness. Hepatitis A infection is not usually associated with a chronic carrier state and usually requires no specific treatment. There are specific treatment regimes to be considered for the chronic infections that are commonly found with hepatitis C virus and with HIV infection.

1.3.1 Hepatitis A

Consideration can be given to immunisation against hepatitis A if appropriate. Hepatitis A vaccine can be given at the same time as hepatitis B vaccine, in separate or combined preparations.

1.3.2 Hepatitis B

Hepatitis B is in many cases sub-clinical or may only present with a flu-like illness. In patients who do not develop symptoms suggestive of hepatitis the illness will only be confirmed by abnormal liver function tests and/or the presence of serological markers of hepatitis B infection.

Hepatitis B vaccination should be carried out as soon after initial presentation as possible in all drug users, regardless of the presence of injecting. Pre-vaccination testing for antibodies indicating past exposure is not necessary.

Incentives for uptake and completion of hepatitis B vaccination could be offered in the form of vouchers or as part of a contract or package of treatment.

A record of vaccinations given should be kept.

Post immunisation testing and repeated boosters are not necessary even when antibody responses are poor.

Accelerated courses may be appropriate in drug users depending upon timing of appointments and assessments.

Household contacts should be immunised in cases where a patient has chronic active infection with hepatitis B.

A combined vaccine formulation for both hepatitis A and B viruses is available. It can be given, when considered appropriate, as three standard-spaced doses or an accelerated schedule at 0, 7 and 21 days.

1.3.3 Hepatitis C

Up to 80 percent of patients with hepatitis C will become chronically infected and most of these patients will show evidence of chronic hepatitis. Hepatitis C is slowly progressive over many years and five to fifteen percent of patients with chronic hepatitis will develop liver cirrhosis over 20 years. Four to nine percent of patients with cirrhosis will develop liver failure and two to five percent of patients with cirrhosis will develop primary hepatocellular carcinoma.

The uptake of testing for hepatitis C for those in contact with drug services has increased in recent years but it is estimated that almost half of injecting drug users with hepatitis C and in contact with these services still remain unaware of their infection.

Patients should be given information and advice on the hepatitis C virus, the risks of infection and its effects, and the role of testing and treatment. Those at risk should be offered access to screening tests and tests to confirm hepatitis C infection. Local pathways need to be in place for additional assessment and advice on management of chronic infection.

NICE technology appraisals on the management of hepatitis C infection published since 2000 have made clear that former intravenous drug users, including those on oral maintenance therapy, need not be excluded from therapy for hepatitis C infection.

In addition, there is now specific guidance in the relevant NICE technology appraisals from 2004 and 2006 that makes clear that those who continue to inject drugs and/or continue to consume/misuse alcohol should not, simply because of those behaviours, be excluded from provision of antiviral treatments for the management of hepatitis C infection, though clearly such issues unaddressed may impact on the effectiveness of treatment in particular cases.

The Scottish Intercollegiate Guidelines Network (SIGN) also produced a guideline, *Management of hepatitis C - a national clinical guideline* (SIGN 2006), which states, “Current injecting drug users infected with HCV should not be excluded from consideration for HCV clinical management, including antiviral therapy, on the basis of their injecting status.”

Specific antiviral treatments for mild, moderate and severe cases of hepatitis C infection should always be explored, including by referral for specialist advice. Some cases will require immediately antiviral therapies and others may require “watchful waiting”.

1.4 Further information

Detailed information about using other immunisations is contained in *Immunisation against infectious disease 2006* available at the Department of Health website or www.tso.co.uk.

Details of testing and treatment are available from NICE (the National Institute for Health and Clinical Excellence) and in the current guideline from the Scottish Intercollegiate Guideline Network.

2 Preventing drug-related deaths

2.1 Introduction

Rates of recorded drug-related deaths among UK drug misusers are among the highest in Europe.

Drug-related overdoses are most commonly caused by opiate-based drugs (heroin or methadone) and remain the second most common cause of 'years of life lost' in young men. Overdoses often involve the use of opiates with other depressant drugs like alcohol and benzodiazepines.

Newly released prisoners are far more likely to die during the first week of release from prison than their peers in the community.

In addition to these "sudden" deaths due to overdose, blood borne viruses (see section #1, chapter #6) continue to contribute to "late onset" deaths (occurring either during a continued drug-using career or following successful achievement of abstinence). It is also, though, important to recognise the role of clinicians in minimising risk of other deaths indirectly linked to drug misuse, for example those due to co-morbid mental health problems and to suicidal risk in drug users, and the risks of death to others due to diversion or due to unsafe storage of prescribed medication.

Despite a substantial increase in the number of methadone prescriptions since the publication of the clinical guidelines in 1999 there has been a steady decrease in the number of deaths associated with prescribed methadone. In part this reduction in deaths is likely to be the result of increased supervised consumption for patients in the early stages of methadone treatment.

2.2 Reducing drug-related deaths

Clinicians can help to reduce drug-related deaths in their patients by:

- providing education and training to drug users and their families on the risks of overdose and how to respond effectively
- advising drug users of the dangers of combining drugs, especially alcohol and benzodiazepines

- contributing to effective care pathways between prisons and the community
- educating new drug misusers that the use of methadone, outside its medical purpose, is extremely dangerous
- educating new patients starting on methadone and buprenorphine on the risks of loss of tolerance
- using supervised consumption in the early stages of methadone and buprenorphine treatment, flexibly and in line with the protocols described in section #1.3, chapter #5
- requiring that patients moving on to take-home methadone and buprenorphine provide details of satisfactory home storage arrangements and recording these in the patient's notes, especially when children are in the home
- making use of local specialist support and referral in complex cases, e.g. cases of poly-pharmacy requiring specialist review
- conducting or arranging for mental health assessments in patients who present a suicide risk.

2.3 Dealing with overdose

All services working with drug misusers should have an emergency protocol in place that covers the management of drug overdoses.

Suitable resuscitation training and equipment should be available for clinical settings. Naloxone, as well staff competent to administer it, may usefully be made available in suitable services working with drug misusers. Naloxone is a prescription only medicine and must be prescribed for a named patient or supplied to an individual by means of a Patient Group Direction. However, it can be administered by anyone to another person “for the purpose of saving life”.

Evidence for the effectiveness of take-home naloxone in preventing overdose-related deaths in opioid misusers is largely anecdotal at present. It is permissible to prescribe take-home naloxone to named patients and is established practice in some parts of the country. It would be legitimate for services to pilot take-home naloxone locally, with suitable training for its users – and for relatives and carers, if appropriate. Further research to establish whether

more widely available naloxone can be effective in reducing drug-related deaths, would be valuable.

There is a need to provide a range of overdose measures to carers of opioid misusers. These might include information, advice and training on avoiding overdose, recognising the signs of overdose and first aid, and might also include the use of naloxone.

3 Drinking and drug misuse

There is a common belief that alcohol related problems occur predominately in middle aged or older people and alcohol deaths are typically from physical diseases such as cirrhosis of the liver, cardiovascular disease, and gastro-intestinal disorders. In reality alcohol is a significant cause of death among young people through alcohol overdose, inhalation of vomit, hypoglycaemia, and accidents or violence. More generally alcohol increases the risk of dropout from treatment and exacerbates mental health problems. Alcohol increases the risk of hepatic cancer in people who are hepatitis C positive. Most of these risks are increased when alcohol and other drugs are taken in combination (ACMD 2000).

The National Treatment Outcomes Research Study (Gossop et al 2001) found 24% of the cohort at the start of the study were drinking above Department of Health recommended sensible limits and 25% were doing so at the five year follow-up. Eight per cent were drinking at 'definitely harmful' levels. About one third of service users receiving methadone have been identified as having a current drink problem and a further one sixth have a history of a drinking problem (Senbanjo et al 2006). It follows that:

- all professionals working with drug users need an awareness that alcohol misuse is not separate from misuse of other drugs
- all professionals working with drug users need to be competent at detecting problem drinking
- all professionals working with drug users need to be able to give harm reduction and educational messages regarding misuse of alcohol
- prescribers, and ideally others, need to be able to manage alcohol misuse emerging alongside pharmacotherapies such as substitute prescribing.

It may be clinically helpful to think of different patterns of drinking associated with drug use:

- drinking that is substantially independent of other drug use
- drinking that is interchangeable with the use of other psychoactive drugs
- drinking, and often other drug use, as a supplement to a substitute prescription.

Assessment of the cumulative effects of high risk behaviours and poly drug use requires some clinical experience and the application of clinical judgements.

3.1 Treatment interventions

Drug misusers who are dependent on alcohol should be offered alcohol interventions. This usually involves detoxification either in the community or as an inpatient followed by a range of psychological and pharmacological interventions to prevent relapse.

The following hints may be helpful in planning treatment:

- The standard treatments for alcohol dependence and misuse apply to those who also misuse other drugs (Raistrick et al 2006). These include psychological interventions specifically directed at alcohol misuse and pharmacology to prevent relapse such as acamprosate and disulfiram.
- The more that drinking behaviour is intertwined with drug misuse, the more the two need dealing with together, probably by a more intensive intervention.
- The stability of what is prescribed and taken is of greater importance than the total amount taken, at least in the short term – accidental or intended overdose is more likely when irregular high doses of a substance are consumed.
- Avoid polypharmacy and consider in what order to deal with multiple drugs of misuse – it is often easiest to leave opioids until the last drug.
- Consider the degree of supervision required for the safe management of alcohol detoxification – inpatient or daycare services are likely to be needed.
- Regular use of breathalyser readings may be useful in monitoring the amount of alcohol consumed and in assisting patients to reduce their use. Many services only issue substitute prescriptions when the breathalyser reading is below a certain level, often the drink driving limit. There is no evidence that this does reduce the amount a patient drinks but it may contribute to the safety of prescribing opioids in clients who are dependent on alcohol.

4 Tobacco

Most patients in drug treatment smoke although it is often the only drug dependence that is not addressed. This is despite smoking-related diseases being highly prevalent in drug misusers and likely to cause premature death in them. Smoking may act as a cue for the misuse of other drugs that are consumed in the same way. Therefore smoking may actually increase the risk of relapse into drug misuse.

Evidence suggests that smoking cessation may be associated with improved drug treatment outcomes. Similar processes apply to smoking cessation treatment as to treatment for other types of drugs, e.g. coping with cravings and preventing relapse.

Despite this most drug treatment services do not offer smoking cessation to drug misusers. This may be because staff have not been appropriately trained, believe that it will interfere with drug treatment or are tobacco smokers themselves. Or it may result from a genuine lack of evidence and clinical experience of using smoking cessation treatments in this patient group.

However, societal attitudes are changing and the smoking bans introduced across the UK in 2006 and 2007 may increase the demand for treatment for tobacco dependence in drug misusers.

There is a large evidence base for the effectiveness of treatment in the general population, with the best outcomes from a combination of behavioural support and pharmacological interventions such as nicotine replacement therapies, bupropion and varenicline (Champix). In the absence of evidence to the contrary it seems likely that drug users will respond to the same treatments as the general population although they may need more intensive options to achieve the same results.

Given the high rates of smoking and the low quit rates in drug misusers it may be reasonable to consider harm reduction approaches to smoking such as replacing cigarettes with clean nicotine in the form of patches for some of the day. This may be particularly useful in alleviating the symptoms of tobacco withdrawal while a patient is in a residential or inpatient drug treatment facility.

Clinicians should encourage patients to stop or reduce their smoking and refer them to smoking cessation services. This may be particularly easy in primary care drug treatment where many GPs and pharmacists have smoking cessation services provided within the

same premises. Specialist services may need to consider providing smoking cessation interventions as part of standard drug treatment. Staff will need to be competent in providing smoking cessation interventions.

CHAPTER 7

CLINICAL SITUATIONS

Key points

- Quality of treatment should be consistent regardless of how patients enter treatment. This includes treatment for those in the criminal justice system, including in prison.
- Appropriate communication and transfer of information between a wide range of professionals coming into contact with or providing interventions for drug misusers is vital to ensure seamless care
- Assessment and evidence-based care provided by liaison or a multi-disciplinary team is appropriate in many clinical situations, including with pregnant women, young people, older drug users, those with a dual diagnosis, drug misusers with acute and chronic pain, drug misusers being admitted to or discharged from hospital, etc.
- Clinicians working with pregnant women need to strike a balance between reducing the amount of prescribed drugs needed to prevent foetal withdrawal and not risking the patient returning to or increasing their misuse of illicit drugs
- Common mental health problems are typical in drug misuse treatment populations. Interventions for these may need to be provided in substance misuse services.
- Young people are likely to need interventions which are different from those in adults and specific competencies are required to deliver them.
- As drug users become older they will have increasing drug-related and non-drug related health needs.
- Drug misusers in pain will have needs for pharmacological and other interventions similar to non-drug users
- Drug misusers in hospital will need treatment which facilitates their medical treatment and, if possible, uses that hospitalisation to improve their engagement with substance misuse treatment

1 Criminal justice

The criminal justice systems of England and Wales, Scotland and Northern Ireland vary. What follows is a general summary of the ways in which clinicians might be involved with drug misusers in the criminal justice system.

1.1 Introduction

There is considerable overlap between those misusing drugs and those committing crimes, especially acquisitive crime and drug dealing (reference NTORS etc). Clinicians should, of course, make treatment decisions on clinical grounds but drug misusers – especially those who commit crimes to fund their drug misuse – may come into contact with, and increasingly be offered treatment in, the criminal justice system at various points and through a number of different arrangements. Clinicians need to understand the nature of these and where their involvement lies.

Drug misusers in the criminal justice system should neither receive higher priority for their treatment nor should their legal status deny them access to care equivalent to that available in the community.

1.2 Criminal justice intervention points and arrangements

1.2.1 Coordinated solutions

Increasingly, there are coordinated solutions for those who commit crimes to fund their drug misuse: engaging with problematic drug users at every stage of the criminal justice system and moving them into appropriate drug treatment and support. Case management begins at an offender's first point of contact with the criminal justice system, through custody, court, sentencing and beyond, into resettlement.

In England and Wales this coordinated case management is provided by criminal justice intervention teams (CJITs) through the Drug Interventions Programme (DIP).

The Drug Interventions Programme does not extend to Scotland or Northern Ireland although similar work linking criminal justice and treatment agencies aims to reduce the number of people who commit crime as a result of their drug misuse.

1.2.2 Police custody

Accurate assessment of drug misuse problems in detainees, including the degree and severity of dependence, and of the need for medical intervention, is essential because both intoxication and withdrawal can put detainees at risk of medical, psychiatric and even legal complications.

There is detailed guidance for forensic physicians in *Substance misuse detainees in police custody - guidelines for clinical management* (AFP & RCPsych 2006). This recognises that the assessment and treatment of drug misusers presents particular challenges which require certain skills and experience to ensure appropriate management. The guidelines contain recommendations and stress the importance of good communication, of working closely with custody officers and of shared responsibility for the safety and care of detainees with substance misuse problems with police custody officers and criminal justice intervention teams.

Criminal justice drug workers working in police custody suites provide information and, where appropriate, referral to treatment or other means of assistance. The involvement of the offender is voluntary. It is not an alternative to prosecution or due process.

It may sometimes be appropriate to ensure continuity of pharmacological treatment for drug misusers taken into custody, for example ensuring that a prescription for methadone can be continued.

1.2.3 Arrest and bail

Those arrested for a “trigger” offence in Great Britain (i.e. one associated with dependent drug misuse, such as burglary), can be drug tested. If the test is positive they can be required to undergo an assessment of their drug misuse or, in England and Wales, their bail can be restricted.

1.2.4 Drug courts

In some areas, dedicated drug courts are aimed at offenders for whom there is an established relationship between a pattern of serious drug misuse and offending. They aim to reduce the level of drug-related offending behaviour and to reduce or eliminate offenders' dependence on or propensity to use drugs. Multi-professional and multi-agency working are key characteristics of the drug court, as is continuity of the sentencer who monitors the offender's progress.

1.2.5 Community sentences

A number of community sentences now exist that incorporate requirements to undergo treatment (with consent). They are usually targeted at offenders with a significant number of previous convictions and custodial sentences.

For any of these sentence options, it is important for clinicians to note that the involvement of the offender is voluntary, although an impetus for the patient's agreement to treatment may be the hope of influencing the outcome of any criminal justice proceeding, for example, reducing the risk of a custodial sentence.

In England and Wales, the Drug Testing and Treatment Order (DTTO) has largely been superseded by the more flexible Drug Rehabilitation Requirement which is itself being subsumed as one of the options in the new Community Order.

DTTOs are available to the High Court and all Sheriff Courts in Scotland.

DTTOs were announced in Northern Ireland in December 2006 as part of a new Sentencing Framework yet to be introduced.

1.2.6 Civil orders

In addition to the sentences for criminal activity described above, there are civil orders designed to get anti-social drug misusers in the community into treatment if they are not already receiving treatment

An Intervention Order, for example, compels the recipient to undergo drug treatment to tackle the root cause of their nuisance behaviour, or face a fine.

1.2.7 Targeting programmes

There are also programmes aimed at identifying, targeting, monitoring and rehabilitating offenders believed to cause most harm to themselves and the local community.

1.2.8 Prison

The treatment of drug misusers remanded in prison or given a custodial sentence is covered in the next section.

1.3 The role of the clinician

In all of the cases described above, the clinician is still required to act in the best interests and according to the needs of the patient, and to provide a standard of treatment equal to that available to other members of the community.

Clinicians may be asked to share some information with other members of the multi-disciplinary team providing interventions to drug misusers through the criminal justice system. This is intended to assist the patient to receive consistent and appropriate care and treatment throughout their journey through the criminal justice system. Patient consent to treatment and to sharing of appropriate and limited information will be required as in other circumstances.

Although all of these issues are determined by professional and ethical considerations, they should also be covered by the clinical governance and other arrangements described in local protocols.

2 Prisons

2.1 Introduction

There is a high concentration of people with a history of problematic drug use in prison. Over a third of the people received into British prisons each year are treated for opiate dependence. Of these 40% report injecting drug use within the 28 days preceding imprisonment (Home Office, 2003). Opiate dependence and injecting are more common still among women prisoners. Many in prison have a wide range of mental and physical health and social care needs (Singleton et al 1998, Social Exclusion Unit 2002).

The average pattern of drug misuse alters markedly when an offender enters prison, with reductions in drug misuse and injecting (NOMS 2006). Although clinicians should regard clinical drug misuse management in prisons as equivalent to any other setting, there are some particular differences that they will need to take into account:

- the lower availability of drugs and alcohol in prisons
- the high volume and frequency of movement of patients
- the risk of overdose on release due to diminished opioid tolerance (Farrell & Marsden 2005).
- a correlation between drug withdrawal and suicide in the first week of prison custody (Shaw et al 2003).
- the high value, relative to the patient's limited income, of drugs
- limited access for clinicians to prisoners and difficulties with monitoring treatment

The above factors have been taken into account in the formulation of prison drug treatment policy.

2.2 Meeting the needs of drug dependent prisoners

2.2.1 Integrated treatment

As with drug misuse management in other settings, there is a need to integrate prescribing practice with psychological, medical and social interventions (Amato et al 2004). Integration

with mental health and primary healthcare services is also very important to address the high levels of complex needs within the prison population.

Clinicians should familiarise themselves with the integrated care pathways that operate in the prison where they work. In the case of a patient with serious mental illness, the mental health service within the prison will lead on the integration of the services the patient requires via the Care Programme Approach.

Clinical supervision provided by a specialist with experience of work in a secure environment will assist clinicians to gain the competence and confidence they require for working in a prison.

Prison presents an opportunity and a challenge to address a wide range of clinical needs of drug misusers, especially harm reduction interventions, e.g. hepatitis B vaccination and hepatitis C treatment.

2.2.2 Appropriate prescribing

Prescribing protocols may provide a solution to the clinical challenges presented by the prison environment.

Patients may stabilise on lower doses in prisons than they would in the community (DH 2006) Clinicians should be prepared to increase doses where needed

Poly-drug use is common among offenders entering custody. In cases of co-dependency on any combination of alcohol, opiates and benzodiazepine, more than one reduction regimen may be required, with additional caution necessary due to the interaction of these drugs. Detoxification from more than one substance should not take place concurrently.

As with practice in community services, non-medical prescribing should be encouraged and developed.

2.2.2.1 Opiates

In view of the potentially rapid onset of withdrawal effects in prison and a heightened risk of suicide among drug misusers during the early days of custody, a clinical response to physical dependence is desirable.

Where detoxification from illicit opiates is indicated, methadone is most commonly prescribed over two to three weeks. Dihydrocodeine is used in Scottish prisons. **Stabilisation** rather

than reduction of the dose should be offered in the first five days due to a risk of self-harm in this period.

Where drug users are received into prison having had their community dose continued in police custody (AFP & RCPsych 2006), this treatment should be continued in prison, subject to regular review. Time spent in police and court custody often results in a break in a patient receiving their methadone between the day of their arrest and their subsequent reception into prison. Sometimes this break can extend to three days or more. In such cases, clinicians will need to take potential diminishment of opioid tolerance into account when deciding on a starting dose of methadone. Clinicians should seek to verify prescriptions (and consumption) with community services and/or the police and use appropriate drug tests to verify the presence of opioids in the body. As offenders frequently arrive in prison in the evening, it may not be possible to secure this information during an initial assessment. Prescribing will therefore need to be circumspect enough to address the risks related to this absence of corroboration.

Some prisons will prescribe sublingual buprenorphine tablets as an alternative to oral methadone mixture. Where this treatment is offered, care needs to be taken to ensure adequate supervised consumption of the sublingual tablets. The relatively long time required for the tablet to be absorbed sublingually (compared to the time needed to swallow methadone mixture) and the reduced supply of drugs in prison mean that sublingual buprenorphine is more amenable to diversion in the prison shadow economy. See elsewhere in this document for advice on the crushing of buprenorphine.

Following induction, patients will commonly achieve stability on doses lower than those prescribed in the community.

Detoxification

Detoxification may be provided once a patient is stabilised. It should be of at least two weeks' duration from opioids, and consistent with guidance for the pacing of benzodiazepine reduction. The patient may elect to simply reduce their currently prescribed opioid, or commence a lofexidine detoxification programme.

2.2.2.2 Stimulants

Stimulant withdrawal should be treated according to clinical indications. Emerging symptoms, such as depressed mood and insomnia, are likely to be short-lived and any prescribing for this should generally be short-term and reviewed before renewal. Patients arriving in prison

with a recent history of stimulant use should be observed during the first three days of custody for any sign of emerging acute physical or psychological problem. Patients demonstrating symptoms of psychological distress should continue to be monitored and referred for mental health assessment if they are showing signs of psychosis or other serious mental health problems.

2.2.2.3 Treatment exits

Treatment exits should be negotiable and revisited. As in all other environments, treatment should not be discontinued punitively. In the event of relapse in prison, the clinician should explore the reasons for this with the patient and discuss treatment options.

2.2.2.4 Working with the patient and carers

When deciding on ongoing clinical management of opioid dependence, clinicians should take the patient's informed wishes, the opinion of any current prescriber, and the recommendation of the patient's drug worker (if applicable) into account. Where possible, and with the consent of the patient, the help of a supportive family member or significant other should be sought to assist with treatment.

2.3 Preparing for release

2.3.1 Continuing care

Preparations for drug treatment post-release, if required, should be planned wherever possible. Where release is unanticipated (when a patient is released following an order from the court, for instance, or where an individual leaves prison outside of standard working hours), clinicians should operate a contingency arrangement, which may involve making a direct referral to a community drug service.

In addition to either a specialist or community drug service referral (via a prison drug worker if applicable), it is recommended that clinicians attempt to secure a GP for their patient before they leave the prison, and that both the drug treatment provider and GP are advised of discharge medications and, if appropriate, the need to quickly take over prescribing.

2.3.2 Reviewing dose

Patients in prison will commonly achieve stability on doses lower than those prescribed in the community. However, prior to release, consideration should be given to reviewing the current dose of methadone with the patient, to optimise their likely retention in treatment upon return

to the community (Bellin et 1999, Dolan et al 2003). This may entail an increase in dose prior to release and explaining to the patient why this is appropriate.

2.3.3 Re-induction

Prior to release some users request re-induction onto opiate substitution treatment. Re-induction may be considered for patients who are about to leave prison and for whom there is a clearly identifiable risk of overdose. Those with the most significant risk of death have a history of injecting opiate use immediately prior to custody, longstanding opioid dependence and polydrug dependence (Farrell & Marsden 2005). Re-induction may be offered after the user has been offered, and declined, relapse prevention interventions and once the patient has had explained – and understands – the implications, both positive and negative, of restarting opiate misuse.

2.3.4 Naltrexone

Naltrexone prior to release from prison for users abstinent from opiates and committed to abstinence may be an adjunct to psychosocial treatment. It is not recommended as a prescribed intervention for patients leaving prison where psychosocial support cannot be secured (Minozzi et al 2006), as fall-out from treatment is associated with heightened risk of drug-related death.

3 Pregnancy and neonatal care

3.1 Introduction

The number of women misusing drugs has increased considerably in the past 30 years, and many are in their child-bearing years. 2-3% children under 16 in England and Wales are known to have a parent with problematic drug or alcohol misuse, the majority being polydrug misusers (ACMD 2003).

Though pregnancy may act as a catalyst for change presenting a 'window of opportunity', drug misusers may not use general health services until late into pregnancy and this increases the health risks for both the mother and child.

Attracting and maintaining women in drug treatment services is vital (Hepburn 1993) as follow-up studies demonstrate that the long-term outcome in women who enter methadone treatment programmes during pregnancy is better in terms of their pregnancy, childbirth and infant development, irrespective of continuing illicit drug misuse (Finnegan 1991). Women attending treatment services usually have better antenatal care and better general health than drug-using women not in treatment, even if they are still using illicit drugs (Batey & Weissel 1993). Therefore services are advised to fast track pregnant women into drug treatment to allow for the earliest engagement possible.

Engagement of a drug misusing partner in treatment is an important aspect of enabling the pregnant women to achieve progress at the earliest possible stage.

3.2 Management by a multidisciplinary team

Local multi-disciplinary policies are recommended to improve communication and reduce risks to children of drug misusing parents (ACMD 2003).

The type of service in each area will depend on local circumstances, the number of pregnant drug misusers presenting for care, expertise of the obstetric and primary care services, and availability of specialist or shared-care support.

Obstetric departments should develop good links with local drug specialists and GPs and the local social services. Local statutory authorities should have a written policy about drug-misusing parents, including the need for planning early in pregnancy, and all professionals involved should be aware of the policy.

3.3 Management of antenatal care

The key aims of management are to attract the women into health care treatment services, provide antenatal care and stabilise or reduce drug use to the lowest possible dose.

Good co-ordination between relevant parties is imperative. A planning meeting is recommended as early in the pregnancy as possible to assess risk, set goals and plan support networks. This should reduce the need for emergency child protection proceedings at birth.

The parents should be informed about all meetings and invited to attend.

3.4 Effects of drugs on the foetus and baby

It is important for clinicians to note that some of the effects of different drugs of misuse during pregnancy are broadly similar and are largely non-drug specific. Intra-uterine growth retardation and pre-term deliveries contribute to increased rates of low birth-weight and increased perinatal mortality rate. These outcomes are multifactorial and are also affected by factors associated with socio-economic deprivation, including smoking (Kaltenbach & Finnegan 1997).

Higher rates of early pregnancy loss and third-trimester placental abruptions appear to be major complications of maternal cocaine use. Increased rates of stillbirth, neonatal death and sudden infant death syndrome are found. Heroin has been shown to have a direct effect on foetal growth and an association with pre-term delivery. It has also been shown to result in a higher rate of small-for-date babies, even when allowing for other confounding factors and the expression of neonatal abstinence syndrome (NAS). There is shown to be a significant correlation between methadone dose and NAS.

3.5 Maternal health problems

There are a number of health problems in pregnancy which need to be discussed with the woman and reviewed throughout the pregnancy. These include general nutrition, risks of anaemia, dental hygiene and complications from chronic infection related to injection practice. These all contribute to the increase rate of obstetric complications and premature delivery found in drug-misusing women.

Drug misusing women are at high risk of antenatal and postnatal mental health problems.

3.6 Management of labour

This is similar to any other woman, but pain relief needs special attention especially as full opiate agonists, e.g. diamorphine or methadone, or partial agonists, e.g. buprenorphine determine the choice of analgesia in the individual pregnancy. Therefore, there should be a low threshold for considering the use of an epidural, clear local guidance on partial vs. full agonist effects explained both to the pregnant woman and the antenatal services and forward planning for how the pregnancy is to be managed. In addition, there may be increased placental insufficiency in pregnancies of drug misusing women, leading to an increased risk of intrapartum hypoxia, foetal distress and meconium staining.

3.7 Neonatal withdrawal

Many babies will not need paediatric interventions, but it is important to have access to skilled neonatal paediatric care.

Signs of withdrawal from opiates are vague and multiple and tend to occur 24–72 hours after delivery. They include a spectrum of symptoms such as a high-pitched cry, rapid breathing, hungry but ineffective sucking, and excessive wakefulness. At the other end of the spectrum symptoms include hypertonicity and convulsions but these are not common. Neonatal withdrawal can be delayed for up to 7–10 days if the woman is taking methadone in conjunction with benzodiazepines. Benzodiazepine use causes more prolonged symptoms, including respiratory problems and depression.

3.8 Postnatal management

Breastfeeding should be encouraged, even if the mother continues to use drugs, except where she uses a very high dose of benzodiazepines. Specialist advice should be sought if she is HIV positive or hepatitis C positive. Methadone treatment is not a contraindication to breastfeeding.

Health professionals should note that the care of the pregnant drug misuser and the safe delivery of the baby is just the start of care. Continuing support, which may need to include parenting advice and skills training, may be desirable after discharge if the ideal outcome of maintaining mother and child together is to be achieved.

3.9 Prescribing drugs for pregnant drug misusers

Substitute prescribing can occur at any time in pregnancy and is lower risk than continuing illicit use. It has the advantage of allowing engagement and therefore identification of both health and social needs as well as offering the opportunity for brief interventions and advice to improve outcomes.

Opiates (Kaltenbach et al 1998)

Opiate treatment will depend on the general principles outlined in this update. The overall evidence indicates that maintenance, at a dose that stops or minimises illicit use, is most appropriate for ensuring continuity of management of pregnancy and aftercare. Many mothers request detoxification, although during the first trimester the patient should normally be stabilised as there is an increased risk of spontaneous abortion. Detoxification in the second trimester may be undertaken in small frequent reductions, e.g. 2-3mg methadone every 3-5 days, as long as illicit opiate use is not continuing.

However, should illicit opiate use be continuing strenuous efforts should be made to stabilise the patient on a prescribed opiate, which may involve increasing its dose. Research evidence suggests that further detoxification should not be undertaken in the third trimester. However, the experience in the UK over the past 40 years is that slow, carefully monitored reductions may safely be continued as long as there are no obstetric complications. There is evidence that the metabolism of methadone is increased in the third trimester of pregnancy. It is recommended that the dose be split from once daily consumption to twice daily consumption and, with this management, it is possible to maintain stability without increasing the dose in some patients. However, in some, it may additionally be necessary to increase the dose.

Methadone has been used safely for many years but buprenorphine is not licensed for pregnant women. However, an increasing number of women, stable on buprenorphine, are being delivered in the UK. The research evidence demonstrates no adverse effects on the pregnancy or neonatal outcomes, with NAS similar to methadone exposure (Johnson et al 2003). Therefore, in a pregnant woman who is stable on buprenorphine and informed of the risks it is reasonable to leave her on a prescribed dose of buprenorphine, rather than transfer to methadone with the risk of inducing withdrawal in the foetus.

If detoxification is unsuccessful and the patient's drug use becomes uncontrolled, reduction could be stopped or the methadone dosage increased until stability is regained, so that detoxification and maintenance can be interchanged.

Cocaine

For those women using cocaine during their pregnancy, it is advised that they stop altogether, as there is no safe drug for substitute prescribing. Psychological therapies including family interventions, should be offered, to this group of women.

Nicotine

Smoking cessation programmes in pregnancy reduce smoking, low birth weight and pre-term delivery and therefore are recommended for all pregnant women (Lumley et al 1999).

Alcohol

Pregnant women who drink alcohol at hazardous and harmful levels have high rates of co-morbidity and social problems and the neonate is at risk from Foetal Alcohol Syndrome. Pregnant women using alcohol should be offered brief and, if appropriate, extended interventions to reduce their alcohol use.

3.10 Further reading

Chasnoff IR (ed) (1986) *Drug use in pregnancy: mother and child*. Lancaster: MTP Press Limited.

Finnegan LP, Kandall SR (1992) Maternal and Neonatal Effects of Alcohol and Drugs, in Lowinson JH, Ruiz P, Millman RB (eds) (1992) *Substance abuse: a comprehensive textbook*. Baltimore: Williams and Wilkins, 1992.

4 Mental health

4.1 Introduction

There are increased rates of psychiatric disorders among individuals using drugs and alcohol problematically. Individuals who have both a mental health and a substance misuse diagnosis are generally regarded as having a “dual diagnosis” although other terms have been used such as complex needs or “comorbidity”. Whatever the term used to describe them patients with such problems have increased rates of service utilisation, poorer levels of social functioning and overall appear to be associated with poorer outcome.

4.2 Prevalence

Studies have shown that prevalence of mental health problems in patients attending substance misuse services is high. In a study in London, some 74.5% of users of drug services and 85.5% of users of alcohol services experienced mental health problems. Most had affective disorders (depression) and anxiety disorders. Almost 30% of the drug treatment population and over 50% of those in treatment for alcohol problems experienced ‘multiple’ morbidity (co-occurrence of a number of psychiatric disorders or substance misuse problems). In the National Treatment Outcome Research Study, 29 per cent of the new admissions reported having suicidal thoughts in the previous three months and 10 per cent reported having a psychiatric hospital admission (NTORS 1998).

There is also recognition that people in contact with general mental health services usually with psychotic illnesses have increased rates of alcohol and drug problems, with approximately one-third reporting such problems (Menezes et al 1996).

4.3 Mental health policy

In 2002 the Department of Health Mental Health Policy Implementation Guide Dual Diagnosis Good Practice Guide (DH 2002) summarised the current policy and good practice in the provision of mental health services to people with severe mental health problems and problematic substance misuse. It charged Local Implementation Teams (LITs) in partnership with DATs with implementing the policy requirements described in the guide.

Individuals with these dual problems should have high quality, patient-focused and integrated care delivered within mental health services, a policy which was referred to as “mainstreaming”. In practice this policy has meant that patient with severe mental illness are

treated for their substance misuse problems and mental health problems within mental health services and those in substance misuse services with common mental illness problems additional to their substance misuse are treated in substance misuse services (see figure). A small group of highly complex patients are treated by both services working together with an emphasis on ensuring that no patients “fall through the gaps”.

The guide also emphasises the importance of local definitions of dual diagnosis being agreed locally by all relevant agencies. Across the country different models of services designed to support patients with dual diagnosis with some services set up just to provide care for patients with a dual diagnosis and in other areas individual workers having a role in encouraging liaison between services, promoting good practice and providing training. Services may be parallel (i.e. an individual attending mental health and substance misuse services) or sequential (i.e. an individual attending one service at a time depending on their needs. There is little evidence for which type of service model produces the best outcome.

Severity of problematic substance misuse	
<i>High</i>	
e.g. a heroin user who experiences increasing anxiety	e.g. an individual with schizophrenia who misuses on a daily basis to compensate for social isolation
SUBSTANCE MISUSE SERVICE	EITHER MENTAL HEALTH SERVICE OR JOINT CARE
Severity of mental illness	High
<i>Low</i>	<i>High</i>
e.g. a recreational misuse of “dance drugs” who has begun to struggle with low mood after weekend use	e.g. an individual with bi-polar disorder whose occasional binge drinking and experimental misuse of other substances destabilises their mental health
PRIMARY CARE	MENTAL HEALTH SERVICE
	<i>Low</i>

(adapted from Dual Diagnosis Good Practice Guide, DH 2002)

4.4 The care programme approach

Patients with mental health problems of sufficient severity to need monitoring under the enhanced care programme approach should have care plans which meet CPA requirements. The CPA arrangements should normally sit within mental health services although local policies may change this. Whatever the local arrangement the CPA should ensure that patients' care is planned and coordinated by individuals with the competencies to do so within a service which is sufficiently resourced.

The individual patient may also have a substance misuse care plan which incorporates the CPA requirements.

4.5 Treatment for mental health problems

Patients with mental health problems should be able to access high quality evidence-based treatment for those problems. In patients with severe mental health problems treatment should be provided in line with appropriate National Service Frameworks and NICE guidelines. For patients with common mental health problems such as anxiety and depressive illness treatment should be in line with NICE guidelines on evidence-based psychosocial interventions (NICE 2007). See chapter #4.

5 Drug treatment for young people

5.1 Young people's patterns of substance misuse are different from adults

Patterns of substance misuse are different from adults. While a significant minority of those under 18 will experiment or use illegal drugs occasionally (often in conjunction with alcohol) most illicit drug use is short term cannabis use. Alcohol use is of experimentation and that of binge type drinking with problems of intoxication. Fewer young people under 18 use regularly or to an extent where drugs and alcohol have a harmful impact on their life (substance misuse). While most drug and alcohol use carries increased risk, few young people experience harm. Some do experience harm, related to intoxication or excessive consumption, but dependence (especially opiate or stimulant dependence) and drug injecting are uncommon. Evidence indicates that young people with other problems are more likely to misuse drugs and alcohol, e.g. young offenders, those with mental health problems or those excluded from school.

5.2 Young people's specialist drug treatment is different from adults

Given the shorter history of substance misuse in those less than 18 years of age, and their continuing development and maturation, there is potential for intervention and change. Treatment goals for those who regularly use/misuse should be to reduce immediate harms from substance misuse, stabilise the young person and enable them to move to abstinence from illegal drug misuse (though some drug misuse may still occur).

Evidence and clinical experience suggest that young people's specialist drug treatment is different from adults, and will vary according to the severity of the drug use and associated problems. Brief interventions may be useful to divert young people from misuse. More intense episodes may be required, perhaps involving family and the young person to change the trajectory of drug misuse lifestyle. It is envisaged that a minority of those under 18 will require longer term retention. For those with complex needs, substance misuse treatment should be set in the context of a wider package of treatment delivered by mainstream children's and families health, social and education services. Young people's drug specific treatment should be provided separately from adult drug services.

Policy and clinical governance issues for substance misuse treatment for those under 18 are also different and require different action from clinicians. These include:

- issues of consent to treatment and competence (or capacity to consent)

- involvement of those with parental responsibility
- confidentiality and information sharing
- child protection needs
- developmental needs of the child
- competence of practitioners
- particular considerations in prescribing for under 18s including drug licensing considerations
- the different legal, statutory and policy framework for young people and families.

Many of these issues are covered in the clinical governance chapter (#2).

5.3 Research evidence on treatment effectiveness with those under 18 years

The evidence-base for substance misuse treatment for those under 18 years is not extensive and almost non-existent in UK or indeed non-US populations. Consequently, guidance based on this literature has limited applicability. Failure to address underlying risks (e.g. ADHD, learning disability) may negate the potential effect of other interventions.

Some cautious extrapolation from evidence of effectiveness in young adults is reasonable. Specific substance misuse treatment would normally involve psychosocial interventions that address the pattern of use/misuse. The NICE guidelines, *Community-based interventions to reduce substance misuse among vulnerable and disadvantaged children and young people* (NICE 2007), address young people up to 25 years and recommend identification and the involvement of multiple professionals, and the use of motivational interviewing for problematic substance misusers. They give guidance on family based programmes for those up to 16 years of age, and on group therapy for younger children with aggressive or disruptive behaviours – although these recommendations are more appropriate to generic children's services. The psychosocial guidance does not specifically address interventions for a younger age group.

There is scant research on specific pharmacological treatments for drug dependence and withdrawal for young people, though extrapolation from the adult literature may be cautiously considered. Buprenorphine and methadone are used in both detoxification and long-term stabilisation. Lofexidine is used in detoxification.

5.4 Assessment

Assessment for young people with substance misuse problems should be comprehensive and multidisciplinary. All domains of functioning should be assessed, including developmental needs, educational and language attainment, mental health and physical needs, and criminal involvement. A risk assessment to assess areas such as self harm, suicide intent and dangerousness should be organised as well as child protection needs, with review of the CAF (Common Assessment Framework (DfES 2006)). See assessment section #1, chapter 3.

5.5 Substance misuse treatment interventions

5.5.1 Brief interventions

Brief psychosocial interventions are indicated for young people misusing alcohol, cannabis and stimulants (see section #3, chapter #4).

5.5.2 Structured substance misuse interventions

Structured treatment by specialist young people's substance misuse treatment services is recommended for those under 18 who have significant substance misuse problems (normally poly-drug and alcohol misuse). This would normally comprise specific harm reduction interventions, psychosocial treatments (motivational therapies, cognitive behavioural treatments, family based supports and treatment) delivered in the context of a care plan which is part of a wider package of interventions to address all the young person's health, social, family and educational needs and perhaps offending behaviour. It may occasionally involve pharmacological interventions, both for drug misuse and co-morbid conditions. These specific substance interventions will normally require co-ordination with interventions provided by other children's agencies, with involvement of a young person's family or those with parental responsibility considered good practice and may be required with regard to consent.

5.5.3 Interventions to reduce specific drug-related harm

A young person should be assessed and receive interventions to prevent and reduce harm such as blood borne viruses, unwanted pregnancy, sexually transmitted disease, weight loss, mental health problems etc. Provision of hepatitis B vaccination, sexual health advice, and interventions such as smoking cessation may be appropriate. The provision of injecting equipment for a young injecting drug user may be required but specialist assessment is advised to prevent escalation of risk.

5.6 Pharmacological treatment for young substance misusers

5.6.1 Multiple dependencies

Pharmacological treatment will be required if a young person is dependent on a combination of alcohol, opiates and benzodiazepines, and this will require more than one pharmacological reduction regimen.

5.6.2 Alcohol dependence

The recommended medication for alcohol detoxification is chlordiazepoxide. The usual regime will be 20mg chlordiazepoxide qds initially and then reducing over 7 days.

Dose of chlordiazepoxide should be titrated until withdrawal symptoms cease.

If withdrawal symptoms do not stabilise, or if there are seizures or delirium symptoms the young person should be transferred to a hospital. Acamprosate or disulfiram may have a role, but only where supported by specialist community substance misuse teams and the young person's family, with an emphasis on compliance and perhaps supervision.

5.6.3 Benzodiazepine dependence

Benzodiazepine use among young people is more often characterised by bingeing rather than dependence. Benzodiazepine maintenance prescribing is not recommended in this age group. Detoxification, if required should be gradual according to the length and severity of dependence. Diazepam at 30mg per day is usually a sufficient maximum detoxification dose, even where previous use was higher. Benzodiazepine dependence and withdrawal can be associated with suicidal and self-harming behaviours in young people so monitoring of mental state is important.

5.6.4 Stimulants

Substitute pharmacological treatment of cocaine or amphetamine is not advocated for children or young people. Stimulant withdrawal may precipitate significant psychological symptoms such as self-harm and suicide, violence, agitation and depression that may require a full mental health assessment, treatment and careful monitoring with close liaison with a child and adolescent or other mental health team. Psychosocial interventions in line with NICE guidelines are recommended for stimulant users.

5.6.5 Cannabis

Withdrawal from cannabis may precipitate decreased appetite, weight loss, sleep problems, craving, irritability and vivid dreams which may require management. Cannabis can contribute to and exacerbate mental health problems. Where there is any evidence of psychoses a full mental health assessment must be completed and anti-psychotic medications, and careful monitoring may be required with close liaison with a child and adolescent or other mental health team. Psychosocial interventions in line with NICE guidelines are recommended for cannabis users.

5.6.6 Inhalants

For very frequent inhalant users withdrawal may precipitate agitation which should be monitored as it may require treatment. Interventions to prevent deaths may be required as these are mostly related to 'sudden sniffing' or accidental injury while intoxicated.

5.6.7 Nicotine

Many young substance misusers are regular and dependent cigarette smokers. While bupropion is not licensed for use in adolescents, nicotine replacement products have a strong evidence base, though evidence is lacking in adolescents. Nicotine patches in adolescents appear to be safe. Smoking cessation programmes should be used to enhance nicotine replacement therapy.

5.6.8 Opioid dependence

5.6.8.1 Regimens

Unless the decision to proceed with dose induction and immediate reduction and detoxification is clear, clinicians suggest a period of stabilisation with buprenorphine or methadone to allow time to stabilise and assess all domains of functioning and organise a future care plan. The use of methadone, buprenorphine and lofexidine (if detoxification is required) is recommended in the treatment of young people who are opioid dependent. Day care titration and in-patient units may be useful for stabilisation and commencement of therapy in those with unclear tolerance, with comorbid problems, with multiple drug use, with less family and social support, and for assessment of all other domains of functioning. All opioid medication should be consumed under supervision.

5.6.8.2 Dose induction

Toxicology is essential to assess and confirm opioid use and to monitor adherence to treatment. Methadone or buprenorphine should not be prescribed in the absence of positive drug testing and care should be taken on assessment of tolerance and dependence in young people. Non-opiate medication, such as lofexidine, should be used as an alternative if tolerance is unclear and prescribing is deemed necessary. Dose induction is similar to that in adults, although care must be taken about assessment of tolerance, which can be more uncertain in the young person, and greater care needs to be taken with dose with regard to body mass. Dose induction on to methadone is generally commenced at doses under 30mg and much lower if tolerance is not clear. It is unclear if the evidence for the value of induction onto higher dose in adults is applicable to adolescents, so close regular clinical review and titration in response to progress are good practice.

5.6.8.3 Stabilisation/ short term maintenance

Anecdotal evidence would suggest that stabilisation on to substitute medication with retention in treatment is greater if parents are involved and supportive. Day-care settings may initially allow greater compliance and encourage greater retention, particularly if parental support is less.

Oral methadone is started below 30mg – and sometimes much less – more often than in adults. It may then still be increased incrementally according to response. Clinical evidence indicates response is similar to the adult literature and international guidelines.

Buprenorphine is more often commenced at 4mg, increased to 8 to 12mg rapidly and increased according to response. All doses must be carefully titrated and adjusted for height, weight and age.

5.6.8.4 Detoxification

Detoxification should be a gradual process in young substance misusers and with treatment considered in the context of the young person's progress in their holistic care plan, taking into account health, social functioning, family context, accommodation, education and offending behaviour.

For those young people with a clear decision for immediate detoxification without a period of substitution treatment, lofexidine is the drug of choice. This may also be the choice for those with presumed low or unknown tolerance. If a young person has been stabilised on opioid medication, they would normally undergo detoxification using the same medication (e.g. methadone or buprenorphine).

5.6.8.5 Preventing relapse

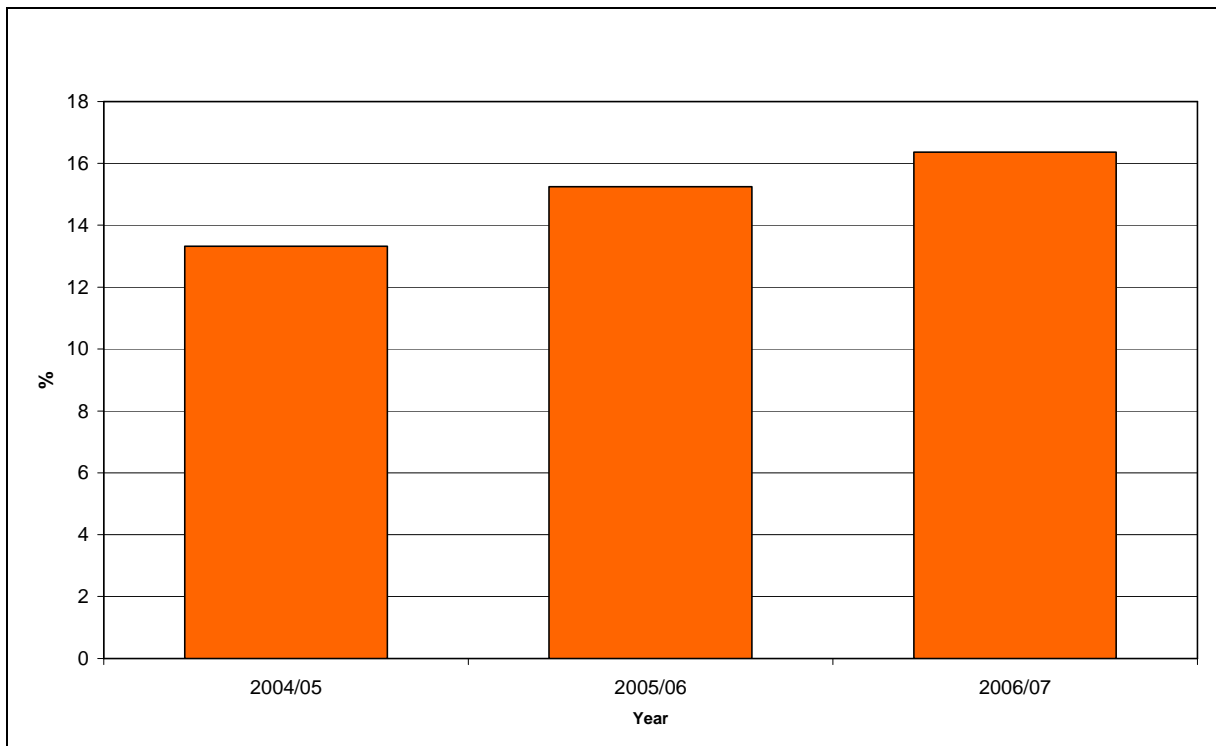
Naltrexone should be considered in young people where there is community support from both substance misuse specialists and family. Young people should also be motivated and understand the full implications of the medication.

5.7 The management of co-morbid disorders

Substance abuse in young people is usually associated with comorbid psychiatric disorders. Substance misuse may also contribute to and exacerbate mental illness. Psychological treatments are the mainstay of treatment but pharmacology may be required on occasions, e.g. for ADHD. Treatment should be in conjunction with child and adolescent psychiatrists and within NICE guidelines (2002/05) for ADHD, adolescent depression and national guidelines on autism and early onset psychoses.

6 Older current and ex-drug misusers

As the number of drug misusers entering treatment services improves and as the number receiving evidence-based substitute medication rises so too do the number of drug misusers maintained over long periods of time on substitute medication. It is not unusual now for clinicians to be caring for patients in their fourth, fifth and even sixth decade receiving methadone or buprenorphine treatment.



Drug misusers aged 40+ as a proportion of all adult drug misusers in treatment (NDTMS data)

Older drug misusers need all the usual screening and monitoring that a non-drug misuser might be offered appropriate to their age and general health status. But, older drug misusers also have special health needs and it is important that, as their patients age, clinicians are mindful of underlying problems caused either by complications of lifelong drug (and alcohol) use or by the problems associated with substitute treatment.

Data indicate a greater risk for drug misusers older than their mid-thirties of dying from drug-related causes than for younger drug misusers, with older intravenous drug users two to six times more likely to die because of drug misuse than young misusers (Bird et al 2003). Older and male injecting drug users are at highest risk of drug-related death. Overdose death

incidence can be represented as a U shaped curve, most common in the young and old age groups.

There are many reasons why increasing age may affect the individual's vulnerability to the effects of drugs (prescribed or non-prescribed) and alcohol. Health problems resulting from prolonged substance use (including alcohol, tobacco and cannabis) can exacerbate the decline in health that older adults already experience. Loneliness, loss of loved ones, or a declining sense of purpose can also lead older adults to return to substances they used casually as young people. As chronic illness increases with advancing age, older people are more likely to have conditions that require medical treatment. Advanced age, frailty, and an increased need for prescription medications are all factors that contribute to a patient's risk of developing a drug-related problem.

Alcohol use disorders in elderly people are associated with widespread impairments in physical, psychological, social, and cognitive health. Age-related changes in body composition mean that, while absorption, metabolism, and excretion of alcohol are largely unchanged, equivalent amounts of alcohol produce higher blood alcohol concentrations in older people.

Drug misusers of any age may have mental health problems and, at any age, are likely to have had more than average contact with mental health services. Combined with experience of conflict with the criminal justice system and many years of negotiating with a healthcare system which is not always sympathetic, the older drug misuser may often seem suspicious, manipulative or hostile to change. An understanding of their lifestyle difficulties is sometimes necessary to manage these attitudes constructively.

Special health needs of ageing drug misusing patients

<p>Complications related to long history of substance misuse</p>	<p>For example:</p> <ul style="list-style-type: none">• hepatic damage due to hepatitis B or C and excess alcohol use (or a combination of these)• HIV infection with or without antiviral chemotherapy• chronic airways disease from cigarette and/or cannabis smoking• chronic lung damage from inhaling drugs• chronic venous and/or arterial damage making IV access difficult or impossible• past cardiac valve destruction
<p>Poly-pharmacy</p>	<p>Risk of drug interactions between methadone/buprenorphine and treatments used to modify other diseases (e.g. antihypertensive, hypoglycaemic)</p>
<p>Normal aging process</p>	<p>Patients on methadone can also develop any of the diseases common in the elderly community, including hypertension, diabetes, chronic airways disease.</p> <p>Interpreting memory loss or cognitive function may be impaired by longstanding drug-related neurological damage</p>

7 Pain management in drug misusers

7.1 Introduction

Pain, both chronic and acute, is a complex biopsychosocial experience and both drug dependence and chronic pain are common conditions with long-term consequences. Chronic pain is estimated to affect 13% of the UK population. Pain can be either acute or chronic. Chronic pain leaves the individual susceptible to mood disorders and reduces their ability to function across domains. The commonest causes are back pain, arthritis and headache – all increasing in prevalence with age. Acute pain occurs commonly in drug misusers as they are at a higher risk of physical illness and traumatic injury as a consequence of their lifestyle. Pharmacological intervention is only one aspect of pain management and non-pharmacological interventions, e.g. CBT, should be considered for drug misusers although considerable support may be needed for these patients to engage in them.

7.2 Acute pain

Acute pain requires full analgesic management in patients dependent on opioids. Such patients may have a lower tolerance of pain together with a higher tolerance of opioid analgesic effect. If pain is mild to moderate, non-opioid analgesia (as used in the general population) is the initial treatment of choice together with appropriate education and advice. In more severe pain, if opioid analgesia is indicated, the treatment will depend on whether the patient is taking full agonist opioids, e.g. methadone, partial agonist opioids, e.g. buprenorphine, or opiate antagonists, e.g. naltrexone.

If the patient is dependent on full agonists the opiate pain relief should be titrated against pain while monitoring respiratory function. Sub-therapeutic doses should be avoided.

If the patient is dependent on a partial agonist, e.g. buprenorphine, especially high doses of full agonist opioids will be required initially, with careful monitoring and anticipated dose reduction in the subsequent 36 to 72 hours.

Opiate antagonists, e.g. naltrexone, will render opiate analgesia ineffective.

All patient and carers should be informed of and understand the effects of opioid substitution and opioid blockade on pain management and are advised to carry a card stating their current medication.

Pregnant women dependent on opioids and in labour should have full pain management as indicated. Once they are tolerant to their maintenance opioid they will need additional analgesia. However the need for monitoring of the respiratory function of the woman and the foetus/neonate should be taken into account.

7.3 Chronic pain

Opioid dependent patients who develop chronic pain report lower pain thresholds than controls (Compton 1994), i.e. that they feel pain more easily. Practitioners should investigate complaints of pain to exclude physical comorbidity and mood disorder. Therefore these patients frequently require assessment by medical, primary care, psychiatric and pain services. The development of joint working arrangements across services for this population is desirable. It should be remembered that complete symptomatic relief of chronic pain is seldom possible and an acceptable balance between improved function and side effects should be seen as the goal. Non-pharmacological interventions must be considered for all patients including OT assessments etc.

Patients should have:

- full joint assessment
- jointly agreed treatment plan including agreement by the patient
- lead agency to manage their treatment
- single prescriber to avoid multiple prescribing
- prescriptions dispensed in ways which minimise over use and diversion
- regular review
- plan for responding to non-compliance or if outcomes are not met.

Patients with pain resulting from terminal illness should be managed by palliative care services. Advice on current good practice in pain management and addiction medicine, and practical pharmacological and non-pharmacological solutions for the treatment of pain in drug dependent patients can be found in *Pain and substance misuse: improving the patient experience* (British Pain Society 2006) which contains common clinical scenarios and solutions.

8 Admission to and discharge from general hospital

8.1 Introduction

Drug misusers may attend at A&E or be admitted to hospital for treatment of conditions common to other patients or directly related to their drug misuse. In either case, hospital medical staff should take proper account of any drug misuse and any treatment being provided in the community.

The objective of substance misuse treatment in hospital should be to stabilise drug use as rapidly as possible in order that the patient can have appropriate treatment for both drug related and non-drug related medical conditions.

On occasions the patient may wish to take the opportunity of a hospital admission to reduce their drug doses or even to detoxify fully. This may occasionally be useful but if not planned is likely to result in relapse on leaving hospital, which in turn exposes an individual to overdose risks.

The transfer of care on admission and discharge requires understanding of the issues involved and a co-ordinated response by all professional staff concerned in the care of the patient. Planned admissions will provide greater opportunities for preparation and effective transfer of care. A&E treatment and emergency admissions may present greater challenges.

8.2 Opioid-dependent patients

8.2.1 Assessment

The doctor must ensure that an adequate assessment has been made before prescribing substitute opiates or other controlled drugs. Full assessment of drug misusers requires specialist knowledge and expertise, and all doctors are strongly encouraged only to initiate opiate substitution prescribing as part of a multi-disciplinary team. Appropriate senior advice should be sought.

Aims of assessment include to:

- enable treatment of any emergency or acute problem or enable an elective procedure to take place
- confirm patient is taking drugs (history, examination and urine analysis)
- identify degree of dependence

- identify complications of drug misuse and evaluate risk behaviour. This may include confirming HIV status, risk of hepatitis B and C infections, general nutrition and alcohol intake. Appropriate pre- and post-test, information and advice, or counselling, should be provided concerning blood borne virus infections.

Hospital staff responsible for the assessment of an opiate-dependent patient are advised to contact their local drug misuse treatment service.

For patients currently being prescribed methadone or buprenorphine for treatment of opiate dependency, good communication between hospital and community is essential for safe patient care. The patient will usually have a named keyworker and a named pharmacy. They will be receiving treatment from either their GP or a local specialist substance misuse service. Prescribing in these cases should be a relatively straightforward matter of continuing the usual dose while in hospital. The hospital doctor should ascertain by independent means (e.g. through communication with the patient's specialist prescriber or GP, or with the community pharmacist or the keyworker) the prescribed daily dose and, if possible, when the last dose of methadone was swallowed or, at least, when last script was issued and how many days have been supplied.

For patients not on opiate substitution treatment, or where there is uncertainty about recent compliance, it is appropriate to exercise particular care in initiating opiate substitution treatment.

8.2.2 Initial dosing schedule for opiate-dependent patients admitted to hospital

Safety first

- Only prescribe following an assessment. Do not give in to undue pressure to prescribe immediately. Take time to assess if necessary. However, remember a patient who is experiencing withdrawal symptoms may not be able to cooperate fully with medical or surgical treatment.
- Poly-drug and alcohol misusers may develop multiple withdrawal syndromes and hospital doctors will need to differentiate these to prioritise treatment. Methadone may initially mask alcohol and benzodiazepine withdrawal symptoms.
- Exercise particular care in cases of respiratory disease, head injury and liver diseases.

- It is important to be extremely careful when prescribing additional drugs such as sedatives. It may be necessary, in some cases, to contact the relevant pain control team for further advice on improving pain control.

Signs of opiate withdrawal

Confirming presence of opiate withdrawal syndrome (and particularly observing objective signs) can be very helpful, when it is clinically feasible, to support a diagnosis of dependence.

Signs of opiate withdrawal are as follows:

**For safety's sake rely more on
OBJECTIVE signs of opiate withdrawal:**

- yawning
- coughing
- sneezing
- runny nose
- lachrymation
- raised blood pressure
- increased pulse
- dilated pupils
- cool, clammy skin
- diarrhoea
- nausea
- fine muscle tremor

**Do not rely on what the patient says, i.e.
SUBJECTIVE signs of opiate withdrawal:**

- restlessness
 - irritability
 - anxiety
- (These may also be useful objective signs)
- sleep disorders
 - depression
 - drug craving
 - abdominal cramps

When it is concluded that it is appropriate to initiate opiate substitution in hospital, to manage the risk of opiate withdrawal, methadone is usually preferred over buprenorphine (as the latter acts as a partial agonist and may interfere with acute pain management) but choice will depend on circumstances of the individual case (particularly, for example, if respiratory depression is a particular concern).

Initially prescribe a small dose of methadone in divided doses (e.g. four times a day) under conditions of supervised consumption. Titrate against opiate withdrawal symptoms. Initial dose should be no more than 10mg four times a day. Final total daily doses may be as little as 30mg or as much as 120mg.

After initial induction (over three to four days) allow time for methadone levels to reach steady-state (and so minimise the risk of an excessive cumulative increase in blood levels in the early days of treatment), then reassess and give the medication as a supervised single daily dose.

Signs of intoxication such as drowsiness, slurred speech or constricted pupils indicate a need to discontinue the drug or reduce dosage. Patients may also continue illicit drug use on the ward leading to such intoxication.

The hospital pharmacist can provide advice on drug interactions, liaison with primary care and the practicalities of issuing instructions to nursing staff about the prescribing of controlled drugs.

8.2.3 Overdose

Treat opiate overdose with standard resuscitation techniques and with the use of naloxone. Naloxone is given 0.2-0.4mg parenterally (IV/IM/SC) and this can be repeated after every 3-4 minutes, up to a maximum dose of 10mg.

It is important to remember the half-life of naloxone is much shorter than methadone and other opiates. This fact should be made clear to patients, particularly in A&E and in other situations where the patient may leave the hospital precipitantly. Patients should be helped to understand that they are at risk of re-emergence of life-threatening sedation when the naloxone wears off. Given that some patients may find it difficult to cope with the precipitated discomfort that can occur on administering naloxone, and so may choose to leave, it is important that they are helped to understand this risk.

8.3 Other drugs of misuse

Behaviour of opiate dependent patients may involve poly-drug and alcohol misuse. It is not uncommon for opiate users (prescribed or illicit), for example, also to be prescribed or taking illicit benzodiazepines and/or be dependent on alcohol. The misuse of these substances may lead to associated withdrawal symptoms and to seizures.

Benzodiazepine prescribing should only be done once dependence has been established by history taking and by exploring the presence of withdrawal symptoms. A slow withdrawal regimen starting at no more than 30mg (and usually lower) and reduced over one to four weeks is appropriate in the inpatient setting. Patients may also require detoxification from alcohol.

Routine prescribing of benzodiazepines as hypnotics and as anxiolytics should be avoided.

8.4 Discharge

8.4.1 Drug misusers not previously in treatment

Attendance at A&E or admission into hospital may present a window of opportunity to put a drug misuser in touch with other services and consider his/her drug misuse. On discharge the following information should be given as a minimum:

- general health promotion advice
- contacts for further help (e.g. needle exchange services, treatment services or self help access)
- advice on prevention of overdose
- advice on reducing risk of blood borne virus infection and its consequences (including support for hepatitis B vaccination).

This information is available from local substance misuse services.

8.4.2 Patients prescribed methadone prior to discharge

If the patient was admitted on a methadone prescription from the community, this should ordinarily be continued on discharge and prescribing responsibility transferred back to the community prescribing service or GP.

- At least 24 hours before discharge, the doctor should contact the local drug service or the patient's GP regarding discharge date and agree how much methadone should be

prescribed to the patient on discharge. This may be influenced by local treatment policies.

- On the day of discharge confirm to the GP or drug service:
 - whether or not that day's dose has been administered at the hospital, and if so how much
 - the number of days' supply that the patient is taking home (minimising this usually to around one day's supply depending on availability of appointment – larger amounts run the risk of overdose or being pressured to hand over or sell their supply)
 - any other drugs that the patient is being prescribed.
- If the patient's drug misuse is being treated by a GP and the GP cannot be contacted, contact the patient's community pharmacist who should be able to advise what the patient's prescription is and whether it is still current.

Take care in prescribing take-home doses. Generally, they should be avoided although one or two days may be necessary to ensure continuity of care. For slightly more extensive periods it may be sensible to limit availability by ensuring daily/frequent pick-up (through instalment dispensing or by provision of multiple appropriately dated prescriptions).

ANNEXES

1 Cardiac assessment and monitoring for methadone prescribing

1.1 Electrocardiogram (ECG) and the heart

During the contraction of any muscle (including heart muscle) electrical changes occur (depolarisations) which can be detected by electrodes attached to the surface of the body. The electrocardiogram (ECG) is a recording of the electrical changes during the contraction of the heart muscle. Although the heart has four chambers, from an electrical view it can be thought as having two. This is because the two atria contract together followed by the two ventricles contracting together.

Contraction of the atria of the heart causes the ECG wave called 'P'. The ventricular mass is large and so causes a larger deflection of the ECG when the ventricles contract. This is called the 'QRS' complex. The 'T' wave of the ECG is caused by the return of the ventricular mass to the resting electrical state (repolarisation). The QT interval is measured from the beginning of the Q wave until the end of the T wave (Figure 1). The QT corrected (QTc) interval is the QT interval corrected for heart rate using a standard formula. QT is measured in milliseconds. Bazett's formula (Figure 2) is commonly used to calculate QTc.

Figure 1: Graphical representation of the ECG showing QT interval measurement

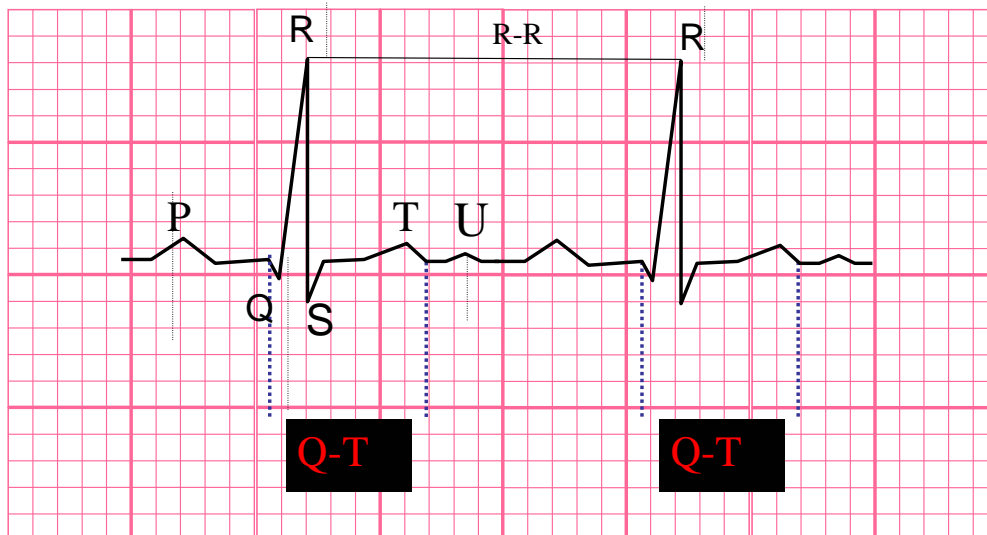


Figure 2: Bazett's Formula

$$QTc \text{ (ms)} = QT \text{ (ms)} / RR^{\frac{1}{2}}$$

1.2 Drug-induced prolongation of the QT interval

The QTc interval is a useful, but imprecise indicator of risk of polymorphic ventricular tachycardias, or torsade de pointes which can be fatal. Limited evidence suggests that the risk of cardiac mortality increases with QTc interval prolongation beyond normal limits (440ms for men and 470 ms for women). More evidence supports QTc values over 500 ms as a predictive risk factor for arrhythmias (Botstein 1993).

Psychotropic medications have been associated with electrocardiogram (ECG) changes and sudden death. In the past decade the most common reason for a drug to be withdrawn from the market has been prolongation of the QTc interval. Cardiac rhythm disorders were the main reason that levacetylmethadol (ORLAAM) was suspended from marketing (EAEMP 2001).

1.3 Methadone and risk of QT prolongation

Methadone may prolong the QTc interval and/or induce torsade de pointes. This was initially documented in a study by Lipski and co-workers in 1973 (Lipski et al 1973). This study examined patients on heroin and methadone and showed ECG changes, predominately QTc prolongation, in the patients on methadone. More recently Krantz and coworkers undertook a retrospective study of 17 methadone maintenance patients who developed torsade de pointes (Krantz et al 2002). They concluded that very-high-dose methadone may be associated with torsade de pointe. A prospective study examined 130 patients entering methadone maintenance for 30 days. This showed that following methadone induction the QTc interval increased by 7.58% for males and 7.97% for females (Huber et al 2001). The mean QTc did not exceed specified thresholds (450 adult males and 470 adult females). A further study had results of ECG's before and during methadone induction and stabilization, for 132 heroin dependent patients. They found the QTc interval to increase significantly by 10.8% from baseline to follow-up, regardless of dose (Martell et al 2003).

A number of case reports have been published documenting incidences of patients on high dose methadone experiencing QT prolongation and torsade de pointes. A further report of four patients with HIV developed QTc prolongation, while on high doses of methadone (Gil et al 2003). This was followed by reduction in the QT interval when the methadone was reduced. Another report documents a methadone maintenance patient who had a cardiac arrest with QTc prolongation. The methadone was stopped and there was a gradual reduction in QTc. Twelve days post-arrest, methadone was restarted and this was followed by QTc prolongation again (Decerf et al 2004).

Kornick et al (2003) presented results of a retrospective study assessing ECGs in patients on and off iv methadone. They found a significant mean difference of 41.7ms between patients on and off methadone. The mean difference of patients on and off morphine was 9.0ms. They concluded that methadone in combination with chlorbutanol additive is particularly associated with a prolonged QTc interval. This additive is not normally used as an additive in the British formulation of methadone.

ECGs of intravenous drug users prescribed methadone were compared to patients not in treatment and it was found that patients with QTc > 500ms were 16.2% in the methadone group as compared to 0% in the control (non methadone group). In addition QTc was weakly associated with methadone dose (Ehret et al 2006). Another study assessed QTc intervals related to methadone dose and serum methadone concentrations in a cross-sectional study. Patients were generally on high dose methadone (mean 170.9 +- 50.3mg) however the mean QTc was within normal limits (418.3 +- 32.8). This paper found that methadone dose and serum levels did not correlate with QTc. However 2 patients died with prolonged QTc intervals during the study follow-up, which although this was not attributed to cardiac origin may have actually been missed diagnoses of torsade de pointes (Peles et al 2007).

Krantz recently reviewed some of the evidence on QTc prolongation or episodes of torsade de pointes in patients on methadone treatment (Krantz & Mehler 2006). This paper discussed the dose dependent effects of methadone on the QTc interval while also accepting that higher doses of methadone are more effective at reducing heroin use. Buprenorphine was proposed as a potential substitute for patients with methadone-related QTc prolongation or torsade de pointes. However this may not be effective for patients on high dose methadone. Lastly, the contentious issue of ECG screening for heroin dependent patients entering screening was addressed. Although ECG screening was not advocated for most individuals entering treatment, it was suggested to be considered in circumstances where individuals starting methadone have structural heart disease or additional QTc prolongation risk factors.

A limitation to the literature is that information is based on mostly retrospective, non-randomised, non-blinded, small studies. In addition, confounding variables may not have been accounted. For instance cocaine has been shown to increase QT intervals acutely (Haigney et al 2006) and may be a confounding factor with many studies. Other confounding factors may be the use of antipsychotics and tricyclic antidepressants that have also been independently associated with QT interval prolongation (www.torsades.org). It is possible that methadone in combination with other QT risk factors may increase the risk of QT

prolongation (Schmittmer et al 2004). However some of the reports are from prospective studies and the data available should at least prompt a greater awareness of the risk that methadone may have for QTc prolongation and torsade de pointes.

In summary the evidence, as currently available, points towards methadone as a risk factor for QT prolongation and torsade de pointes with a possible dose-dependent action.

1.3.1 MHRA guidance 2006

The Medicines and Healthcare products Regulatory Agency (MHRA) reports on current problems in pharmacovigilance. In May 2006 it was documented that methadone spontaneous reports in Europe and the literature (5) have 'highlighted the risk of QT prolongation in patients taking methadone, especially at high doses'. The MHRA has recommended there should be careful monitoring for patients on high dose methadone (>100mg daily) and/or with other QT interval prolongation risk factors including heart or liver disease, electrolyte abnormalities, concomitant treatment with CYP 3A4 inhibitors, or other drugs with the potential to cause QT interval prolongation (MHRA 2006).

1.4 Patient consent and information

The patient should be fully informed of the available evidence, the reasons for the clinical assessment and fully involved in the decision making process for their treatment. If a patient refuses to have the ECG this should be documented and their GP informed. A patient information leaflet may be useful to inform the patient of the available evidence. Please see Figure 4 in the appendix section for an example.

1.5 Clinical assessment of opioid dependent patients on methadone maintenance

The information below is based on the available evidence and the MHRA guidelines. Please also refer to the general section on clinical assessment for substance misuse patients before proceeding.

A standard physical health assessment and physical examination should be carried out all patients who are on methadone maintenance treatment as per clinical practice and department of health guidelines. For patients already in methadone treatment, the clinical assessment should specifically include assessment of heart or liver disease, concomitant treatment with CYP 3A4 inhibitors, other drugs with the potential to cause QT interval prolongation and the presence of electrolyte abnormalities.

1.5.1 History

Particular information to obtain as part of the history:

- substance use history, particularly cocaine or amphetamine use
- previous history or investigation for heart disease, including palpitations, fainting, dizziness or chest pain
- medical conditions that may cause a metabolic imbalance, e.g. eating disorder, diarrhoea, vomiting, liver, kidney disease, HIV or hepatitis
- medication:
 - dose of methadone
 - specifically assess presence of CYP 3A4 inhibitors or other medications with a potential to cause QT prolongation.
- family history of arrhythmia.

1.5.2 Physical examination

Particular information to obtain from the examination:

- pulse
- blood pressure
- jugular venous pulse
- presence of murmur
- pulmonary crepitations
- presence of oedema.

1.5.3 Investigations

- drug screens (detection of cocaine or amphetamines)
- blood tests:
 - detection of hypokalaemia (urea and electrolytes)

- detection of liver disease (liver function test and hepatitis testing)

1.6 Cardiac monitoring for patients on methadone

An ECG should be undertaken if MHRA criteria are fulfilled, such that the patient has evidence of:

- heart disease
- liver disease
- concomitant treatment with CYP 3A4 inhibitors
- use of other QTc prolonging drugs
- electrolyte abnormalities
- methadone dose >100mg a day.

A computer generated QTc interval is normally documented on the ECG recording. This may be used for most clinical purposes, however if there is documented QTc prolongation, it may be useful to perform a manual measurement of the QT interval (Figure 1) and correct for heart rate using a standard formula (for example see Figure 2). If there is doubt whether the ECG shows QTc prolongation or evidence of other cardiac abnormalities, referral for the ECG/patient to be assessed by a cardiologist should be considered.

1.6.1 Recommended action following an ECG

If the ECG is normal with no evidence of QTc prolongation - consider 6-12 monthly ECG monitoring based on MHRA criteria

If the QTc interval is prolonged - consider actions as documented below

If the ECG is otherwise abnormal – consider referral to a cardiologist

Figure 3: Recommended actions following QTc prolongation

	Gender	QTc	Action
Borderline prolonged QTc	Female	≥470ms	<ul style="list-style-type: none"> • Repeat ECG • Electrolytes • Assess and modify QT risk factors • Monthly ECGs
	Male	≥450ms	
Prolonged QTc	Males and females	≥500ms	<ul style="list-style-type: none"> • Manual QTc • Repeat ECG • Electrolytes • Assess and modify QT risk factors • Consider reducing methadone dose, risk:benefit analysis • Referral to cardiologist • Weekly ECGs
Very prolonged QTc	Males and females	≥550ms	<p>As above, in addition:</p> <ul style="list-style-type: none"> • Consider reducing or stopping methadone, risk:benefit analysis • Consider transfer to buprenorphine • Urgent referral to cardiologist • Seek specialist advice on frequency of ECGs

1.7 Clinical assessment of opioid dependent patients when initiating methadone

At present, ECG screening prior to commencing methadone treatment is not advocated. This should be based on a risk-benefit analysis. However a baseline ECG may be considered in patients with evidence of heart or liver disease, concomitant treatment with CYP 3A4 inhibitors, use of other QTc prolonging drugs or electrolyte abnormalities. Currently ECG screening before commencing methadone treatment is undertaken as standard practice in Norway (personal communication).

If an ECG is performed at baseline and results in an abnormal recording, including QTc prolongation, the guidelines in Figure 3 should be followed. The question as to whether to start methadone when an abnormal QTc is recorded would depend on an analysis of the risks of not commencing methadone as compared with the benefits of commencing methadone. Alternatives to methadone could be considered. It would also be important to

address other QTc risk factors (e.g. cocaine use) and to ensure the patient is fully informed and involved in the decision making process.

1.8 Summary

- Methadone may be a risk factor for QT prolongation and torsade de pointes with a possible dose-dependent action.
- The MHRA recommends monitoring for patients on high dose methadone (>100mg daily) and/or with other QT interval prolongation risk factors.
- Patients should be fully informed of the reasons for the clinical assessment and involved in the decision making process for their treatment.
- Screening before commencing methadone treatment is not currently advocated but may be considered.
- QTc \geq 500ms needs investigation, specialist referral, QT risk factor modification and frequent ECG monitoring.

Figure 4: Sample patient information sheet

<p style="text-align: center;">Opioids and abnormal heart rhythms</p> <ul style="list-style-type: none">• Many conditions can affect the heart beat such as age, disease and drugs• Abnormal heart beats may cause sudden death although this is rare• Methadone may be a risk factor for developing abnormal heart beats• Some patients on methadone may be advised to have an ECG to identify any risk of serious abnormal heart rhythms <p>At rest, the heart usually pumps blood at a rate of 60 to 90 beats per minute. Although extra beats occasionally occur, the normal pattern (rhythm) of heartbeats is fairly regular. The heart has an electrical system in which tiny electrical currents spread through the heart muscle and make it contract (beat), controlling the heart rate and rhythm. Age, disease, drugs and alcohol can affect the electrical system and cause abnormal rhythms (arrhythmia). Abnormal heart beats (arrhythmias) can cause the following; palpitations in the chest (feeling of the heart beat), fainting, shortness of breath, swollen legs. Rarely arrhythmias can cause a cardiac arrest – a sudden and complete failure of the heart to pump blood, which can result in sudden death. One form of this cardiac arrest is called torsade de pointes. There are many factors that increase the chance of a person developing torsade de pointes.</p> <p>Methadone and risk of irregular heart beats and torsade de pointes</p> <p>In the last 5 years there have been a number of reports of patients on methadone suffering torsade de pointes, sometimes resulting in sudden death. It is difficult to know whether it is the methadone or other factors (such as other drugs used) that caused this to happen. At this stage, we do not know how much being on opioid treatment increases someone's risk of developing these problems. However given the hundreds of thousands of people treated with opioids over many years across the world, it is unlikely that opioids alone greatly increase the risk for most people. It may be more likely to happen in patients on high doses (e.g. greater than 100mg methadone), those with heart or liver disease, taking certain medications, or other drugs.</p> <p>How do I know if I am at risk of developing irregular heart beats (arrhythmias)?</p> <p>The best way to assess whether someone is at risk of developing these heart problems is by having a simple test called an electrocardiogram or 'ECG'. An ECG records how the heart's electrical system is working. An ECG recording is painless and harmless (the ECG machine records electrical impulses coming from your body - it does not put any electricity into your body), and takes about 5 minutes to do. It can identify people at risk of developing arrhythmias by looking at the shape of the 'electric wave', and by measuring how long it takes for the electricity to pass through the heart – this is called the QT time. People with very long QT times are at greater risk of developing severe arrhythmias such as torsade de pointes.</p> <p>What if I have a long QT time? This means that you may have a greater risk of developing torsade de pointes than other people. Although, most people with long QT intervals do not develop torsade de pointes, it is wise to look at whether there are some risk factors that can be changed to reduce your risk. Your key-worker will work through the options with you.</p> <p>What if I have a normal QT time? This means that you are at low risk of developing torsade de pointes, and no further action need be taken at this time.</p> <p>Please talk to your keyworker or doctor if you have any concerns about these matters.</p>
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2 Writing prescriptions

NB This annex covers the requirements for writing prescriptions for controlled drugs for the treatment of drug dependence for dispensing by a community pharmacist.

2.1 General considerations

Writing prescriptions for controlled drugs is complicated as it is necessary to consider:

- the safety of the patient
- communication between the prescriber and the dispensing pharmacist
- the legal requirements as required by the Misuse of Drugs legislation, NHS legislation and the legal and good practice requirements implemented as a result of the Shipman inquiry
- additional requirements when prescribing relating to instalment prescriptions
- the requirements for NHS pricing.

2.2 The safety of the patient

Patients must be warned:

- that methadone and other prescribed drugs must be kept out of reach and out of sight of children and vulnerable individuals
- of the risks of overdose and death if opiates are taken by an opiate naïve person.

Children of patients prescribed substitute medication must not be authorised to collect parent's (or others') medication from the pharmacy.

The person collecting the medicine from the dispensing pharmacy will be required to sign the back of the prescription form when collecting schedule 2 or schedule 3 controlled drugs.

Legislation states that the pharmacist **MUST** ascertain whether the person collecting is the patient, patient's representative or healthcare professional. In the case of schedule 2 prescriptions (e.g. methadone), the person will be asked to present some form of identification. Note the requirements for signing the prescription and identification on collection do not apply to instalment prescriptions except the first time the client presents. It

is at the discretion of the pharmacist who in special circumstances may dispense without the above requirements.

The patient should collect the CD in person. If he or she is unable to collect prescriptions personally, the patient may arrange for a representative to collect it. In such circumstances, pharmacists will require a letter from a patient, stating that a named person is authorised to collect the drug on the client's behalf. (Such authorisation is also recommended, for example when a patient is in custody, to authorise a named police officer to collect an instalment from the pharmacy). This is not a legal requirement, but it may prevent misunderstandings or deceit. The person collecting may then be asked to sign in a record book. It is at the pharmacist's discretion whether to supply to another person if for any reason the pharmacist is concerned the request is not genuine.

2.3 The legal and good practice requirements

Do not leave blank prescription forms unattended. When not in use, keep in a locked drawer.

It is an offence for a prescriber to issue an incomplete prescription and a pharmacist is not allowed to dispense a controlled drug unless all the information required by law is given on the prescription. This means the pharmacist cannot agree alterations by telephone or authorisation letter. All the correct relevant information must be on the prescription before it can be dispensed. If an incomplete prescription is returned by the pharmacist then the prescriber signing the prescription must make the necessary alteration. In an emergency, the Home Office has stated that it would be acceptable for another doctor or health professional, who is allowed to prescribe CDs under the legislative rules, to amend a controlled drug prescription provided that he or she signs and dates it.

A prescription must:

- be indelible
- be signed by the prescriber, (usual signature/handwriting) – the dispensing pharmacist must be acquainted with the prescriber's signature or must be able to be satisfied that the signature is genuine.
- be dated (a computer generated date or rubber stamp is acceptable)

- specify the prescriber's address which must be in the UK (NB the UK does not include the Channel Islands or the Isle of Man). Although one prescriber in a practice may stamp the prescription and another prescriber in the same practice may write and sign it because the prescriber's address will be the same, the Department of Health does not consider this to be good practice.

The prescriber's name should be legible for example by printing the name in block capitals after the signature or by ensuring the name is pre-printed on the prescription. It is good practice to include the prescriber's registration number and the profession of the person signing the prescription.

Non-medical prescribers must include particulars on the prescription to indicate the type of non-medical prescriber, the relevant wording for non-medical prescribers together with the PIN or RPSGB registration number, as appropriate. (At the time of writing (June 2007) only nurse and pharmacist supplementary prescribers are allowed to prescribe controlled drugs used in the treatment of addiction, in accordance with a clinical management plan).

Prescribers can now issue computer generated prescriptions, only the signature needs to be in the prescriber's own handwriting. Handwritten prescriptions should be written by an appropriate healthcare professional. "Own handwriting" requirements for schedule 2 and 3 controlled drugs were removed in November 2005. Prescription requirements for the total quantity to be in words and figures, and for the strength, form and full dose to be included all remain in place.

Carbon copied or faxed prescriptions are not acceptable for Schedule 2 and 3 controlled drugs.

The prescription must always state:

- the name and address of the patient. An e-mail address or PO Box is NOT acceptable. "No fixed abode" IS acceptable as an address for homeless persons
- in the case of a preparation, the form and where appropriate the strength of the preparation
- the total quantity of the preparation, or the number of dose units in both words and figures

- the daily dose, or dose of each amount to be taken, and the frequency (note that “as directed” is not acceptable – see table below).

Other points:

- As a general principle, substitute drugs should be prescribed in daily instalments (see section #1.1, chapter #5).
- In England, Wales and Northern Ireland, use the special instalment prescription forms where more than one pick up is required. In Scotland forms GP190 and HBP(A) can be used for prescribing instalments.
- When prescribing in instalments, the prescription must contain a direction specifying the amount of the instalment which may be supplied and the intervals observed when supplying. It is not a legal requirement for the number of instalments to be specified.
- The prescription must specify amounts to be collected on days to cover when the pharmacy is closed (e.g. Sundays and public holidays)
- The pharmacist must only dispense the prescription on the date on which it is due. If the patient does not collect an instalment when it is due, that supply is no longer valid – the patient cannot collect that instalment on another day.
- Additional wording can be added to the prescription to allow the pharmacist to dispense part instalments. This wording must be specifically approved by the Home Office. Examples of Home Office approved wording are given in the table below. Pharmacists will need to be informed through official channels (such as their own professional networks) when new wording has been approved by the Home Office.
- Only medical practitioners, who hold a special licence issued by the Home Secretary may prescribe, administer or supply diamorphine, dipipanone or cocaine in the treatment of drug addiction. (Currently, non-medical prescribers are not “medical practitioners” in this sense and may not prescribe these drugs or obtain a special licence).
- In most circumstances, it is good practice not to supply more than one week’s total dose at one time, except for holidays and special arrangements, when prescribing substitute drugs.

- Prescribers should restrict prescriptions for schedule 2, 3 and 4 controlled drugs to amounts of no more than is sufficient to meet the patient's clinical needs for up to 30 days, except in exceptional circumstances.
- It is good practice to write a start date on the prescription. Prescriptions for schedule 2, 3 and 4 controlled drugs are only valid for 28 days from the date of signing if no start date is specified. A start date, even if more than 28 days after the date of signing, will ensure the prescription is still valid. The pharmacist will not be able to dispense the prescription before the start date or date of signing. Where a start date is not included, in the case of instalment prescriptions, the first instalment must be dispensed within 28 days of the date of signing, with the remainder instalments dispensed in accordance with the instructions.
- It is good practice to include the patient's identifier on the prescription; in England this is the patient's NHS number, in Scotland this is the Community Health Index (CHI) number; in Wales and in Northern Ireland, it is still to be decided. This is likely to become a mandatory requirement at a later date.
- Alterations are best avoided but if any are made they should be clear and unambiguous, add initials against altered items.
- The name of the dispensing pharmacy (chosen by the patient) may be added to the top of the prescription.

2.4 Minor amendments (applicable in England, Wales and Scotland)

New regulations from 7 July 2006 allow pharmacists to make minor amendments to CD prescriptions (for schedule 2 or 3 drugs, except temazepam) where the prescriber's intentions are clear. The error must be a minor spelling or typographical error or the omission of either words or figures in the total quantity (but not both). The pharmacist making the amendment must make it clear they are responsible for it and should:

- ensure the prescription is genuine
- be sure they are supplying what the prescriber intended
- amend the prescription in ink and initial the amendment.

2.5 Additional country-specific rules

England

- Do not write prescriptions for durations of longer than 14 days on FP10MDA forms.
- Instalment prescriptions (FP10MDA) can only be used for the treatment of addiction using schedule 2 controlled drugs (e.g. methadone), buprenorphine (schedule 3) and diazepam (schedule 4). DH advice has been sought about the inclusion of buprenorphine with naloxone (Suboxone) (schedule 3) in the list of drugs prescribable for instalment dispensing – currently community pharmacists are reimbursed at the discretion of the Prescription Pricing Division. Single supplies of water for injections can also be prescribed where appropriate, e.g. when diamorphine dry powder injection is prescribed.
- The FP10MDA instalment prescription forms cannot be used for other controlled drugs; for example, dihydrocodeine 30mg tablets (schedule 5) or temazepam (schedule 3) cannot be prescribed in instalments using this form.
- FP10MDA forms are available as either pads of 10 prescriptions or as FP10MDA SS (single sheet). FP10MDA SS are intended for computer generated prescribing although they can also be used for handwritten prescribing.
- Hospital FP10MDA forms are overwritten with the words “HOSPITAL PRESCRIBER”. Hospital prescribers (only) can also prescribe single supplies of any other medicine prescribable on FP10 using FP10MDA SS forms.
- FP10(c) or FP10(FP10 (NC) forms can only be used to order a single supply. Patients should be warned that, in the case of schedule 2 CDs, they may be required to show photo identification to the dispensing pharmacist when collecting their CDs.

Wales

- Do not write prescriptions for durations of longer than 14 days on the WP10MDA forms.
- Instalment prescriptions (WP10MDA) can be used to order any schedule 2,3,4 and 5 controlled drug in instalments.
- Pharmacists in England can only dispense Welsh instalment prescriptions for schedule 2 controlled drugs, buprenorphine and diazepam and therefore cannot dispense instalment

prescriptions for other schedule 3, 4 and 5 controlled drugs. DH approval is being sought for buprenorphine with naloxone (Suboxone) (schedule 3) to be included in the list of drugs prescribable in instalments - currently community pharmacists are re-imbursed at the discretion of the Prescription Pricing Division.

- WP10HP(WP10HP (AD) forms are intended for use in hospitals to prescribe instalment schedule 2 prescriptions although schedule 3, 4 and 5 controlled drugs prescribed on these forms will still be dispensed by (Welsh) pharmacies.
- WP10 forms can only be used to order a single supply. Patients should be warned that, in the case of schedule 2 CDs, they will be required to show photo identification to the dispensing pharmacist.

Scotland

- There is no 14 day instalment restriction (as separate instalment prescriptions are not used). Prescriptions for schedule 2, 3 and 4 CDs will be valid for 28 days from the date signed by the prescriber or from the date specified by the prescriber. The 30 days supply stated in the guidance is good practice.
- Form GP10 can be used to prescribe any drug (including non-schedule Prescription Only Medicines) to be dispensed in instalments.
- Form HBP(A) is issued in Scotland by drug addiction clinics and can be used to order any drug used in the treatment of addiction.

Northern Ireland

- In the community, form HS21 is used by prescribers in Northern Ireland treating drug users.
- Form SP1 is used by drug addiction clinics.
- Forms HS21 and SP1 can be used to prescribe methadone mixture 1mg in 1ml or sublingual buprenorphine subject to Department of Health, Social Services and Public Safety (DHSSPS) guidelines. (Awaiting guidance from NI as to whether buprenorphine with naloxone (Suboxone) can be prescribed in instalments.)

2.6 Other considerations

For liquid preparations, e.g. methadone mixture 1mg in 1ml, it is important to ensure the patient will be able to accurately measure their daily dose. When more than one dose is to be given to the patient, e.g. weekends and bank holidays, the dispensing pharmacist will dispense each day's dose in individual containers only if specifically instructed to do so (see table below for specific approved wording). Otherwise the pharmacist may supply all take home doses in a single large container and only supply the patient with the Drug Tariff 5ml spoon.

Tablet forms, e.g. methadone tablets, that are likely to be crushed and inappropriately injected should not be prescribed. Buprenorphine and buprenorphine with naloxone (Suboxone) may also carry a risk of being injected and this risk must form part of the patient assessment.

If local policies support pharmacists crushing buprenorphine tablets (an unlicensed use of the medicine) then the local policy and lines of accountability should be clearly indicated in the policy/protocol. Pharmacists may need to take out additional insurance to cover this procedure (the National Pharmacy Association will indemnify members provided they comply with the NPA model protocol). Procedures prescribing the crushing of doses must be evidence based, fully supported by the local shared care monitoring group, the prescriber, and clinical governance leads, and informed patient consent must be obtained. A risk assessment must be made to minimise/remove any risks to the operator or patient as a result of crushing (examples of potential risks include danger from inhaling the powder, danger from crushing the tablets so finely that they create a sludge that sticks to the buccal mucosa). Patients should be offered a drink of water before taking their dose.

Colour free or higher strength methadone mixture is not recommended for routine use due to the possible increased potential for misuse.

Local dental policies may advocate always prescribing sugar-free preparations. However, sugar-free methadone mixture may have unacceptable gastro-intestinal side effects due to the high sorbitol content present in some brands. Sugar-free methadone mixture has not been shown to be less likely to cause dental caries than the sugar-containing methadone oral mixture as methadone itself is acidic. If prescribed, patients should still be advised to rinse their mouths with water, and preferably brush their teeth, after consuming their

methadone to minimise adverse effects on their teeth. Pharmacists can only dispense sugar-free methadone oral mixture if specifically prescribed.

It is good practice, when prescribing schedule 4 CDs, e.g. benzodiazepines, and schedule 5 CDs, e.g. dihydrocodeine tablets, to state the total quantity to be dispensed in words and figures.

2.7 Examples of what to write on a prescription

In the table overleaf:

∅ indicates mandatory requirement for a controlled drug prescription,

† indicates those things not legally required but strongly recommended to use on a regular basis as part of the enhanced service to prevent missed doses, errors and ensure the patient receives optimum care.

What you want to prescribe	Examples of what to write on the prescription	
Drug ø	methadone	Buprenorphine. (NB: Temgesic 200 and 400 microgram tablets are licensed for analgesia - not substitute prescribing and should not be prescribed or dispensed for treatment of addiction – as the patient information leaflet supplied will not give appropriate information))
Form ø	Mixture	Tablets (can be done as part of total quantity below). The word “tablets” must still be included even if implicit in the name
Strength ø	1mg in 1ml (10mg in 1ml only to be dispensed after dilution)	400microgrammes, 2mg, 8 mg or a combination (can be done as part of total quantity below)
Sugar Free (must not be supplied unless specifically prescribed)	SF	
Dose ø	60mg daily	12mg daily
	“to be taken as directed” is not acceptable “one as directed” is acceptable for solid dose formulations.	
For how long †	14 days	7 days
Start date †	Start date: 22 nd November 2007	Start date: 30/09/07
Total quantity of dose units in WORDS and FIGURES ø	840ml Eight hundred and forty mls (or millilitres) (milligrammes or mg is NOT acceptable);	7 (seven) x 8mg tabs 14 (fourteen) x 2mg tabs. The prescriber must list the individual strengths and quantities required For clarity, the name of the drug should also appear each time for each different strength so that there can be no ambiguity
Supply in instalments – this may be written against individual dates	Supply 60ml daily	Supply 10mg daily
If you want supervised consumption † (Local enhanced service agreement must be in place)	Please supervise consumption (The frequency of supervised consumption may also be added if necessary)	
If you want the buprenorphine tablets crushed (Local policy/agreement must be in place)		Please crush

What you want to prescribe	Examples of what to write on the prescription	
To cover daily pick ups due on Sundays and bank holidays. †	Supply Sunday and Bank Holiday doses on preceding pick up day immediately prior to closure	
If you want pick up to be less than daily. (If a patient misses a pick up one day they cannot collect their medicine until the next specified collection day unless the wording in the line below is added.)	Collect on Monday Wednesday and Friday.	Collect on Tuesday each week
	Alternatively, amounts to be dispensed can be specified for individual dates	
If you want methadone to be measured in individual bottles for the patient (otherwise patient will be supplied with multiple take home doses in a single container)	Dispense in daily dose containers in advance (a rubber stamp may be used for this)	<i>Not needed as the tablets are easily counted</i>
If you want patients who pick up their medicine less frequently than daily to be able to collect as soon as possible after they miss a dose then add this wording to the prescription.	If an instalment prescription covers more than one day and is not collected on the specified day, the total amount prescribed less the amount prescribed for the day(s) missed may be supplied.	
If you want the patient to be supervised consuming their dose on the days that they collect from the pharmacy but still want them to be able to obtain their medicine if they miss their prescribed collection day.	Supervised consumption of daily dose on specified days; the remainder of the supply to take home. If an instalment prescription covers more than one day and is not collected on the specified day, the total amount prescribed less the amount prescribed for the day(s) missed may be supplied.	
If you want to ensure that the patient is not supplied with their dose if they have missed collecting for three days	Instalment prescriptions covering more than one day should be collected on the specified day. If this collection is missed, the remainder of the instalment (i.e. the total amount less the instalment(s) for the day(s) missed) may continue to be supplied in the specified instalments at the stated intervals, provided no more than 3 days are missed.	
For Bank holidays when unsure which days the pharmacy is closed	Instalments due on days when the pharmacy is closed should be dispensed on the day immediately prior to closure.	

2.8 Private prescriptions

Standardised private prescription forms must now be used for the private prescribing of all schedule 2 and 3 CDs dispensed in community pharmacies or in dispensing practices.

- In England – forms FP10(PCD)
- In Scotland – forms PPCD(1)
- In Wales – forms WP10PCD and WP10PCD SS
- In Northern Ireland – forms PCD1 (issued by the CSA)

In England private prescriptions for schedule 2 and 3 CDs must include the prescriber's six figure identification number. Forms are obtained from the local primary care organisation.

In Scotland valid NHS prescriber codes will be used where available. New private prescriber codes will be issued where necessary. Private prescribers of schedule 2 and 3 controlled drugs must register with their Local Health Board. Private prescribers will be allocated a prescriber code. Valid NHS prescriber codes will be used where available.

In Wales unique prescriber identification codes will be issued for all private prescribers of schedule 2 and 3 CDs. The number is issued by the relevant NHS agency (i.e. primary care organisation) for the purpose of that person's private prescribing. This number is not the person's professional registration number.

Private prescribers may also issue prescriptions for instalment dispensing but may not prescribe repeat prescriptions for schedule 2 and 3 controlled drugs. Private repeat prescriptions for schedule 4 and 5 CDs are allowed.

2.9 Further information

Refer to *Controlled drugs and community pharmacy*, Fitness to Practise and Legal Affairs Directorate, fact sheet one. The latest edition is available from the Royal Pharmaceutical Society of Great Britain website www.rpsgb.org.

3 Interactions

3.1 Medicinal interactions

Two or more drugs taken at the same time (whether prescribable, obtained “over the counter”, herbal, or illicit) may exert their effects independently or may interact. The interaction may be potentiation or antagonism of one drug or another, or occasionally some other effect. Alcohol and/or nicotine can also interact with other drugs.

Refer to appendix 1 of the latest edition of the BNF for an up to date list of drug interactions.

Drug interactions may be pharmacodynamic or pharmacokinetic and an explanation of these terms is included in BNF appendix 1. Drugs are organised in the BNF appendix 1 by approved name and by pharmacological classification. Interactions with alcohol are also listed.

The sections of most relevance to the substance misuse field are:

- alcohol
- anabolic steroids
- anaesthetics, general (e.g. ketamine)
- antidepressants, SSRI
- antidepressants, tricyclic
- antihistamines
- antipsychotics
- anxiolytics and hypnotics
- barbiturates
- disulfiram
- opioid analgesics
- sympathomimetics (e.g. dexamfetamine)
- tobacco
- opioid interactions.

Compared to most other street drugs, there are more data on the potential interactions between opioids and conventional medicines because opioids are so widely used therapeutically.

Factors which may pre-dispose opioids to interact may include:

- All of them are central nervous system (CNS) depressants and so will have at least additive effects with medicines (and other illicit drugs) that have this property.
- Methadone and buprenorphine are both metabolised by the enzyme CYP3A4.
- The enzyme CYP2D6 is occasionally important in interactions. For example, it is responsible for the metabolism of oxycodone, and for the transformation of codeine and tramadol into active metabolite. Methadone inhibits CYP2D6.

Some important drug interactions with opioids, e.g. methadone and buprenorphine

Interaction type	Which drugs?	How?	Effect?
CNS depressants and opioids (including buprenorphine)	Other opioids Benzodiazepines Many tricyclic antidepressants Many antipsychotics Older antihistamines alcohol	Increased CNS depression	Additive effect – potentiation of respiratory depression.
Drugs which increase methadone or buprenorphine levels	Cimetidine Ciprofloxacin Erythromycin Clarithromycin Fluconazole Ketoconazole Fluvoxamine and possibly other SSRIs	Increased blood levels of methadone or buprenorphine by inhibition of the enzyme CYP3A4	Dose of methadone or buprenorphine may need to be decreased to prevent toxicity or overdose AND may need to be increased when the enzyme inhibitor is stopped to prevent withdrawal symptoms
Drugs which decrease methadone or buprenorphine levels	Anticonvulsants (e.g. barbiturates, carbamazepine, phenytoin) HIV medicines (e.g. efavirenz, nevirapine) Rifampicin Spironolactone St. John's Wort	Decreased blood levels of methadone or buprenorphine by induction of enzyme CYP3A4.	Dose of methadone or buprenorphine may need to be increased to prevent withdrawal symptoms AND decreased when the enzyme inducer is stopped to prevent overdose.
Buprenorphine and other opioid agonists	Methadone Diamorphine Other full agonists	Buprenorphine is a partial agonist and displaces other opioids from receptor sites	Can precipitate withdrawal symptoms – advise waiting until opioid is excreted (confirmed by presence of withdrawal symptoms) before taking buprenorphine

Interaction type	Which drugs?	How?	Effect?
Opioid agonists or partial agonists with opioid antagonists	Naltrexone (active orally) naloxone (active intranasally and parenterally)	Naltrexone and naloxone are full antagonists and displace other opioids (including buprenorphine) from receptor sites	Will precipitate withdrawal symptoms if taken when agonist or partial agonists have recently been taken
Methadone plus Medicines affecting QTc interval	Tricyclic antidepressants	Prolongation of QTc interval	Can cause torsades de pointes. Use cautiously with methadone – see section #4, chapter #3 and annex #1.
Drugs affecting urine pH	Vitamin C Sodium bicarbonate (antacids)	Affect excretion of methadone – increased excretion in acidic urine Decreased excretion in alkaline urine	Increased excretion may cause withdrawal; decreased excretion may cause toxicity

3.2 Interactions with illicit drugs

Interactions between illicit drugs and conventional medicines have not been systematically studied in humans. Most data are derived from case reports and small –scale laboratory research and so should be interpreted cautiously. In addition, there are the added complications that many illicit drugs are often “cut” (i.e. diluted) with unknown compounds – some of which may have pharmacological actions which also may interact adversely with the illicit drug or any other drug taken.

Many drug users are polydrug users and so the potential for these substances to interact should not be overlooked.

Drug users may not report all drugs, e.g. cannabis, benzodiazepines, alcohol, over the counter drugs, nicotine – all of which may interact with each other and other drugs.

Drug users may be taking counterfeit or fake drugs, e.g. anabolic steroid users, benzodiazepine users may buy drugs over the internet which may not contain what it says on the label.

3.3 Further reading

Drugs of abuse – second edition. Simon Wills, Pharmaceutical Press

4 Marketing authorisations

Pharmacological group/drug	Drug	Marketing authorisation status for the treatment of drug dependency
Opiates agonists/ antagonists	Methadone oral solution 1mg in 1ml Methadone oral solution 1mg in 1ml sugar free	Authorised
	Methadone oral concentrate (blue) 10mg in 1ml Methadone oral concentrate (brown) 20mg in 1ml Methadose diluent	Authorised (NB: The final strength of the methadone mixture to be dispensed to the patient must be specified on the prescription)
	Methadone injection 25mg in 1ml – ampoules of 2ml Methadone injection 50mg in 1ml – ampoules of 1ml	Authorised
	Naltrexone (oral)	Authorised as adjunct for relapse prevention
	Buprenorphine (sub-lingual)	Authorised
	Buprenorphine with naltrexone (Suboxone) (sub-lingual)	Authorised
	Dihydrocodeine (any route) Codeine (any route)	Not authorised
	Diamorphine (heroin) (any route)	Not authorised
	Benzodiazepines	Diazepam (oral)
Chlordiazepoxide (oral)		Authorised for alcohol withdrawal
Amphetamines/ amfetamines	Dexamfetamine (any route)	Not authorised
Alpha-adrenergic agonists	Lofexidine (oral)	Authorised for management of opioid withdrawal
Alcohol dependence	Acamprosate (oral)	Authorised for maintenance of abstinence in alcohol dependence
	Disulfiram (oral)	Authorised as adjunct in treatment of alcohol dependence
Cigarette smoking	Bupropion (oral)	Authorised as adjunct to smoking cessation in combination with motivational support
	Nicotine (patches, gum, lozenges, nasal spray, inhalator)	Authorised as adjunct to smoking cessation
	Varenicline (Champix)	Authorised as adjunct to smoking cessation

When the clinical guidelines were last published in 1999 the Medicines Control Agency was responsible for licensing medicines under the Medicines Act 1971. At the time of publication of this update, European Community (EC) legislation takes precedence over the Medicines Act, and the Medicines and Healthcare products Regulatory Agency (MHRA) is responsible for issuing marketing authorisations. A marketing authorisation lasts for five years and covers all the main activities associated with the marketing of a medicinal product.

5 Licensing of medications: consideration for use with young people

In the United Kingdom, ‘licensed’ medicines are those that receive a marketing authorisation (previously called a product license). Licensing arrangements are determined by the Medicines Act 1968 and are implemented through the Medicines and Healthcare products Regulatory Agency. For each medicine, the doses, indications, cautions, contraindications and side effects given in the British National Formulary (BNF) reflect those in the manufacturer’s data sheets or Summary of Product Characteristics. The BNF also indicates when a treatment recommendation is for the use of a medicine outside the licensed indication for that product (off-label use).

Absence of a licence does not necessarily mean the absence of evidence for the proposed interventions. Most medicines have only been tested for safe and effective use in the adult population; typically evaluation takes place in subjects between 18 and 65 years of age, with few medicines used in adults specifically licensed for use in the treatment of children. Medicines prescribed for a child that are not licensed for that age group or for their health problems are referred to as “off label” and medicines that do not have a licence at all as “unlicensed”. Children are different from adults, their bodies metabolise medicines differently from those of adults, and young children respond differently from older children. Thus detailed care and attention needs to be taken when making prescribing decisions for children and young people, taking into account their age, weight and developmental stage (DfES 2004). When making the clinical decision to prescribe these drugs, the risks and benefits of the treatment must be considered and fully documented.

The informed use of “unlicensed” or “off label” medicines is often unavoidable if children are to have access to the most effective medicines. Both scenarios are quite common and allowed for in legislation if prescribed by a registered doctor.

The Medicines Act 1968 and its Regulations provide exemptions that enable doctors to use or advise the use of licensed medicines outside the recommendations for the license, or to override the warnings and precautions given in the license. In these circumstances, the doctor must be able to justify this action in accordance with a respectable, responsible body of professional opinion.

Information must be given to the young person and their parents on the nature of the drug to be used, the likely effect, the timing of this effect and the safety and licensing of the

medication. It would be useful if this information was available in leaflet form as well as discussed verbally. Any difficulties in literacy skills need to be acknowledged.

This information is important for a number of reasons:

- young people need to feel their dosage adjustments are for their own comfort and safety, rather than any punishment system
- to ensure informed consent can be given
- to facilitate understanding of treatment given including likely outcomes.

Primary Care Trusts, prescribers, dispensers and those administering medicines must take precautions to ensure that the use of 'off label' or 'unlicensed' medications is managed properly. There should be local safety standards and arrangement in place to monitor the use of unlicensed and off label medicines.

Markers of good practice in the prescribing of medication for young people

National Service Framework for Children, Young People and Maternity Services: Medicines (2004) Department for Education and Skills and Department of Health

- The use of medicines in children is based on the best available evidence of clinical and cost-effectiveness and safety, ideally derived from clinical trials, but also including, where appropriate, medicines that are not licensed for their age group or for their particular health problem ('off-label'), or those that do not have a licence at all ('unlicensed') in order to achieve the best possible health outcomes and minimise harm and side effects.
- In all settings and whatever the circumstances, children and young people have equitable access to safe, clinically and cost-effective medicines in age appropriate formulations.
- Appropriate information and decision support is available for professionals who prescribe, dispense and administer medicines for children and young people.
- Children, young people and their parents/carers receive consistent, up-to-date, comprehensive, timely information on the safe and effective use of medicines.
- In all settings, professionals enable parents, young people and, where appropriate, children to be active partners in the decisions about the medicines prescribed for them.
- Primary Care Trusts, NHS Trusts and other organisations ensure that the use of medicines in children is incorporated in their clinical governance and audit arrangements.
- The contribution of pharmacists in the effective and safe use of medicines in children is maximised.

5.1 Age criteria and licensed medications for the management of substance misuse

The following is a list of the current licensing arrangements for medications used in the management of substance misuse:

- Acamprosate is licensed from 18 years upwards.
- Buprenorphine is licensed from age 16 for those with opiate dependence.
- Bupropion is not recommended in those under 18 years.
- Dihydrocodeine is not licensed for the treatment of dependence and is not recommended.
- Lofexidine is licensed from age 18 for use in those with opiate dependence.
- Methadone is not licensed for children. 'Children' in this context is generally recognised to mean those aged 13 and younger, however, manufacturers note the lack of evidence for adolescents.
- Naltrexone is licensed for those post opiate detoxification over 18 years. It is not licensed for the management of relapse prevention for alcohol misuse in the UK.
- Nicotine Replacement Therapies are licensed from 18 years upwards.

5.2 Policies and procedures

There should be active involvement of all staff in developing protocols. These should be based on evidence of good practice, and help to improve clarity of roles and responsibilities and understanding of these roles between different members of staff. Many of these protocols will already be available but it is important that staff are properly inducted to them and that they are regularly reviewed.

Protocols are required for:

- provision of injecting equipment and needle exchange services
- assessment
- assessing capacity and obtaining consent to treatment

- sharing of information, confidentiality, and involvement of parents
- where child protection concerns are identified
- prescribing protocols for under 18s, including monitoring of the young person during the first 72 hours of opioid prescription, or the first phase of pharmacological management.
- record keeping between teams and working in partnerships
- overdose management
- supervised consumption of medication.

6 Child protection in Scotland

The following text outlines the broad position in Scotland re child protection:

Guidance on inter-agency co-operation

www.scotland.gov.uk/library/documents-w3/pch-00.htm

Scotland recognises and promotes the need to provide better outcomes for children, especially for those in need of care and protection, and the importance of joined-up working for those agencies involved with children. An example of this would be the guidance published in 1998, *Protecting children – a shared responsibility*. This remains the crucial reference for all agencies working with children and families who may have to respond to information or allegations that a child is at risk of significant harm or abuse. It should inform local agency guidelines and procedures.

More recently, in Scotland, as part of a 3-year programme of sustained activity to reform child protection services, Multi-Agency Child Protection Committees in all local authority areas have been strengthened to ensure that all relevant partners play their part in identifying and responding to child protection concerns. The reform programme also developed guidance for children, professionals and their agencies including:

The Children's Charter

www.scotland.gov.uk/Topics/People/Young-People/children-families/17834/10300

The Charter sets out what children and young people need and expect to help protect them when they are in danger of being, or already have been, harmed by another person.

It has been developed through talking to children and young people who have experienced the need to be protected and supported - but what they are saying is how any child facing difficulties could expect to be treated.

The response to the 13 statements from children is a set of 11 pledges and an outline of work to be done to help deliver on these.

Framework for Standards

www.scotland.gov.uk/Publications/2004/03/19102/34603

The Framework for Standards has been developed for children and young people, their parents and for all adults and agencies that work with children in Scotland. It is a means for translating the commitments made to children in the Charter into practice. It sets out what each child in Scotland can expect from professionals and agencies to ensure that they are adequately protected and their needs are met. It also sets out what parents or other adults who may report abuse and neglect can expect.

7 Useful documents

7.1 NICE technology appraisals and guidelines relevant to drug misuse (also see annex #9)

NICE (2007) *Naltrexone for the management of opioid dependence: NICE technology appraisal guidance 115*. London: National Institute for Health and Clinical Excellence.

NICE (2007) *Methadone and buprenorphine for the management of opioid dependence: NICE technology appraisal guidance 114*. London: National Institute for Health and Clinical Excellence.

NICE (2007) *Drug misuse: opiate detoxification for drug misuse: NICE guideline draft*. London: National Institute for Health and Clinical Excellence.

NICE (2007) *Drug misuse: psychosocial management of drug misuse: NICE guideline draft*. London: National Institute for Health and Clinical Excellence.

All available at www.nice.org.uk

7.2 Other drug misuse clinical guidelines

Prisons: Department of Health (2006) *Clinical management of drug dependence in the adult prison setting*. London: Department of Health.

Police custody: AFP & RCPsych (2006) *Substance misuse detainees in police custody: guidelines for clinical management (third edition)*. London: AFP & RCPsych.

Available at www.rcpsych.ac.uk/files/pdfversion/cr132.pdf

7.3 Service guidance

7.3.1 England

National Treatment Agency (2006). *Models of care for treatment of adult drug misusers: update 2006*. London: National Treatment Agency for Substance Misuse.

National Treatment Agency (2006). *Care planning practice guidance: update 2007*. London: National Treatment Agency for Substance Misuse.

Available at www.nta.nhs.uk

7.3.2 (Others to follow)

7.4 Other issues

British Pain Society (2006) *Pain and substance misuse: improving the patient experience, a consensus document*. www.britishpainsociety.org

A range of RCGP guidance for working with drug misusers in primary care is available on the SMMGP website at www.smmgp.co.uk

8 Contacts

8.1 Drug treatment monitoring systems

a) England

National Drug Treatment Monitoring System
Tel 020 7261 8902

www.nta.nhs.uk/areas/ndtms/regional_NDTMS_contacts.aspx for regional contacts

b) Scotland

The Scottish Drug Misuse Database
Tel 0131 275 7097

www.drugmisuse.isdscotland.org/sdmd/sdmd.htm

c) Wales

Welsh National Database
Tel 02920 503343

www.wales.gov.uk/substancemisuse

d) Northern Ireland

Northern Ireland Drug Misuse Database
Tel 02890 522501

www.dhsspsni.gov.uk/index/stats_research/stats-drugs.htm

8.2 Other contacts

ADFAM (families, drugs and alcohol)

25 Corsham Street

London N1 6DR

Tel 020 7553 7640

Fax 020 7253 7991

Email admin@adfam.org.uk

www.adfam.org.uk

Alcohol Concern

First floor, 8 Shelton St

London WC2H 9JR

Tel 020 7395 4000

Fax 0202 7395 4005

E-mail contact@alcoholconcern.org.uk

www.alcoholconcern.org.uk

Alcohol Focus Scotland

Second Floor

166 Buchanan Street

Glasgow G1 2LW

Tel 0141 572 6700

Fax 0141 333 1606

Email enquiries@alcohol-focus-scotland.org.uk

www.alcohol-focus-scotland.org

ASH Scotland
8 Frederick Street
Edinburgh EH2 2HB
Tel 0131 225 4725
Fax 0131 225 4759
Email ashscotland@ashscotland.org.uk

Association of Nurses in Substance Abuse
37 Star Street
Ware SG12 7AA
Tel 0870 241 3503
Fax 01920 462730
Email ansa@profbriefings.co.uk, ansa@fsmail.net (admin)
www.ansa.uk.net

Association of Nurses in Substance Abuse Scotland
Email chair@ansa-scotland.org

Department of Health Substance Misuse Team
6th Floor Wellington House
133-155 Waterloo Road
London SE1 8UG
Tel 020 7972 2000
Fax 020 7972 4998
Email drugs@dh.gsi.gov.uk
www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/SubstanceMisuse/fs/en

Department of Health, Social Services and Public Safety Alcohol and Drug Policy Branch
Email nidast@dhsspsni.gov.uk
www.dhsspsni.gov.uk

DrugScope
40 Bermondsey Street
London
SE1 3UD
Tel 020 7928 1211
Fax 020 7928 1771
Email info@drugscope.org.uk
www.drugscope.co.uk

Home Office Drug Strategy Directorate
Horseferry House
Dean Ryle Street
London SW1P 2AW
Tel 020 7035 4848
Fax 020 7035 4745
Email public.enquiries@homeoffice.gsi.gov.uk
www.homeoffice.gov.uk/drugs

Narcotics Anonymous (NA)
202 City Road
London EC1V 2PH
Helpline 0845 3733366
Telephone 020 7251 4007
Fax 020 7251 4006
Email ukso@ukna.org
www.ukna.org

National Institute for Health and Clinical Excellence (NICE)
MidCity Place
71 High Holborn
London WC1V 6NA
Tel 020 7067 5800
Fax 020 7067 5801
Email nice@nice.org.uk
www.nice.org.uk

National Treatment Agency for Substance Misuse
8th Floor, Hercules House
Hercules Road
London SE1 7DU
Tel 020 7261 8801
Fax 020 7261 8883
Email nta.enquiries@nta-nhs.org.uk
www.nta.nhs.uk

Release (legal and heroin helplines)
388 Old Street
London EC1V 9LT
Helplines 0845 4500 215
Tel 020 7729 5255
Fax 020 7729 2599
Email ask@release.org.uk
www.release.org.uk

Royal College of General Practitioners Substance Misuse Unit
14 Princes Gate
Hyde Park
London SW7 1PU
Tel 0845 456 4041
Fax 020 7225 3047
E-mail info@rcgp.org.uk
www.rcgp.org.uk/substance_misuse/substance_misuse_home.aspx

Royal College of General Practitioners Scotland
25 Queen Street
Edinburgh
Tel 0131 260 6800
Fax 0131 260 6836
Email scottishc@rcgp.org.uk

Royal College of Psychiatrists Substance Misuse Faculty
17 Belgrave Square
London SW1X 8PG
Tel 020 7235 2351
Fax 020 7245 1231
Email rcpsych@rcpsych.ac.uk
www.rcpsych.ac.uk/college/faculties/addictions.aspx

Royal Pharmaceutical Society of Great Britain
1 Lambeth High Street
London SE1 7JN
Tel 020 7735 9141
Fax 020 7735 7629
Email enquiries@rpsgb.org
www.rpsgb.org.uk

Scottish Drugs Forum
91 Mitchell Street
Glasgow
G1 3LN
Tel 0141 221 1175
Fax 0141 248 6414
Email enquiries@sdf.org.uk
www.sdf.org.uk

Scottish Executive Health Department Alcohol and Drug Misuse Team
Area 3EN
St Andrews House
Regent Road
Edinburgh EH1 3DG
Tel/Fax
Email
www.scotland.gov.uk/Topics/Health

Scottish Executive Justice Department: Safer Communities Division
Area 1W South
St Andrew's House
Regent Road
Edinburgh
EH1 3DG
Tel 0131 244 2208
www.scotland.gov.uk

Specialist Clinical Addiction Network (SCAN)
(national network for UK addiction specialists)
8th Floor. Hercules House
Hercules Road
London SE1 7DU
Tel 020 7261 8728
Fax 020 7261 8883 (marked "for the attention of SCAN")
Email amy.wolstenholme@nta-nhs.org.uk
www.scan.uk.net

Substance Misuse Management in General Practice
c/o Bolton, Salford & Trafford Mental Health NHS Trust
Bury New Road
Prestwich
Manchester M25 3BL
Tel 0161 772 3546
Fax 0161 772 3783
www.smmgp.org.uk

TACADE (Personal, Social, Health and Citizenship Education for Children and Young People)
Old Exchange Buildings
6 St Ann's Passage
King Street
Manchester M2 6AD
Tel 0161 836 6850
Fax 0161 836 6859
Email ho@tacade.co.uk
www.tacade.com

Tackling Drugs, Changing Lives (cross-government website for clinicians)
www.drugs.gov.uk

Talk to Frank (national drugs helpline)
Tel 0800 776600
Email frank@talktofrank.com
www.talktofrank.com
Free confidential drugs information and advice 24 hours a day, including information on local services.

Welsh Assembly Government Substance Misuse Policy Development Team
Merthyr Tydfil Office
Rhydycar
Merthyr Tydfil CF48 1UZ
Tel 01685 729067
Fax 01685 729547
Email john.lenaghan@wales.gsi.gov.uk

To find out the contact details for the nearest Drug Action Team partnership in England, see the www.drugs.gov.uk website.

9 NICE summaries

Will be added after NICE publication.

REFERENCES

Full references will be included in the final Update. Details of individual references are available on request.