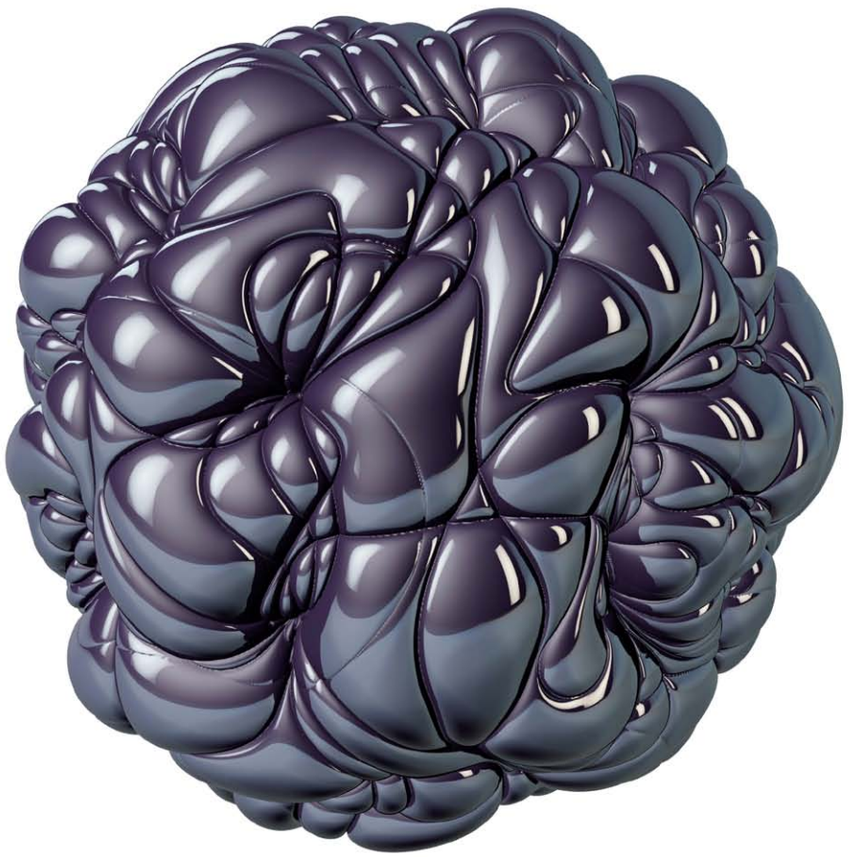
NHS
Rotherham

SHARED CARE

GUIDELINES 2012



CONTENTS OF GUIDELINES

INTRODUCTION

Shared care for patients who misuse drugs is now well established in primary care. The service in Rotherham is one that we can be proud of as it has remained true to the vision of providing holistic, personalised care within the patient's own practice.

It has been successful because of the enthusiasm of Rotherham's GPs, the support provided by the drug workers from RDASH, and the encouragement of NHSR.

Rotherham leads the country in the retention of people in the substance misuse services. We have now entered a new era of treatment and those people who we have successfully retained for the past few years are now to be encouraged to explore recovery. The emphasis now will be on how successfully we can assist our patients to leave our services. We can do this knowing that we have achieved good rates of testing for blood borne viruses, immunisation and harm reduction.

Whilst this will continue, throughout the patient's journey we will be aware of the need to encourage recovery. These guidelines have been written and presented in the form of node link maps to emphasise this. It is intended that they will be updated on line, and Liz Jones, Shared Care Team Leader, Dave Tossell, Primary Care, Care Co-ordinator and I will be interested to receive feedback and hope you find them useful.

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FORMAT OF THE GUIDELINES

NODE LINK MAPPING

As guidelines in the Orange Book (2007) suggest techniques such as node-link mapping are effective in recording interactions between a patient and a clinician, using this format within these guidelines will allow clinicians a better insight into drug services delivering psychosocial interventions.

The adoption of mapping as a communication tool at all levels of an organisation is recommended in order to provide opportunities for synergistic impacts (Dansereau & Simpson, 2009).

The main purpose is to systematise the change process and provide a "paper trail" that can act as an organisational memory, and as a foundation for explaining changes to appropriate constituencies, including accrediting agencies:

GMS care arranged as necessary, if required a further consultation may need to be booked

Assess drugs used:
- *Illicit and legal (tobacco and alcohol)*
- *Regular use/intermittent use*
- *Age of first use for each drug*
- *Amount used per day*
- *Route of use (Smoked/IV etc)*
- *Injection sites if IV*

If terms used by patients are not clear, record actual words used/clarify

Treatment History:
- *Have they been in treatment before*
- *When/where and how long*
- *Last period of abstinence*
- *Presently receiving a prescription (GP should assess and obtain confirmation of current treatment regime with the out of area prescriber)*

Past medical History:
- *Chronic disease (e.g. asthma/diabetes)*
- *Liver disease - hepatitis status if known*

Psychiatric History:
- *Including any present medication or OPD attendance*

Criminal Justice:
- *Court dates*
- *Services involved at this time*
- *Previous history of offending (including any previous incarceration)*

Social:
- *Accommodation*
- *Partner of a drug user*
- *Any dependant children (up to 18yrs)*
- *Any other family members living with them*

Immediate needs:
- *Acute infection*
- *DVT (more common in injectors)*
- *Pregnancy (may merit specialist referral if GP not confident always refer to specialist midwife)*
- *Child safeguarding issues*
- *Offer vaccination*
- *Discussion should take place with regard to patient's goals e.g. abstinence, harm reduction and with regard to possible prescribing of medication (for example methadone, buprenorphine or naltrexone)*

Examination:
- *Injection sites for infection*
- *Any other disclosures of infection*

Investigation:
- *Urinalysis (see section urine screen)*

10 MINUTE GP CONSULTATION

The following is intended to outline important points to cover in an initial consultation

Eligibility criteria

Suitable patients must be discussed with the GP and key worker prior to the decision being made:

- *Age 18 and over*
- *Relatively stable mental state*
- *An ability to integrate with the practice population without causing undue disruption.*
- *Clients needing less than 120mls Methadone (may be increased if the GP feels confident & with supervision of Medical Advisor)*
- *Registered with a GP providing Shared Care or GP with an agreement*
- *Patients who have children are assessed with regard to safeguarding.*

Non eligibility

- *Significant benzodiazepine or alcohol use (over 30 units per day)*
- *Under 18years of age*
- *Significant mental health problems (e.g. needs to be under the care of a psychiatrist)*

The GP should make a decision regarding suitability based on own competence or confidence and consideration should be given to the following:

- *Following assessment with regard to Safeguarding child/children are subject to child protection plan*

NB. GPs are encouraged to discuss any complex issues or problems with the Specialist services.

What to do if you think the Client is inappropriate for Shared Care:

- *Discuss with the Care Coordinator regarding suitability*
- *If Client is a transfer from specialist services discuss with Care Coordinator regarding non suitability*
- *If new client not in treatment referral to Specialist services*
- *Ensure discussion takes place with patient in regard to recovery and recovery plan.*

Remember

- *There are several factors that will increase the risk of QTC prolongation and these should be identified as part of the assessment*

- *Using any medication causing QTC prolongation*
- *Having any history of structural heart disease (such as ischaemic heart disease, long QT syndrome, myocarditis, left ventricular failure)*
- *Using prescribed injectable formulations*
- *Having any relevant medical factors such as hypothyroidism, liver disease, malnourishment, HIV infection, anorexia nervosa and alcohol dependence*
- *Using stimulants*

COMPREHENSIVE ASSESSMENT

The drugs worker will complete a comprehensive assessment which has three principle elements and includes a full risk assessment.

Give Information:

- *Service rules/patient contract around confidentiality and information sharing, what they can expect from treatment,*
- *Involvement of carers and advocacy services.*
- *Information given with regard to recovery and recovery focused treatment options:*
- *Abstinence or maintenance options*
- *Health and Well being*
- *Rehab options*
- *Detoxification options and associated risks*
- *Prescribing – including maintenance and different prescribing options*
- *Self help groups – AA and NA*
- *Group work*
- *Psycho social interventions*
- *Harm minimisation advice – including overdose advice*
- *Relapse prevention*
- *Abstinence*
- *Effects of prescribed medication and safe storage of prescribed drugs*

A full and comprehensive assessment of the patient's presenting needs is essential to the planning and delivery of the most appropriate recovery focused package of care of each patient. It is important that treatment for drug misuse needs to be a recovery care planned approach following a full assessment and is not seen as a medical emergency.

NICE clinical guidelines – ''Treatment and care should take into account patient s needs and preferences. Patient's who misuse opioids should have the opportunity to make informed decisions about their care and treatment, in partnership with their healthcare professionals.''If patient's do not have the capacity to make decisions, healthcare professionals should follow the Department of Health guidelines – 'Reference guide to consent for examination or treatment' (2001). Since April 2007 healthcare professionals need to follow a code of practice accompanying the Mental Capacity Act.

Good communication between staff and patients is essential. It should be supported by evidence based written information tailored to the patient's needs. Treatment and care, and the information patients are given about it should be culturally appropriate. It should also be accessible to people with additional needs such as physical, sensory or learning disabilities, and to people who do not speak or read English.

Collect Information

- *Drug using history*
- *Medical history*
- *Mental health history*
- *Social situation*
- *Cultural/religious background*
- *Employment / training*
- *Current drug use*
- *Family support*
- *Forensic history*
- *HIV/Hep A, B and C status*
- *IV drug use/examination of injecting sites*
- *Other agency involvement*
- *Previous treatment*

Develop Care Plan For Treatment

A recovery focused plan of care will be developed with patient following discussion to ensure that the patient is giving informed consent to all treatment. It is essential that all information is given prior to this so that the patient makes an informed choice (please see above). This plan will be done in consultation with the prescribing clinician

Long and short term objectives identified, with plans for recovery.

SAFEGUARDING

All patients who have problematic substance misuse and care for children need to be assessed to establish if and / or how their substance misuse is impacting on their ability to care for children.

The following should be taken into consideration:-

- *Effect of drug misuse on functioning, for example, intoxication, agitation.*
- *Effect of drug seeking behaviour, for example, leaving children unsupervised, contact with unsuitable characters*
- *Impact of parent's physical and mental health on parenting.*
- *How drug use is funded, for example, sex working, diversion of family income.*
- *Emotional availability to children.*
- *Effects on family routines, for example, getting children to school on time.*
- *Other support networks, for example, family support.*
- *Ability to access professional support.*
- *Storage of illicit drugs, prescribed medication and drug-using paraphernalia*

GP Considers

- *Are the children and or other carers registered at the practice and if so what information is held by the practice which would impact on the safeguarding decisions?*
- *Does the patient want the family to be involved in their care?*
- *Does the family want support in their own right?*
- *Does the patient understand safe storage?*

On Review GP Considers

Whether or not the patient needs to be on supervised consumption and a record should be made of why this decision has been reached.

Transfers onto or out of area should always be put back on supervised consumption which minimises any potential risk to children.

Please see link below for procedures manual for the Rotherham Local Safeguarding Children Board:

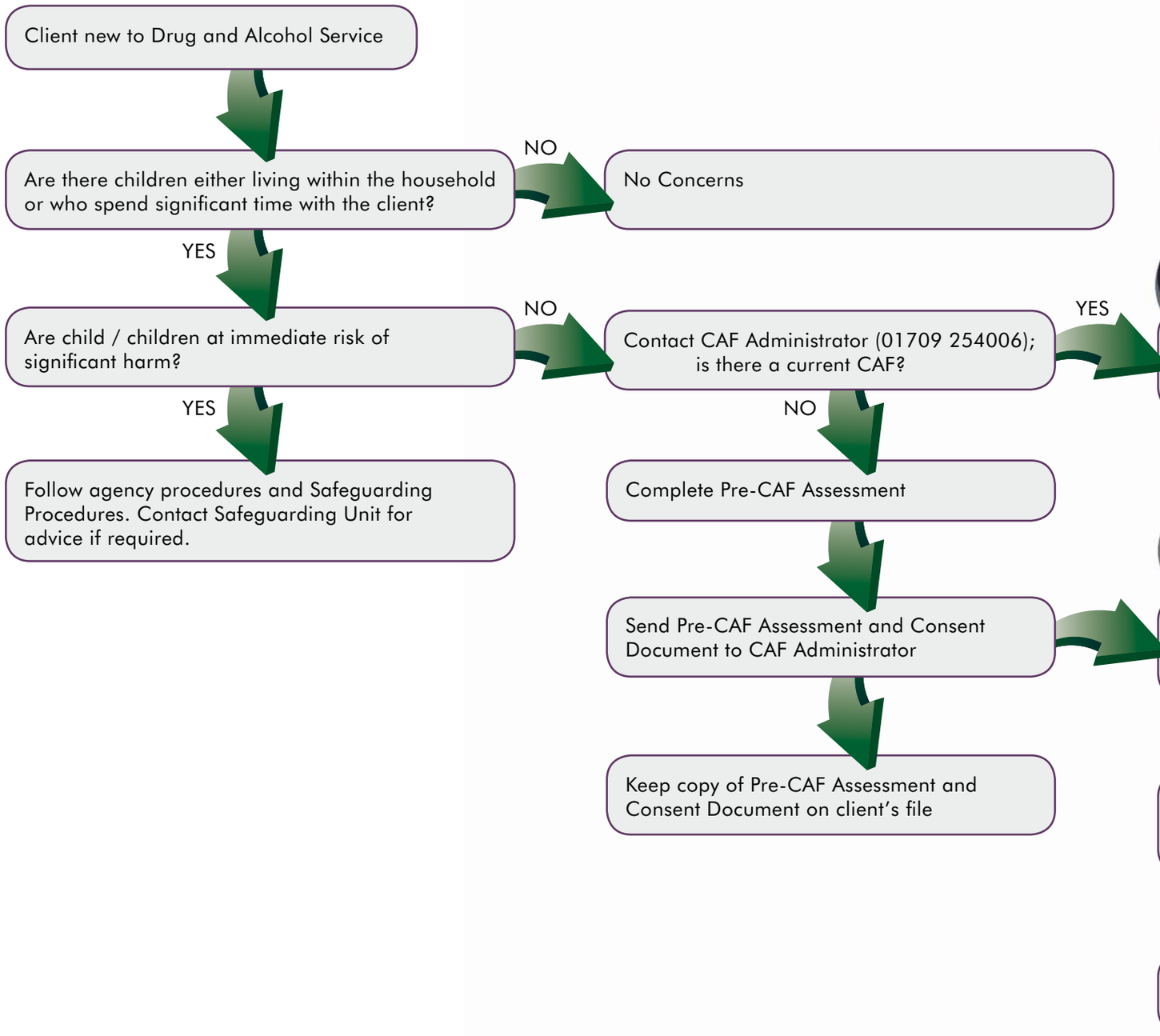
http://rotherhamscb.proceduresonline.com/chapters/p_chil_drug_mis_par.html

SAFEGUARDING - CAF

Ensure that you have parental consent in writing to follow CAF / Prevention & Early Intervention processes

Constant review of the parental capacity to safeguard and care for the child / children must be undertaken and shared with the team around the child.

Clients consent required for CAF process



MAINTENANCE AND DETOXIFICATION

The setting in which detoxification is conducted is generally in the community following assessment of the patient's home environment.

Adjunctive medications

Only use them when clinically indicated, such as when agitation, nausea, insomnia, pain and/or diarrhoea are present.

Use the minimum effective dosage and number of drugs needed to manage symptoms.

Be alert to the risks of adjunctive medications, as well as interactions between them and with opioid agonist

The Choice of Medication for Detoxification:

Methadone or buprenorphine should be offered as first line treatment in opioid detoxification. The following should be considered: whether the patient is receiving maintenance treatment with methadone or buprenorphine, if so opioid detoxification should be normally started with the same medication and the preference of the patient.

Lofexidine may be considered for patients who have made an informed and clinically appropriate decision not to use methadone or buprenorphine for detoxification and, who have made an informed and clinically appropriate decision to detoxify within a short period of time with mild or uncertain dependence

Dosage and duration of detoxification

When determining the starting dose, duration and regime of opioid detoxification, the following should be taken into account

- *Severity of dependence (particular caution should be exercised where there is uncertainty about dependence)*
- *Stability of the patient (including polydrug and alcohol use and co-morbid mental health problems)*

Monitoring of detoxification medication

There should be awareness that medications used in opioid detoxification are open to risk of misuse and diversion in all settings. So the following should be considered:

- *Monitoring of medication concordance*
- *Methods of limiting the risk of diversion where necessary including supervised consumption*

The patient should be routinely offered a community based programme however exceptions to this may be:

- *Need medical and or nursing care because of significant co morbid physical or mental health problems*
- *Are experiencing significant social problems that will limit the benefit of community based detoxification*
- *Require complex polydrug detoxification for example concurrent detoxification from alcohol or benzodiazepines*
- *Have not benefited from previous community based detoxification*

Maintenance
Is suitable for patients who want to stop using illicit opioids but are unable to achieve abstinence from all opioids at present. Prescribing is long term at effective doses individualised for each patient. The goal is harm reduction and stabilisation of life style.

Detoxification
Can be attempted with patients who wish to detoxify from all opioids. There is a high relapse rate to heroin use unless detoxification is combined with psychosocial interventions. As such detoxification should not normally be seen as a stand alone treatment modality and should not be imposed.

Detoxification should be readily available treatment option for patient's who are opioid dependant and have expressed an informed choice to become abstinent. The following information should be given to the patient:

- *The physical and psychological aspects of opioid withdrawal, including the duration and intensity of symptoms, and how these may be managed*
- *The use of non – pharmacological approaches to manage or cope with opioid withdrawal symptoms*
- *The loss of opioid tolerance following detoxification, and the ensuing increased risk of overdose and death from illicit drug use that may be potentiated by the use of alcohol or benzodiaazepines*
- *The importance of continued support, as well as psychosocial and appropriate pharmacological interventions, to maintain abstinence, treat co-morbid mental health problems and reduce the risk of adverse outcomes (including death).*

CHOOSING BETWEEN BUPRENORPHINE AND METHADONE PRESCRIBING

There appears to be a consensus amongst clinicians experienced in choosing between buprenorphine and methadone that buprenorphine:

- *may be better suited to those who wish to cease using heroin completely, as the blockade effects of even moderated dose buprenorphine interfere with the subjective effects of additional heroin use.*
- *Withdrawal from buprenorphine appears to be easier than from methadone.*
- *The transition from buprenorphine to naltrexone can be accomplished much earlier than the transition from methadone to naltrexone.*
- *Buprenorphine is less sedating than methadone. This may be positive or negative for different patients.*
- *Using buprenorphine alone is safer in overdose.*
- *buprenorphine is less affected by interactions with hepatic enzyme inducers/inhibitors (anti convulsant, rifampicin, and ribavirin)*

Example of use:

- *a patient who is working and requires a 'clear head' may be more suitable for buprenorphine*
- *a patient who wants emotional availability may be more suitable for buprenorphine*
- *a patient who feels unable to cope with their emotions and wishes to have more sedation may be more suitable for methadone*

Patients doing well on either methadone or buprenorphine should remain on that medication.

A recent Cochrane systematic review for maintenance evaluated the effects of buprenorphine maintenance and methadone maintenance in suppressing illicit drug use. The reviewers conclude that buprenoraphine is an effective intervention for use in the maintenance treatment of heroin dependence, but it is not more effective than methadone at adequate dosages. Also buprenorphine is not significantly different from methadone in the impact on other substance use e.g. cocaine, benzodiazepines and alcohol.

With similar outcomes, the choice between methadone and buprenorphine should be informed by other factors. There is limited evidence of the superiority of either medication. The use of either medication should be made in consultation with each patient.

PRESCRIBING - INDUCTION OF METHADONE

Prior to prescribing clear goals must be set between the prescriber/drugs worker and the patient

Aim - reduction of street drugs to enable

- *Reduction of mortality*
- *Reduction of crime*
- *Stabilisation of patient with a view to recovery from dependence*
- *Improve personal, family and social function*
- *Recovery*

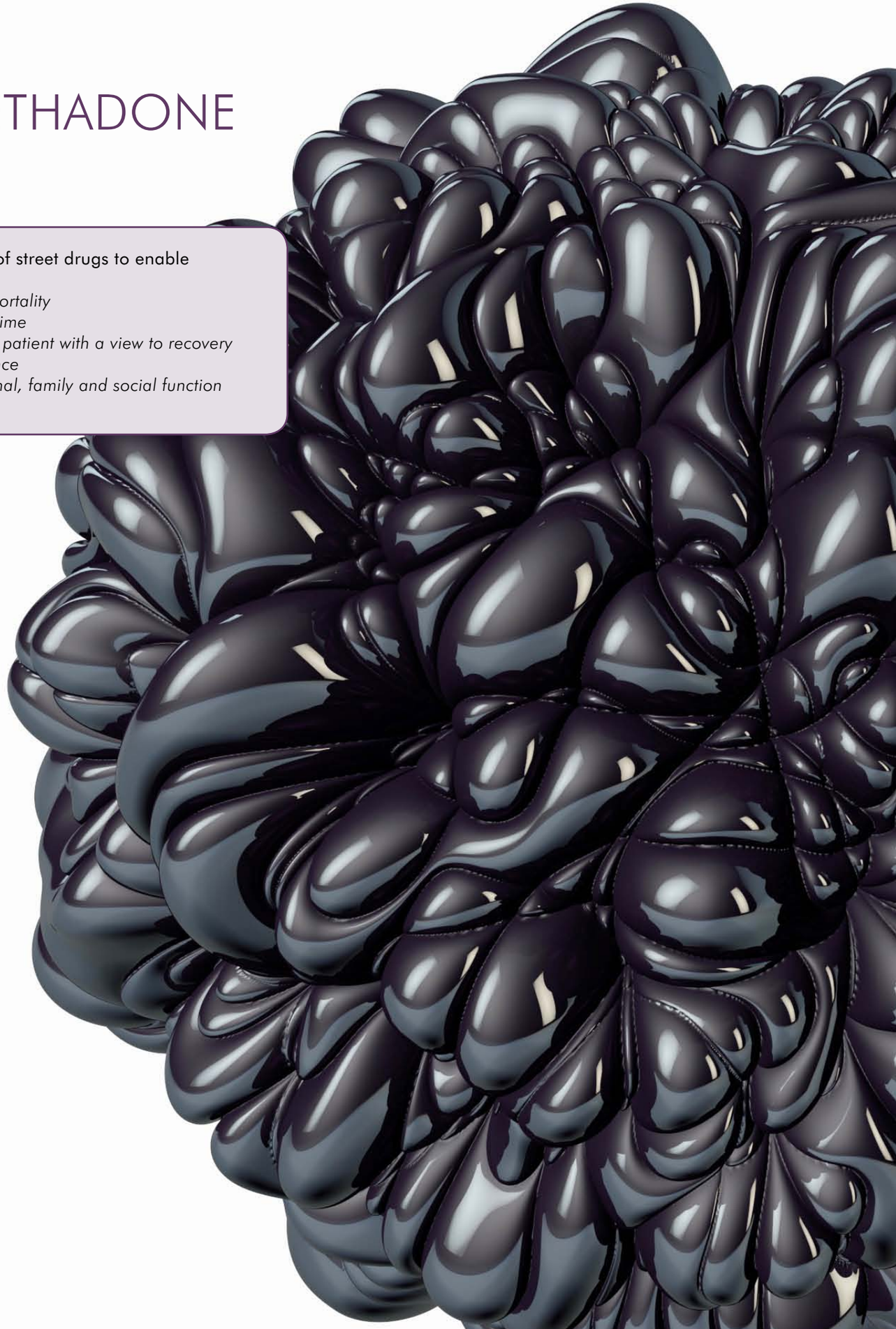
Aims regarding harm reduction should focus on the following:

Reduction of street drugs, if IV use raise awareness of BBV

Urinalysis must be carried out prior to prescribing any opiate maintenance regime

Start low and go slow, always prescribe supervised consumption to new patients for up to three months.

Review weekly until therapeutic level has been achieved.



INDUCTION ON TO METHADONE

Always confirm opioid dependence prior to commencing methadone.
Confirm by urinalysis (see urinalysis page...)
Dose induction "start low & go slow"
Explain to patient why you are being cautious during dose induction.

Day 1

- *Before commencement urinalysis must be positive for opioids (opiates or methadone)*
- *Check for objective signs of opiate dependence*
- *Dilated pupils when a patient is withdrawing*

- *Commence methadone initiation with 10mls to 30mls, 1mg/1ml oral solution supervised consumption.*
- *The removal of supervised consumption should not take place for at least three months (to reduce risk)*
- *If tolerance low or uncertain then starting doses of 10mls to 20mls should be used*

Methadone increases of between 10mg and 20mg a week are recommended - The patient should be seen by the prescribing GP at each dosage change and only increase at these times.

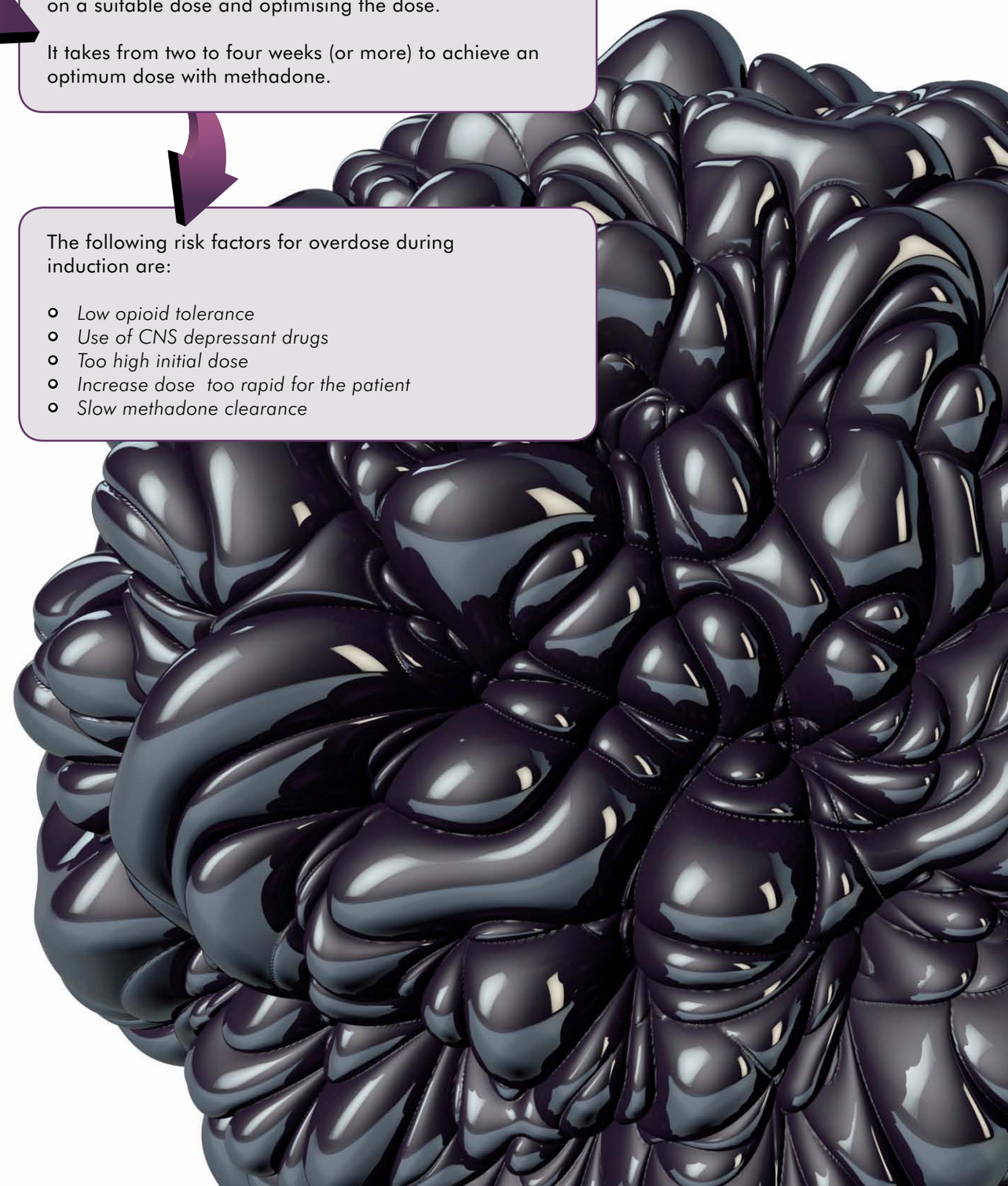
NB Frequent contact needs to be maintained with the patient during this period of titration

Induction of methadone is the process of starting a patient on a suitable dose and optimising the dose.

It takes from two to four weeks (or more) to achieve an optimum dose with methadone.

The following risk factors for overdose during induction are:

- *Low opioid tolerance*
- *Use of CNS depressant drugs*
- *Too high initial dose*
- *Increase dose too rapid for the patient*
- *Slow methadone clearance*



INDUCTION ON TO BUPRENORPHINE (SUBUTEX)

Buprenorphine therapy:

Sublingual tablets in sizes of:
- *400mcg*
- *2mg*
- *8mg*

Use for opiate dependency
Urinalysis prior to prescribing is mandatory
Discuss starting doses with prescriber, drug worker and patient

Starting dose 4 - 8mg daily and dose increases of 2 to 4mg per day are usually adequate, although dose increases of up to 8mg are safe and can be used.

Supervised consumption daily for three months (minimum)

Review prior to any increase, but can be increased quickly

Initial dose should be at least 8hrs post heroin use, or 24hrs post Methadone use (max dose of 30mls daily)

Patient should be observed for 30 - 60mins

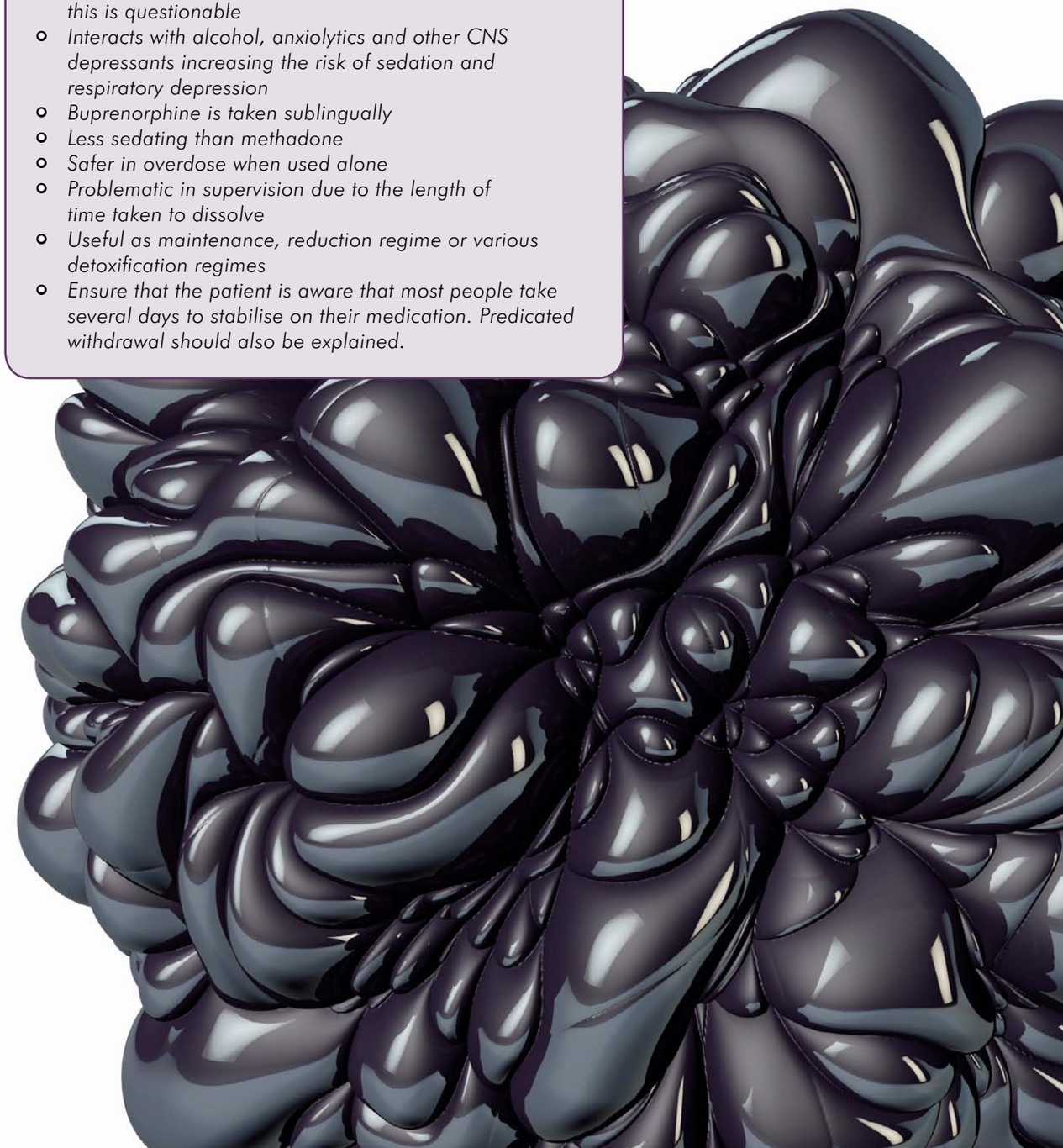
Ensure frequent review of the patient and provide a full explanation to the patient and their partner/carer if appropriate (supported by written information).

Usual dose 8 - 16mg daily

Optimum doses give optimum results

Supervision may be relaxed post three months on regime and proven abstinence from heroin or when the patient's condition is considered stable by the treatment team

- *Buprenorphine is a mixed agonist-antagonist*
- *Prevents or alleviates withdrawal*
- *At a dose over 8mg has an additional blocking effect on opioid receptors*
- *Liver function tests are recommended prior commencement of treatment, but the relevance of this is questionable*
- *Interacts with alcohol, anxiolytics and other CNS depressants increasing the risk of sedation and respiratory depression*
- *Buprenorphine is taken sublingually*
- *Less sedating than methadone*
- *Safer in overdose when used alone*
- *Problematic in supervision due to the length of time taken to dissolve*
- *Useful as maintenance, reduction regime or various detoxification regimes*
- *Ensure that the patient is aware that most people take several days to stabilise on their medication. Predicated withdrawal should also be explained.*



METHADONE MAINTENANCE

The large part of titration can be undertaken in the first few weeks. During the first two weeks ideally the patient should be seen every few days to allow a steady state to be reached after a dose change.

Please see induction onto Methadone regime.

When a patient is on a methadone maintenance regime it is important, and good practice, that regular reviews of three month or less take place between the GP, drugs worker and the patient.

(see 3 months review page...)

It is important that urinalysis takes place on a regular basis.

(See urinalysis page...)

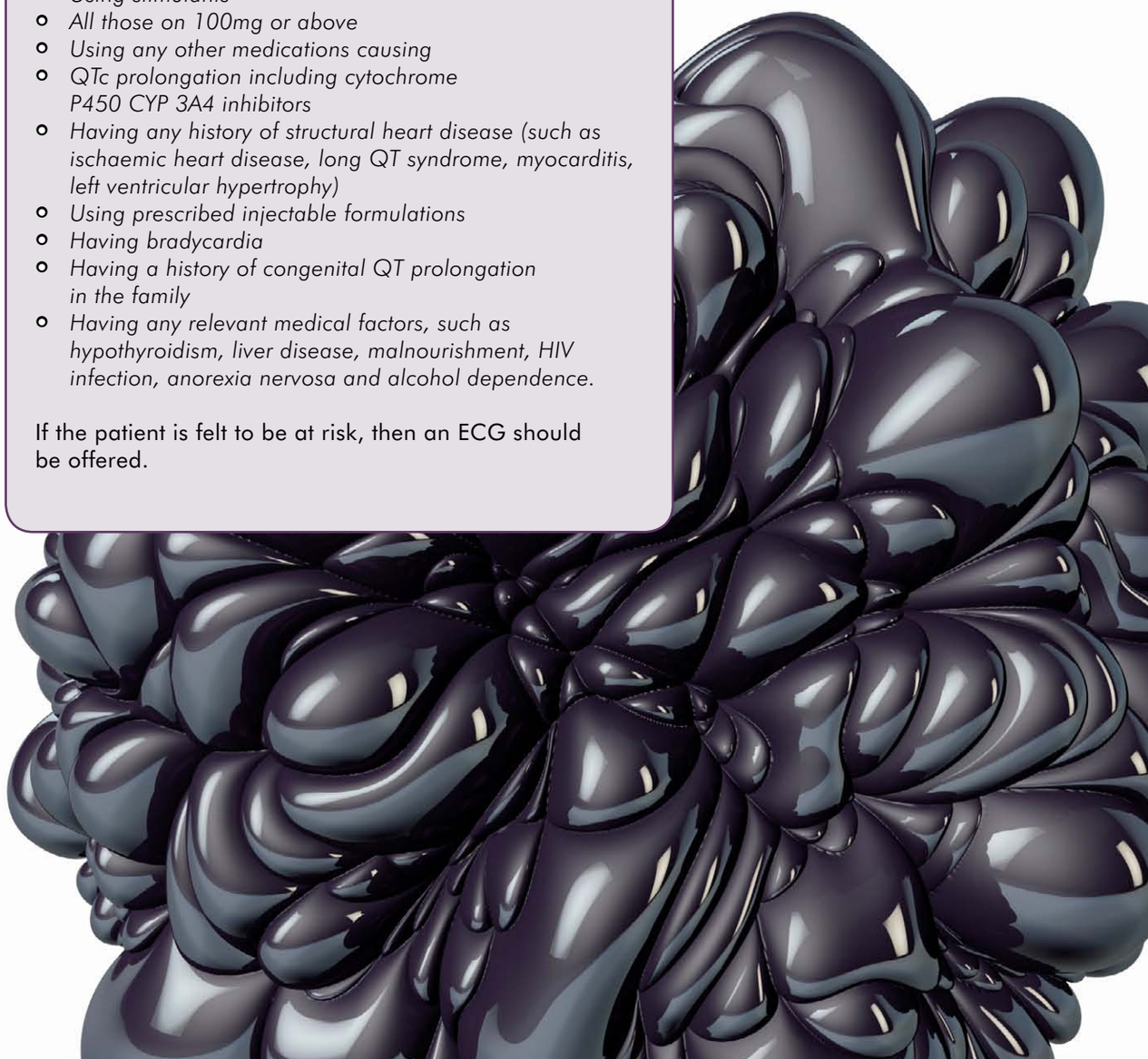
Evidence confirms that doses of 60mls to 120mls daily are more effective than lower doses. Due to individual factors some patients require significantly greater or lower doses for treatment success.

If higher doses above 120mls daily are required a referral to specialist services may take place.

There are several factors that will increase the risk of QTc prolongation so ECGs should be completed for the following:

- *Using stimulants*
- *All those on 100mg or above*
- *Using any other medications causing QTc prolongation including cytochrome P450 CYP 3A4 inhibitors*
- *Having any history of structural heart disease (such as ischaemic heart disease, long QT syndrome, myocarditis, left ventricular hypertrophy)*
- *Using prescribed injectable formulations*
- *Having bradycardia*
- *Having a history of congenital QT prolongation in the family*
- *Having any relevant medical factors, such as hypothyroidism, liver disease, malnourishment, HIV infection, anorexia nervosa and alcohol dependence.*

If the patient is felt to be at risk, then an ECG should be offered.



BUPRENORPHINE MAINTENANCE

Supervised consumption should be continued where possible until the prescriber is satisfied that the patient has been stabilised on the correct dose and maintains a reasonable level of compliance

Once the patient is sufficiently stable, there may be less frequent dispensing and take home doses can be given. If giving take home doses, it may help to change the frequency of pick ups gradually, to:

- *three times weekly*
- *twice weekly.*

Assessing stability at each stage.

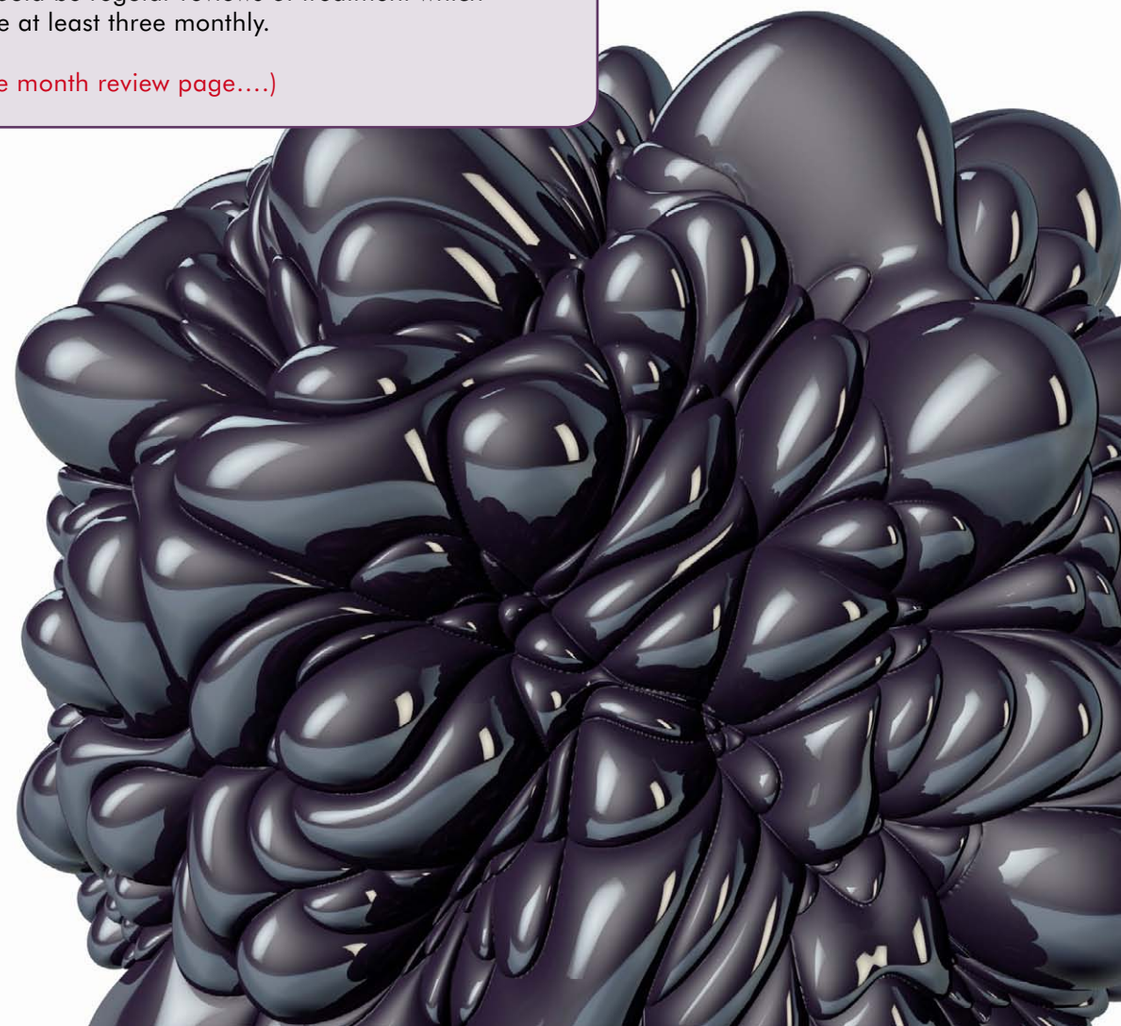
One tool that may be used to measure stability of use may be urinalysis

(see urinalysis page…)

The value of substitute maintenance prescribing for opioid dependence is well established. The dose range of buprenorphine maintenance is 8mg to 32mg daily. The usual range used to achieve abstinence is between 12 to 24mg daily. As a partial agonist, higher doses of buprenorphine may not produce the responding increases in effects, so increasing the dose may not make any difference in subjective effects. (e.g. increase euphoria), but may further reduce illicit opoid use by increasing the blockade effect.

There should be regular reviews of treatment which should be at least three monthly.

(see three month review page….)



METHADONE TRANSFER TO BUPRENORPHINE

Day 1

2 - 4mg buprenorphine. 8mg/day has been shown to be as effective as methadone 60mg in holding clients in treatment.

Day 2

4 - 8mg (increase day 1 dose by 2 or 4 mg if signs of withdrawal and /or cravings present.

Decrease day 1 dose by 2mg if signs of Intoxication or severe side effects.

Day 3

8 - 16mg (increase Day 2 dose by 2 - 8mg if signs of withdrawal and/or craving are present.)

Prior to Day 1

The patient should reduce their dose of methadone to 30mg or less and/or reduce their use of heroin. The first dose of buprenorphine should be taken at least 24 hours following a dose of methadone, or at least 8 hours after a dose of heroin. It is helpful if a client has mild withdrawal symptoms but explain that buprenorphine can take 90 to 120 minutes to work.

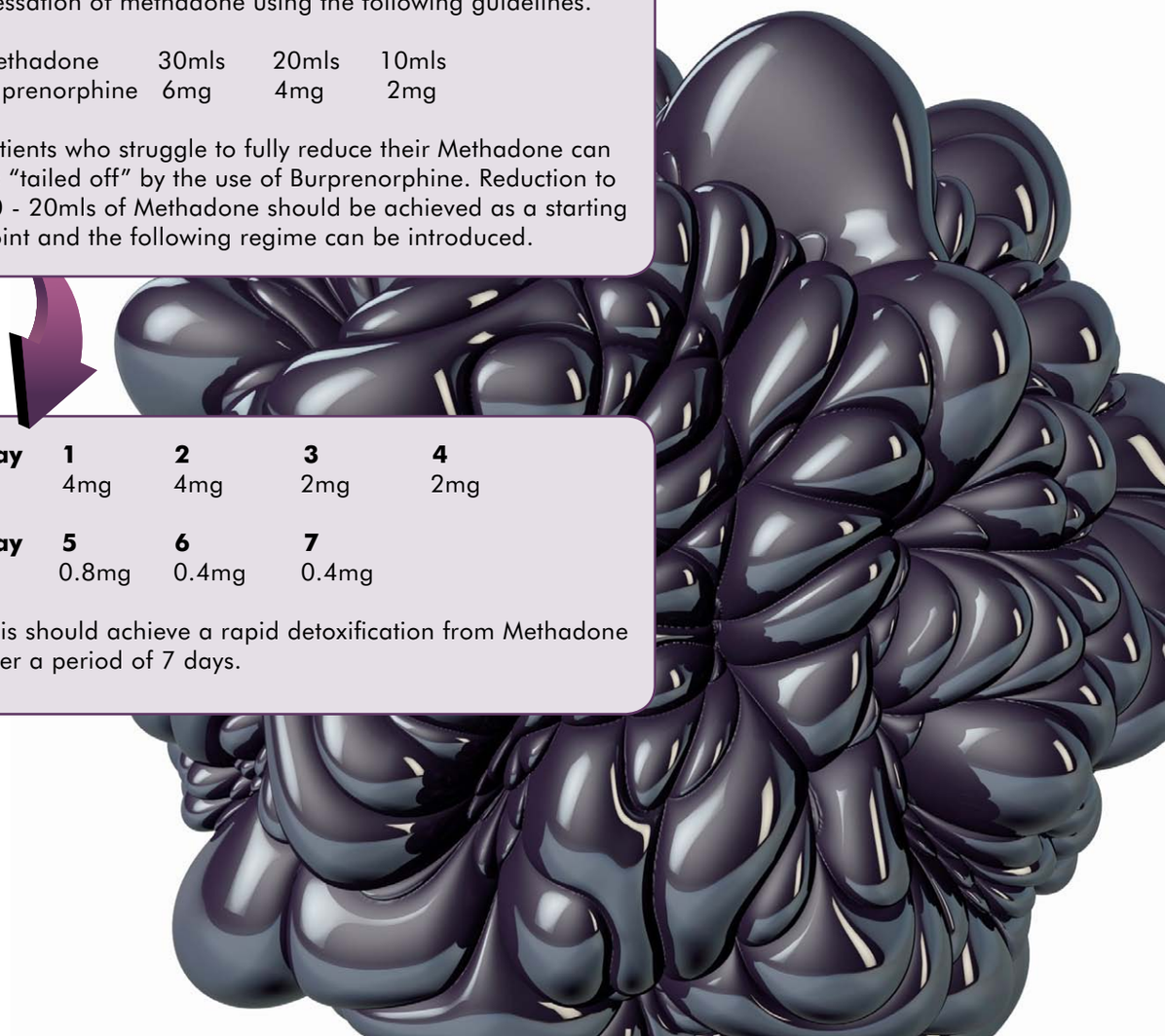
Buprenorphine can be introduced following the Cessation of methadone using the following guidelines.

Methadone	30mls	20mls	10mls
Buprenorphine	6mg	4mg	2mg

Patients who struggle to fully reduce their Methadone can be "tailed off" by the use of Burprenorphine. Reduction to 10 - 20mls of Methadone should be achieved as a starting point and the following regime can be introduced.

Day	**1**	**2**	**3**	**4**
	4mg	4mg	2mg	2mg
Day	**5**	**6**	**7**	
	0.8mg	0.4mg	0.4mg	

This should achieve a rapid detoxification from Methadone over a period of 7 days.



BUPRENORPHINE/SUBUTEX TRANSFER TO METHADONE

Day 1

Initial dose of 40mls and then titrate according to the response. Be mindful of any residue blocking effect of buprenorphine which may last for a number of days and the half life of methadone.

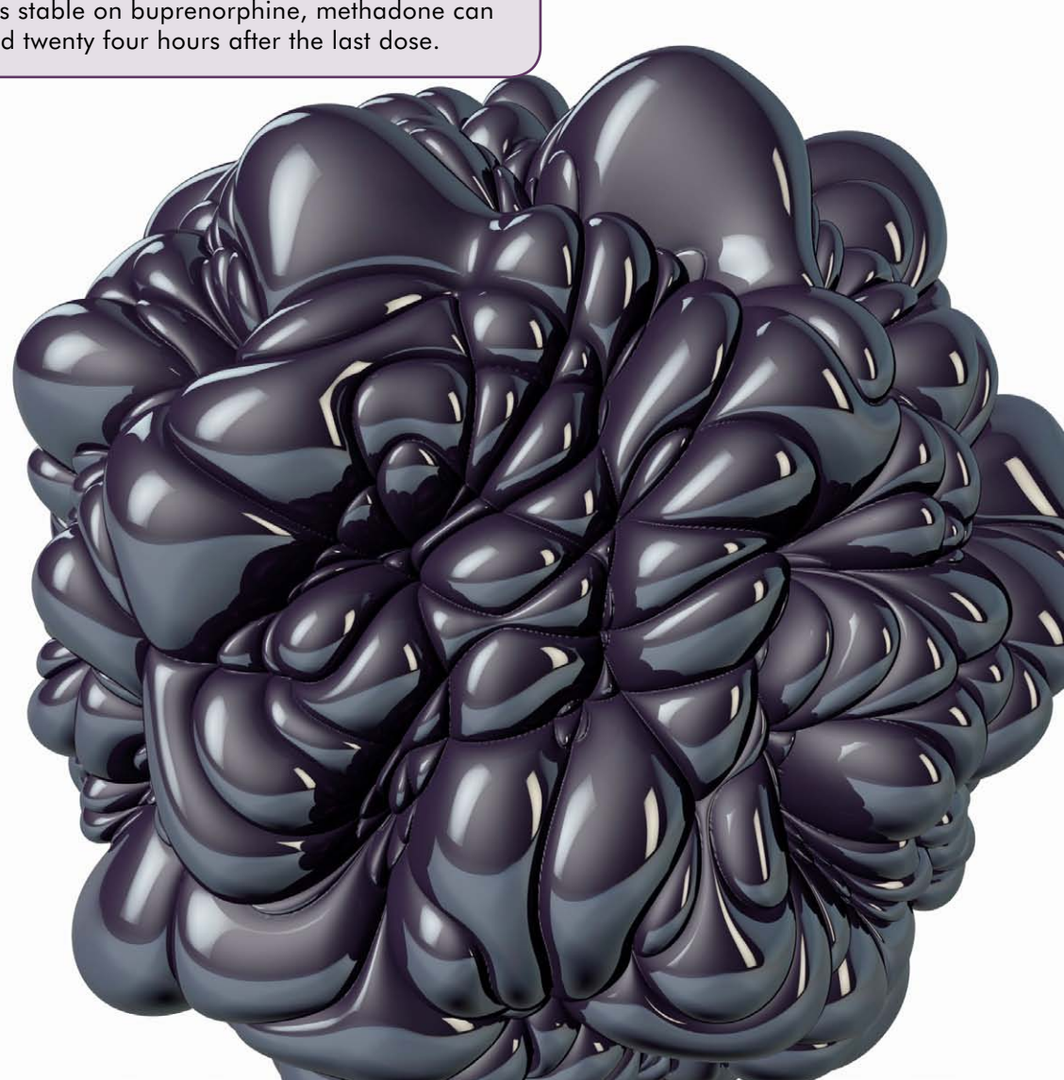
Refer to titration of methadone

Prior to Day 1

Some patients may need to transfer from buprenorphine to methadone due to intolerable side effects, and inadequate treatment response and complications around the interaction of other things such as opiate agonists e.g.;

- *Patient requesting treatment with opioid analgesia for pain management.*

If the patient is stable on buprenorphine, methadone can be commenced twenty four hours after the last dose.



THREE MONTHLY REVIEW

The following is intended to outline important points to cover in a 3 month consultation review; this should be an ongoing process

Assess continuation of drug use and review aims of treatment

- *Illicit and legal (tobacco and alcohol)*
- *Regular use/intermittent use*
- *Amount used per day*
- *Route of use (Smoked/IV etc)*
- *Injection sites if IV*

If terms used by patient are not clear, record actual words used to clarify

Examination:

- *Injection sites for infection*
- *Any other disclosures of infection*

Investigation:

- *Urinalysis (see urinalysis)*

Treatment Review:

- *Discuss current prescribing regime*
- *Discuss review of BBV, screening for Hepatitis A,B,C and HIV and any vaccination required for Hepatitis A,B*

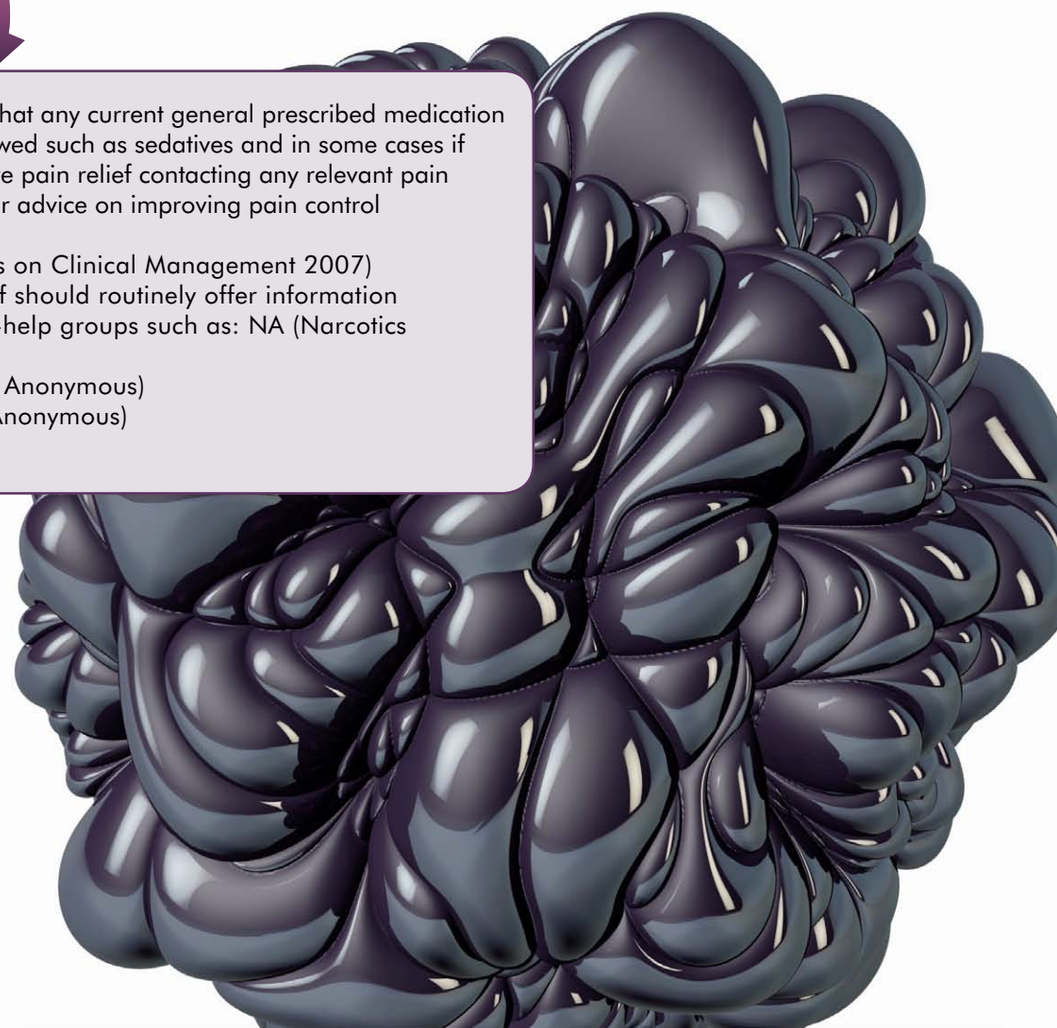
Three monthly GP reviews should be an ongoing process of assessment in which the GP may identify changes, if any within the individual's lifestyle. It may be deemed appropriate to review more frequently than the three month window if an increased risk has been identified. The review assessment should highlight the following areas:

- *Substance misuse*
- *Physical/psychological*
- *Social*
- *Crime*
- *Safeguarding issues child/adult*

The GP may discuss treatment further with the drugs worker, patient and if appropriate liaise with the Pharmacist.

It is important that any current general prescribed medication has been reviewed such as sedatives and in some cases if using alternative pain relief contacting any relevant pain control team for advice on improving pain control

(UK Guidelines on Clinical Management 2007)
All clinical staff should routinely offer information regarding self-help groups such as: NA (Narcotics Anonymous)
AA (Alcoholics Anonymous)
CA (Cocaine Anonymous)



BUPRENORPHINE/SUBUTEX DETOXIFICATION FROM HEROIN 12 DAYS

Day 1
4mg- Take 2 x 2mg tablets

Day 2 & 3
8mg- Take 1 x 8mg tablet

Days 4
6mg- Take 3 x 2mg tablets

Day 5 & 6
4mg- Take 2 x 2mg tablets

Day 7&8
2mg – Take 1 x 2mg tablet

Day 9
1.6mg – Take 4 x 0.4mg Tablets

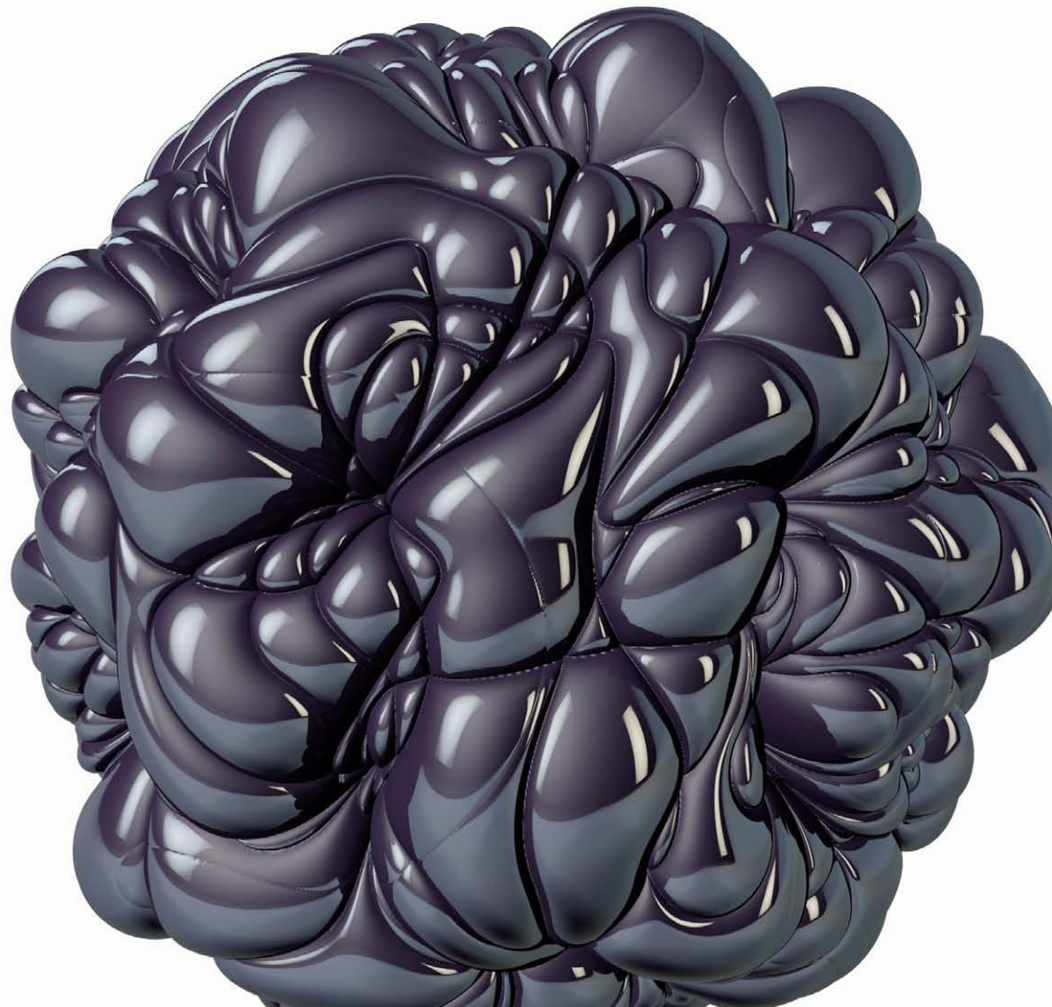
Day 10
1.2mg – Take 3 x 0.4mg Tablets

Day 11
0.8mg – Take 2 x 0.4mg Tablets

Day 12
0.4mg – Take 1 x 0.4mg Tablet

Advice

- *The worst withdrawal symptoms will be during days 1 to 5.*
- *Side effects may be drowsiness, dry mouth, dry throat and nose, slow pulse and dizziness. Taking more than the recommended dose of Subutex will only increase any side effects - it will NOT reduce any withdrawal symptoms.*
- *Do not take any more than the recommended maximum dose.*
- *Tolerance to Heroin will drop very quickly. So, if the patient starts to use again there is a risk of overdose.*
- *If the patient experiences any problems advise to contact GP.*



BUPRENORPHINE/SUBUTEX DETOXIFICATION FROM HEROIN 36 DAYS

Day 1
4mg - Take 2 x 2mg tablets

Day 2 ,3, 4
8mg - Take 1 x 8mg tablet

Days 5,6,7,8
6mg - Take 3 x 2mg tablets

Days 9,10,11,12
4mg - Take 2 x 2mg tablets

Days 13,14,15,16
2.8mg - Take 1 x 2mg tablet
Take 2 x 0.4mg tablets

Days 17,18,19,20
2mg - Take 1 x 2mg Tablets

Days 21,22,23,24
1.6mg - Take 4 x 0.4mg Tablets

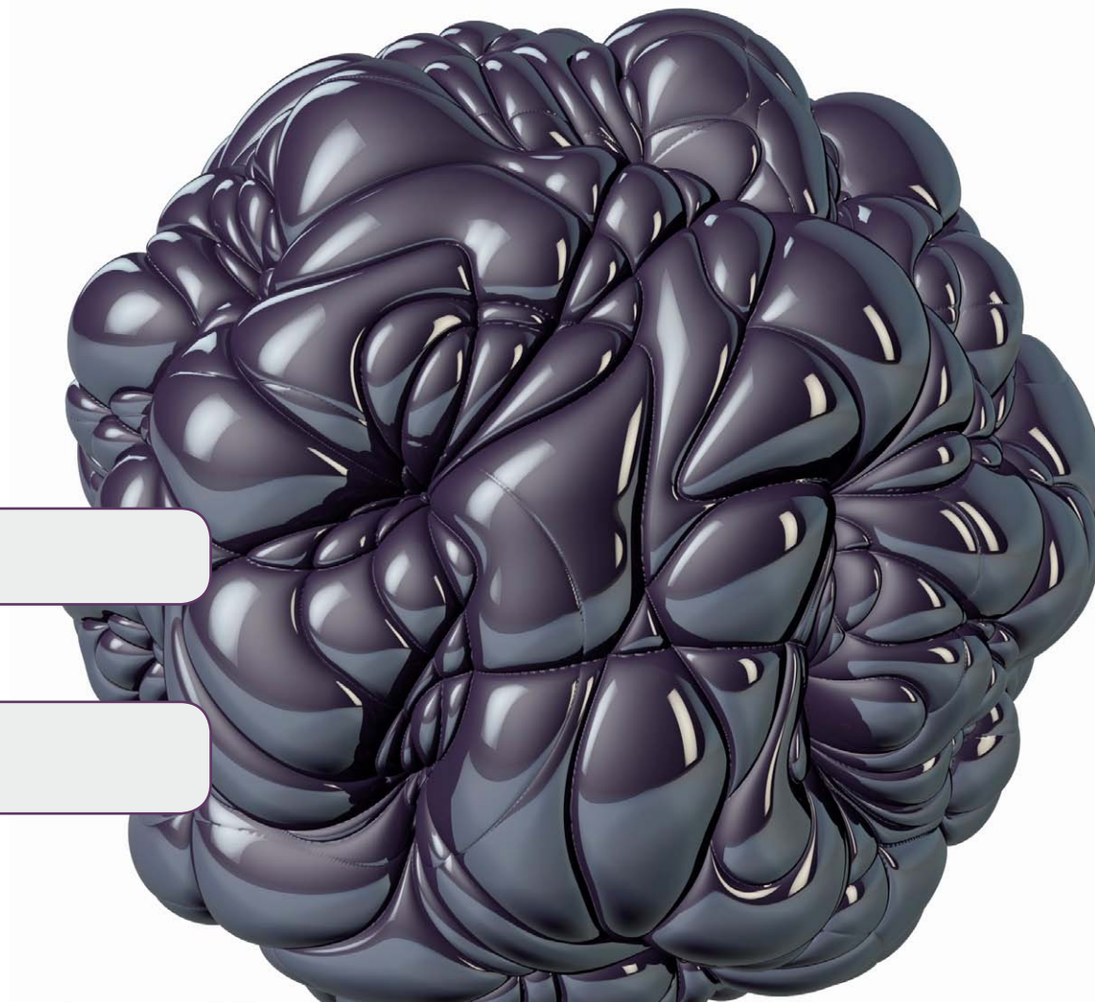
Days 25,26,27,28
1.2mg - Take 3 x 0.4mg Tablets

Days 29,30,31,32
0.8mg - Take 2 x 0.4mg Tablets

Days 29,30,31,32
0.8mg - Take 2 x 0.4mg Tablets

Advice

- *The worst withdrawal symptoms will be during days 1 to 5.*
- *Side effects may be drowsiness, dry mouth, dry throat and nose, slow pulse and dizziness. Taking more than the recommended dose of Subutex will only increase any side effects - it will NOT reduce any withdrawal symptoms.*
- *Do not take any more than the recommended maximum dose.*
- *Tolerance to Heroin will drop very quickly. So, if the patient starts to use again there is a risk of overdose.*
- *If the patient experiences any problems advise to contact GP.*



LOFEXIDINE DETOXIFICATION FROM HEROIN

Lofexidine therapy:

Tablets in sizes of:
- *200mcg*

Day 1
Take 1 tablet at 10am/2pm/6pm/10pm
= total 4 tablets in the day

Day 2
Take 2 tablets at 10am/2pm/6pm/10pm
= total 8 tablets in the day

Days 3 - 4 - 5 - 6 - 7
Take 3 tablets at 10am/2pm/6pm/10pm
= total 12 tablets in the day

Day 8
Take 2 tablets at 10am/2pm/6pm/10pm
= total 8 tablets in the day

Day 9
Take 1 tablet at 10am/2pm/6pm/10pm
= total 4 tablets in the day

Day 10
Take 1 tablet at 10am and 10pm
= total 2 tablets in the day

Advice

- *The worst withdrawal symptoms will be during days 1 to 5.*
- *Side effects may be drowsiness, dry mouth, dry throat and nose, slow pulse and dizziness. Taking more than the recommended dose of Lofexidine will only increase any side effects - it will NOT reduce any withdrawal symptoms.*
- *Do not take any more than the recommended maximum dose. If giddiness is a problem, take less Lofexidine that day.*
- *Tolerance to Heroin will drop very quickly. So, if the patient starts to use again there is a risk of overdose.*
- *If the patient experiences any problems advise to contact GP.*

NALTREXONE HYDROCHLORIDE

Important at this stage is raising awareness regarding low tolerance of opiates and a high risk of overdose, if a patient decides to return to using. Advise to smoke rather than any IV use.

Written or verbal advice to patients before treatment
Verbal advice (accompanied by product information leaflet and card) should be given to the patient regarding the importance of not using opioid medication and of informing any other medical practitioner that they are receiving naltrexone treatment.

Description of Treatment

Name of treatment – Naltrexone (50mg tablets)
Legal status – POM (Prescription-only medicine)
Dosage – 25mg (½ tablet initially followed by further 25mg following observation). Total dose 50 mg (1 tablet) daily.
Prescription printed on a green FP10 form. Naltrexone should not be administered until a urine screen has been taken and a negative opiate/methadone result has been obtained.

Initial Administration

½ tablet (25mg) to be administered under supervision. The patient should then be asked to remain with the surgery nurse for a minimum of 30 minutes in the event that any opiate withdrawal symptoms are observed or reported. If no withdrawal symptoms are observed or reported a further ½ tablet (25mg) is administered.

The Patient should be given a card indicating that they are maintained on Naltrexone.

NICE Guidance

''naltrexone is recommended as a treatment for people who have been opioid dependant but who have stopped using opioids, and who are highly motivated to stay free from the drugs in an abstinence programme.''

The patient should have support to enable them to maintain abstinence. Relapse prevention should be offered either by one to one sessions or group work. Mutual aid organisations such as NA (Narcotics Anonymous) can be of great importance.

Naltrexone is a drug used to help people stay off opioids altogether. It is given after the patient has stopped taking opioids for at least 7 to 10 days. It works by blocking the effects of the opioids, so that the patients do not get the same result from taking them.

Liver Function Tests (Normal Ranges)

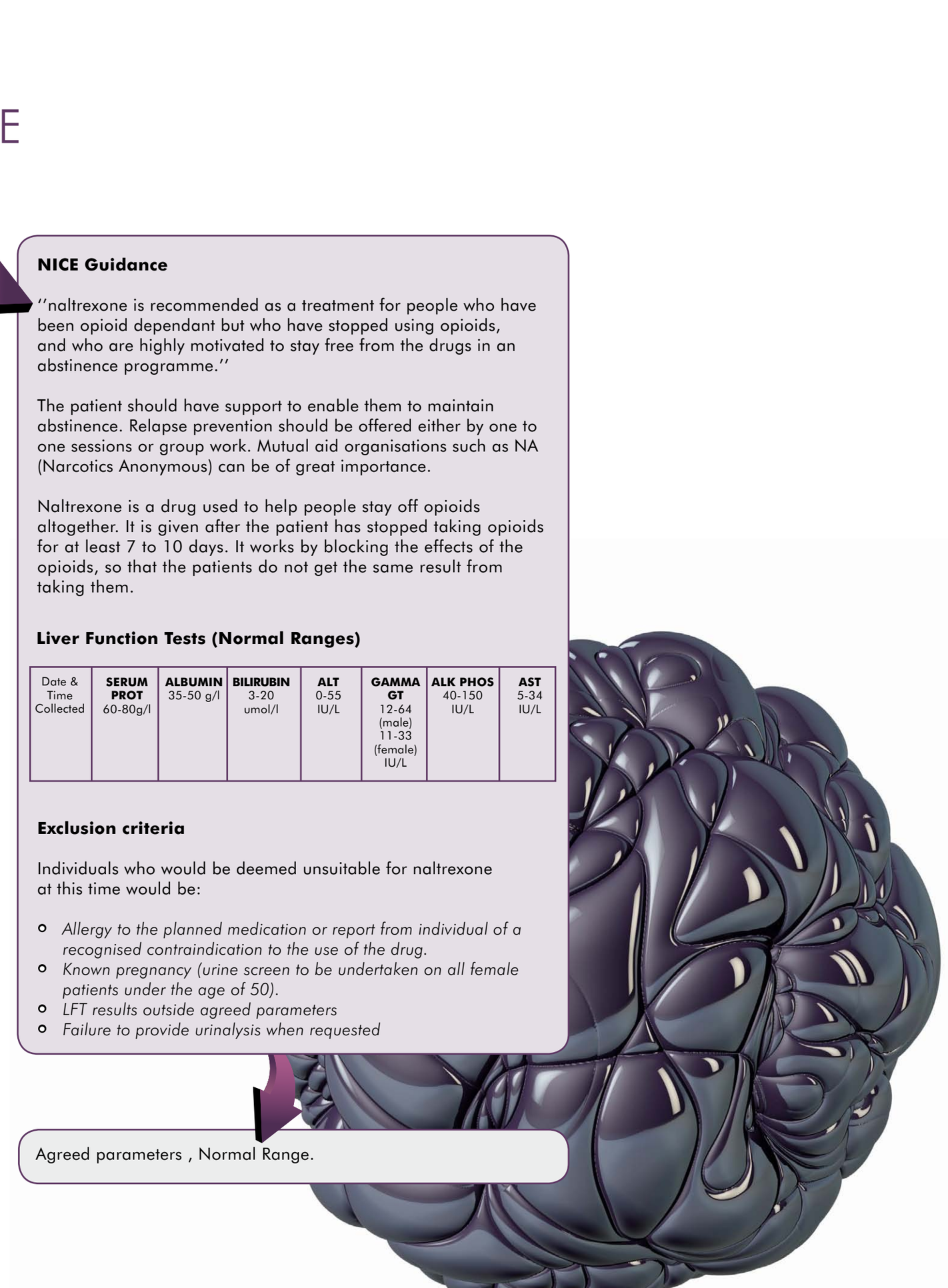
Date & Time Collected	**SERUM PROT** 60-80g/l	**ALBUMIN** 35-50 g/l	**BILIRUBIN** 3-20 umol/l	**ALT** 0-55 IU/L	**GAMMA GT** 12-64 (male) 11-33 (female) IU/L	**ALK PHOS** 40-150 IU/L	**AST** 5-34 IU/L

Exclusion criteria

Individuals who would be deemed unsuitable for naltrexone at this time would be:

- *Allergy to the planned medication or report from individual of a recognised contraindication to the use of the drug.*
- *Known pregnancy (urine screen to be undertaken on all female patients under the age of 50).*
- *LFT results outside agreed parameters*
- *Failure to provide urinalysis when requested*

Agreed parameters , Normal Range.



BENZODIAZEPINES

- *Occasionally primary drug of misuse*
- *Alleviates symptoms of withdrawal from other drugs, it may enhance effect of opiates, and can cause intoxication when used alone*
- *Diazepam 5mg and 10mg most commonly used*

90% of patients have used them in the past year

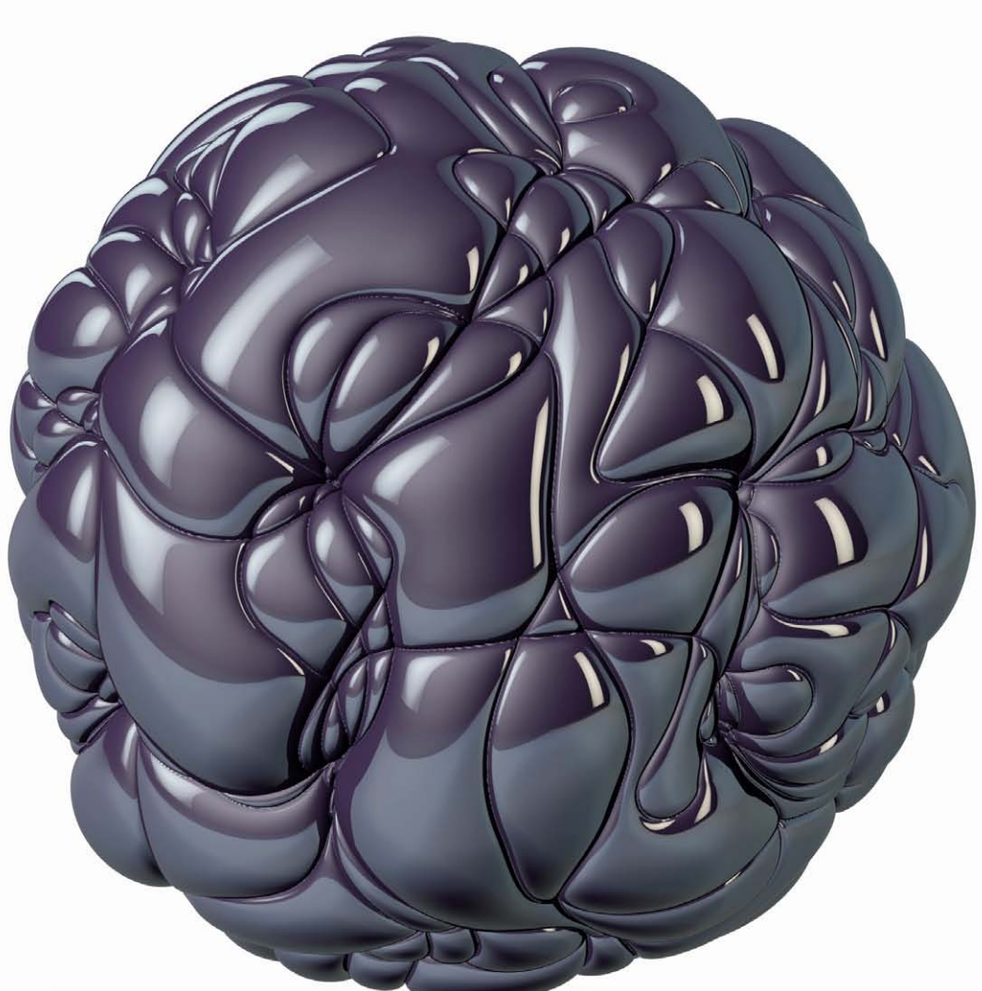
Licensed for short term use only - 2-4 weeks of severe anxiety or insomnia

Use above 30mg Diazepam daily is associated with cognitive impairment

Use of diazepam is associated with impulsive risk taking behaviour

- *No evidence of benefit for maintenance prescribing.*
- *Can be prescribed daily pick up (FP10MDA)*
- *Any prescription should be for stabilisation followed by reduction.*
- *Treat underlying anxiety/insomnia with psychosocial methods*

Be more cautious to initiate prescription for Benzodiazepine than Methadone



SUPERVISED CONSUMPTION

New patients being prescribed Methadone or Buprenorphine should be required to commence on supervised consumption up to a minimum of three months. This is discussed as part of a multi disciplinary review which involves the assessment of needs and complexity of patient.

- *The clinical need for supervised consumption should be reviewed on a regular basis and when to relax supervision should lie with the individual clinician following a multi disciplinary review.*
- *Long term daily supervised consumption may be problematic for a patient in regular full time employment, unless a suitable agreement with out of hour's pharmacy.*

When re-starting a patient with a Methadone/ Buprenorphine regime following a break in treatment or receiving a significant increase in the dosage, daily dispensing- ideally with supervision should be reinstated for a period of time which is agreed within local guidelines.

Patients in treatment who appear to be not meeting their goals within treatment - a period of supervised consumption can improve observation of progress and increase interventions to improve outcomes.

Supervised consumption may have a role in managing a treatment regime and can be regarded as an incentive if relaxed supervision following a plan of progress, such as drug free urinalysis, and not deemed as a means of punishment.

Orange guidelines (2007) describes that supervised consumption by an appropriate professional provided the best guarantee that medication is taken as directed. It highlights reports of drug related deaths (ACMD 2000) and appraisal of Methadone and Buprenorphine (NICE 2007a) gave the following recommendations:

Removal of supervised consumption

Supervised consumption should only be removed for the following reasons:

- *The prescriber has good reason to believe that compliance will be maintained (orange guidelines section 5.5)*

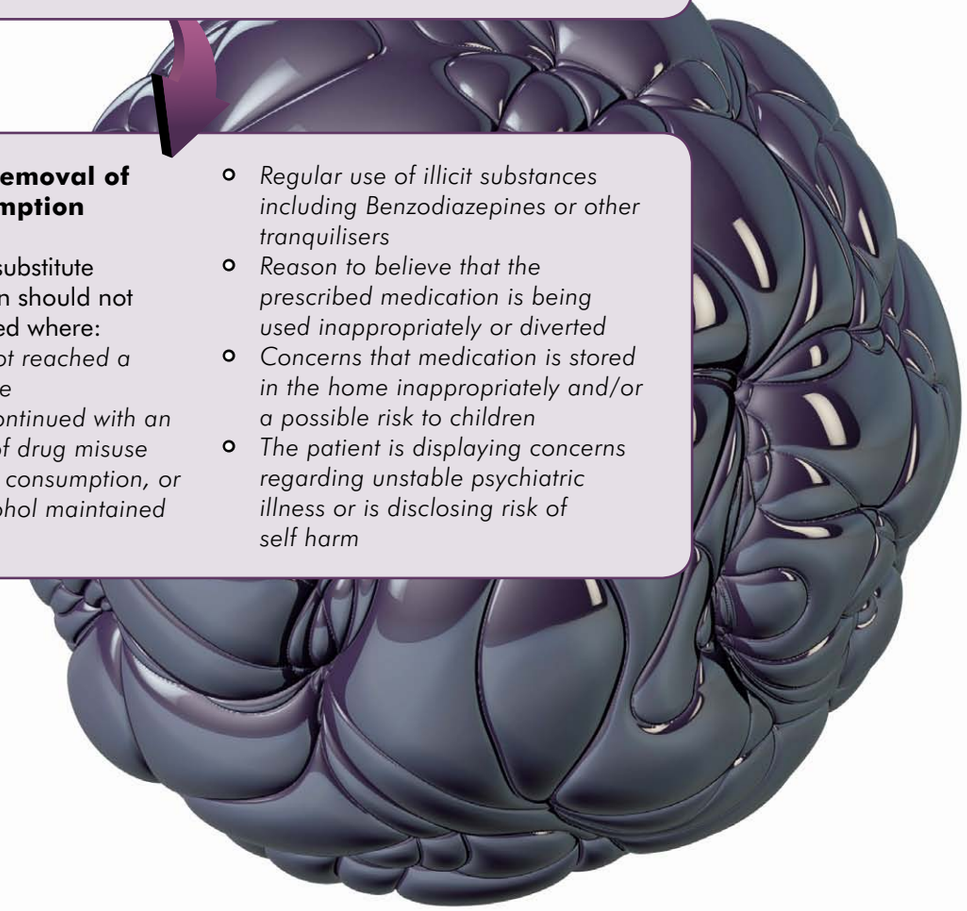
The prescriber needs to assess the following:

- *Drug taking behaviours such as injecting*
- *Compliance with prescribed drug treatment*
- *Significant change in drug misuse and compliance with other elements in their care plan*
- *Regular attendance of appointments*

Reasons for non removal of supervised consumption

Take home doses of substitute prescribed medication should not normally be prescribed where:

- *The patient has not reached a stable dose regime*
- *The patient has continued with an unstable pattern of drug misuse*
- *Increased alcohol consumption, or high levels of alcohol maintained*
- *Regular use of illicit substances including Benzodiazepines or other tranquilisers*
- *Reason to believe that the prescribed medication is being used inappropriately or diverted*
- *Concerns that medication is stored in the home inappropriately and/or a possible risk to children*
- *The patient is displaying concerns regarding unstable psychiatric illness or is disclosing risk of self harm*



MONITORING OF PATIENTS THROUGH URINALYSIS

Discuss with patient reasons for urinalysis

Provide multi-test kit with temperature gauge, patient to provide adequate amount of urine.

Allow up to 5 minutes for test to complete. Multi test kits may have the following:

MTD = Methadone
Mop = Opiates
Bzo = Benzodiazepine
Met = Methamphetamine
All the above require 2 lines for a negative test.

THC = Cannabis
Coc = Cocaine
Amp = Amphetamine
These require 1 line for negative test

NB. A single kit can be used for buprenorphine (Subutex)

Following urinalysis, discuss with patient outcome and proceed with treatment accordingly

Aim

- *To reduce the risk of patient being prescribed methadone/buprenorphine when showing a lack of opiate/opioids within their metabolism i.e., overdose*
- *To reduce chance of production of fraudulent urine*
- *To allow a more accurate baseline of which substances the client is taking*
- *To check if unsupervised consumption clients are actually taking their methadone*
- *Can be used as a motivational tool*
- *Buprenorphine kits are available in single cassette form*

Full toxicology screens are available from Biochemistry department at Rotherham Hospital NHS Foundation Trust

NB. However, there is no foolproof method of ensuring that the specimen tested is what it is declared to be. These are guidelines only.

HEPATITIS C SCREENING

What to test

Hepatitis C Virus (HCV) antibody test will indicate whether a person has been exposed to HCV. About 25% of individuals who become infected with HCV will clear the virus at an acute stage; however, these individuals will still have positive antibody results. Bloods should also be taken at the same time for hepatitis A, B and HIV antibody tests.

Detection of HCV RNA by nucleic acid tests, usually using PCR test.

If the HCV antibody test is positive then further tests including a polymerase chain reaction (PCR) test which detects HCV RNA is required to establish if the virus is still present, hence indicating current circulating virus. More sophisticated tests can then identify the amount of viral load and the genotype of the virus.

HCV positive and HCV RNA negative

If the HCV RNA is negative, individuals should undergo a second test after six months, particularly as the date of infection may not be known and they may be in the window period, and, if still negative the individual may be told that they have cleared the virus.

These individuals who are antibody positive, but are HCV RNA negative do not need treatment, but further discussions should take place around prevention of re-infection, alcohol intake, injecting behaviour etc.

HCV RNA testing should be done 6 to 12 monthly to exclude re-infection and to reinforce risk reduction management.

Hepatitis C infection can cause slow progressive and often asymptomatic disease of the liver. HCV is a blood borne ribonucleic acid (RNA) virus that exists as a number of different strains (genotypes) that are defined by molecular analysis of the viral genome. The effects of the infection vary from one individual to the next. Many people will remain symptom free, some may develop cirrhosis and a few will develop liver failure or primary liver cancer. Unlike hepatitis A and B there is no vaccine, but infection is preventable through strategies that reduce transmission.

Please see link below with regard to infection control:

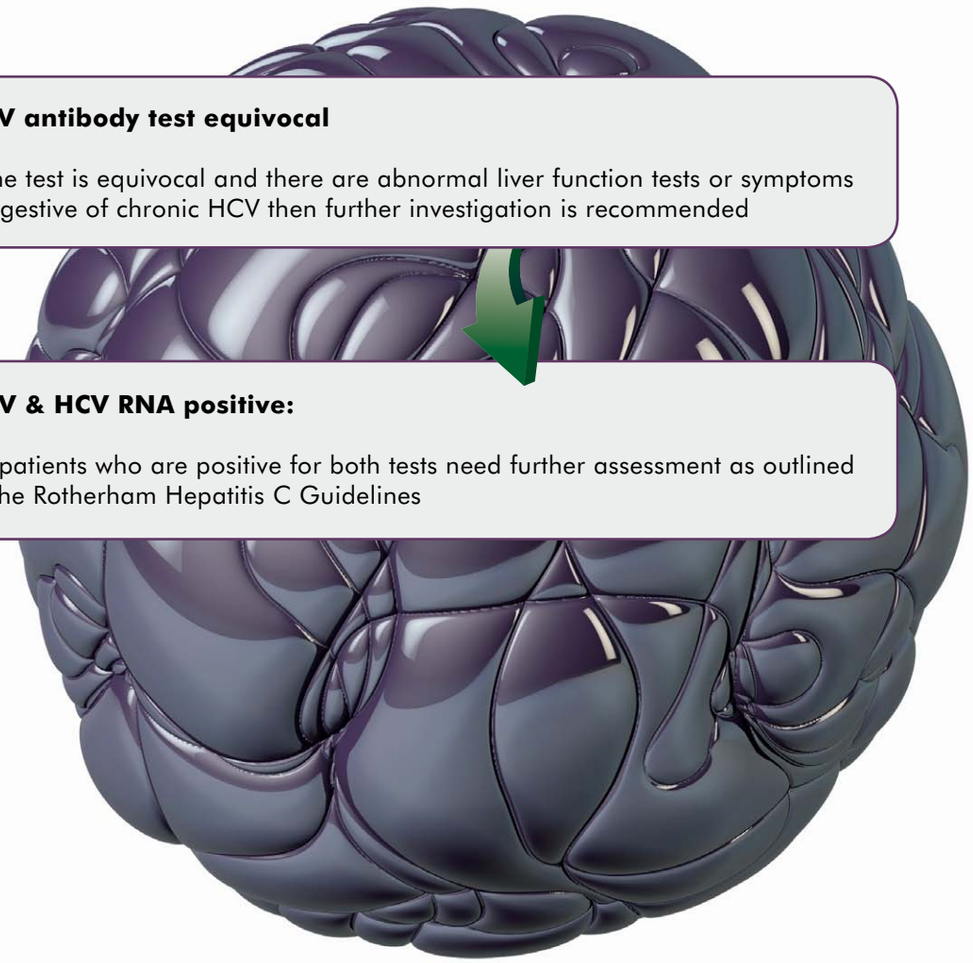
http://websrv.rotherhampct.nhs.uk/intranetapps/pctIntranet/ViewDocuments/ViewLevel4Cats.asp?L2=15&L3=3409&L4=5276&L1BackLink=default.asp&L1BackText=Level%201&L2BackLink=ViewLevel2Cats.asp&L2BackText=Level%202&L3BackLink=ViewLevel3Cats.asp&L3BackText=Level%203

HCV antibody test equivocal

If the test is equivocal and there are abnormal liver function tests or symptoms suggestive of chronic HCV then further investigation is recommended

HCV & HCV RNA positive:

All patients who are positive for both tests need further assessment as outlined in the Rotherham Hepatitis C Guidelines



HEPATITIS A VACCINATION

As for Hepatitis B it is advisable to offer drug users a Hepatitis A vaccine without pre-testing because of the risk that the opportunity to vaccinate may be lost, e.g. due to drug users not returning.

Injecting drug users (IDU) have a higher risk of hepatitis A infection due to poor living conditions, with spread occurring through faecal contamination of drugs or injecting paraphernalia. Blood to blood spread through needle sharing dirty works is also possible.

Hepatitis A Vaccination of IDUs infected with Hepatitis C with chronic liver disease has been recommended for many years because of the risk of more serious illness if they become infected.

Hepatitis A vaccine is available as a single component vaccine or combined with Hepatitis B vaccine. The likelihood of a drug user returning for subsequent dose needs to be taken into account when selecting a single vaccine or the combined vaccine. One dose of Hepatitis A vaccine offers a greater protection against Hepatitis A than one dose of the combined vaccine because the combined vaccine has half the amount of Hepatitis A antigen than the single component vaccine.

HEPATITIS B VACCINATION

Primary Vaccination schedule:

An active approach to vaccination schedule is recommended. Every time a service user has contact with the practice Hepatitis B vaccination should be offered. Lack of certainty regarding vaccination status should not act as a barrier to vaccination and reliance on vaccination is not advised

Accelerated schedules:

0,1 and 2 months or 0,7 and 21 days. Now recognised as the most appropriate

Even incomplete vaccination schedules offer some protection
In addition services need to ensure that there is a robust system for recall

Booster doses:

Best practice is to give a booster at 12 months

An alternative approach is to test for antibodies to the Hepatitis B surface antigen (anti-HBs) at least 1 month after the primary course and make a decision about whether a booster dose is needed depending on the antibody levels

Post vaccination antibody testing:

Antibody level: miu/ ml 10
Status: No response
Action: Screen for markers of present or past infection. Hbs Ag anti HBc give additional dose, consider repeating full course.

Antibody level: miu/ml 10 - 100
Status: Poor response
Action: Give additional dose

Antibody level: miu/ml ≥ 100
Status: Protected
Action: No further action needed immune competent

Hepatitis B vaccination should be considered an essential component of care offered in Primary Care. To address this, vaccination needs to be carried out opportunistically. Pre vaccination testing should never act as a barrier or delay to vaccination. Injecting drug users (IDU's) are at a high risk from hepatitis B due to sharing of equipment and through sexual exposure. Hepatitis B can be prevented by vaccination
The partners and children of drug users are at risk of hepatitis B infection but their need for vaccination is often overlooked. Hepatitis B can be transmitted through sexual contact and nonsexual intimate contact. Children infected with hepatitis B have a higher risk of chronic infection than adults.

RECOMMENDED SCHEDULES FOR HEPATITIS A AND B VACCINES

Hepatitis Vaccines Single A

Schedule:
2 doses with second dose post 6 - 12 months second dose may be delayed for up to 3 years

Combined Hepatitis A & B vaccines

Routine 0,1,6 months

Accelerated 0,7,21 days with booster ideally at 12 months

Injecting drug users (IDU) have a higher risk of Hepatitis A/B infection due to poor living conditions with spread occurring through faecal contamination of drugs or injecting paraphernalia. Blood to blood spread through needle sharing dirty works is also possible.

Hepatitis A/B Vaccination of IDUs infected with Hepatitis C with chronic liver disease has been recommended for many years because of the risk of more serious illness if they become infected

PREGNANCY

Suspected pregnancy disclosed to drugs worker or prescribing clinician and pregnancy confirmed. Multi disciplinary meeting and discussion completed in regard to suitability for the patient to remain in Shared Care. This includes assessment by drugs worker and prescribing clinician of any child protection concerns following Rotherham ACPC Guidelines. Suitability for Shared Care is also dependant on the experience and competence of prescribing clinician.

Suitable for Shared Care

Following confirmation of pregnancy referral should be made to Specialist Midwife and referral to Consultant in Specialist Substance Misuse for advice with regard to treatment plan.

If the patient remains in shared care regular reviews between the prescribing clinician and the drugs worker must take place.

Not suitable for Shared care

- *Referral to Secondary Care Substance Misuse team*
- *Referral to Specialist Midwife*
- *Referral to Secondary Care Consultant in Substance Misuse*

Patient discharged from Shared Care

Pregnancy is a critical time for a woman who is misusing substances. Substance misuse is often associated with poverty and other social problems, therefore pregnant drug using women may be in poor general health, as well has having problems related to drug use. However, pregnancy can often act as a strong incentive to make a positive change to substance misusing behaviour. It is important that the patient engages in treatment for their substance misuse, and regularly accesses antenatal care. In addition this maternity care is normalised as much as possible whilst recognising the social and medical problems associated with substance misuse.

(See Obstetric and Gynecology Directorate - Guidelines for the Management of Pregnant Women who misuse psychoactive substances)

DUAL DIAGNOSIS

Dual Diagnosis

People who misuse drugs commonly have problems with alcohol and mental health.

The majority have mild to moderate problems such as anxiety, agoraphobia, and depression

Assessment and treatment can be offered within primary care.

The primary care mental health services see and treat people who misuse drugs if the drug misuse is not the presenting problem.

More complex patients can be referred for provision of other therapies by qualified staff at substance misuse secondary care.

Treatment of depression should follow local guidelines.

Be very reluctant to prescribe Benzodiazepines for anxiety.

Patients with Severe enduring mental illness should be referred to secondary care psychiatric and substance misuse services for joint working led by mental health team.

Avoid tricyclics with methadone as this is identified as a risk for prolongation of QTc interval.

Be aware of the theoretical risk of need to reduce methadone with SSRIs

RECOVERY

Recovery will commence at the first point of contact with the patient, allowing the GP/worker and patient to commence planning their recovery journey. This can be facilitated by the use of Node Link maps. Extensive research has shown that this easy-to-use and innovative technique – which enables GP/workers to visually represent their patient's thinking in a series of personal maps – improves the engagement and motivation of drug misusers (NTA 2010)

The 2010 National Drug Strategy states that, "The goal of all treatment is for drug users to; achieve abstinence from their drug – or drugs -of dependency". (NTA 2009)
Partnerships and services will want to articulate the ambition of patients and their families and that all systems provide options that meet these ambitions. This will mean that Shared Care Services will remain up to date with patient aspirations. Local Drug Strategies highlight that partnership working will build opportunities in a local Shared Care Services for families and carers to have positive impact on a patient's recovery journey and to assist with getting their lives back on track. The use of Node Link maps deriving from the International Treatment Effectiveness Project (ITEP) allows GP/workers to map out the patient's recovery journey.

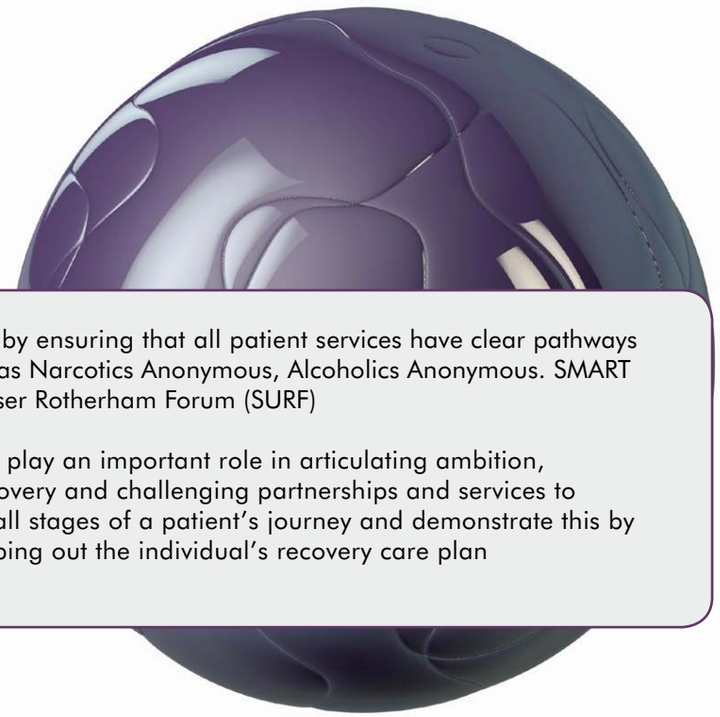
Check with patient's Node Link map and recovery care plan at the 3 monthly review stage or more as individually required. Seek to enhance opportunities as they present in a patient's journey, building on the benefits of being in recovery treatment. The individual's recovery steps should be foremost at all times. During these consultations both clinical and non-clinical issues should be discussed. These areas should include:

- *Reduction regimes*
- *Pre-detoxification*
- *Detoxification*
- *Rehabilitation*
- *Relapse Prevention*
- *Recovery self help groups*

This three way consultation between patient, GP and worker is an ongoing process throughout the patient's journey. During this time it is important that the patient's recovery journey is measured. The Treatment Outcomes Profile (TOPs) allows the multi disciplinary team to measure any progress made, or offer further interventions if the patient has a shown a deterioration in their recovery and/or requests additional help. (See TOP pathway)

Reintegration

Options in both employment and housing along with patient empowerment are an integral part of recovery care planning. The offer of individual and group work in a therapeutic setting to enhance individual recovery should be offered throughout their journey.



Offer support for recovery by ensuring that all patient services have clear pathways to mutual aid groups such as Narcotics Anonymous, Alcoholics Anonymous. SMART recovery and the Service User Rotherham Forum (SURF)

Recovery champions could play an important role in articulating ambition, championing routes to recovery and challenging partnerships and services to retain a recovery focus at all stages of a patient's journey and demonstrate this by implementing this by mapping out the individual's recovery care plan

MOTIVATIONAL INTERVIEWING

The goal is to increase the patient's intrinsic motivation and is achieved by adhering to five general principles:

1) Express Empathy: accept people as they are and where they are (based on C. Roger). Ambivalence to change is seen as normal, consistent with reality. The therapist tries to elicit self-motivational statements.
2) Develop Discrepancy: "Motivation for change is created when people perceive a discrepancy between their present behaviour and important personal goals." (Miller, 1991)
3) Avoid Argumentation: Start with the patient where he is. Avoid direct confrontation in order to avoid resistance and avoid labelling.
4) Roll with Resistance: Reframe statements of patient to create a new momentum towards change. The therapist invites the patient to consider new information and perspectives. The patient is actively involved in finding solutions for his problem.
5) Support Self-Efficacy: The GP/worker is an enabler to help the patient help themselves. The purpose is to help the patient to believe in themselves and to have confidence that they can carry out the changes they have chosen (i.e. reduced drinking/drug use, occasional use or possibly working towards abstinence).

"Motivational interviewing (MI) refers to a counselling approach in part developed by clinical psychologists Professor William R Miller, Ph.D. and Professor Stephen Rollnick, Ph.D. It is a patient-centered, semi-directive method of engaging intrinsic motivation to change behaviour by developing discrepancy and exploring and resolving ambivalence within the patient".

Motivational interviewing recognizes and accepts the fact that patients who need to make changes in their lives approach counselling at different levels of readiness to change their behaviour. If the counselling is mandated, they may never have thought of changing the behaviour in question. Some may have thought about it but not taken steps to change it. Others, especially those voluntarily seeking counselling, may be actively trying to change their behaviour and may have been doing so unsuccessfully for years.

Motivational interviewing is non-judgmental, non-confrontational and non-adversarial. The approach attempts to increase the patient's awareness of the potential problems caused, consequences experienced, and risks faced as a result of the behaviour in question. Alternately, therapists help patients envisage a better future, and become increasingly motivated to achieve it. Either way, the strategy seeks to help patients think differently about their behaviour and ultimately to consider what might be gained through change.

The theoretical background of MI is contained in the principles of "Problem Solving, Accurate Empathy & Behavioural Psychology" by changing what an individual does to how they change what they think.

Secondly, in creating a cognitive dissonance, however subtly or gently you may do that, you are inevitably directing the patient to where, in many ways, the GP/worker reinforces emphasis on personal choice and responsibility. However, there may be patients who would deny the existence of concepts such as personal choice and responsibility. In such circumstances GP/worker may attempt the use of cognitive restructuring:

Clinical application of MI contains working within the context of Prochaska and DiClemente's model of change. This model describes a series of stages the individual may enter during the process of change (pre-contemplation, contemplation, decision, action, maintenance and relapse). MI intends to 'help the person move from pre-contemplation to action' (Miller, 1983). It tries to establish first of all, whether the patient is ready for change, if not, how to help them to decide whether change is desired and what this change would entail and how to go about it.

TREATMENT OUTCOME PROFILE (TOP)

The NTA suggests that experience has shown that several key points can be beneficial in achieving a high standard of TOP completion.

The NTA designed the TOP in partnership with treatment services. The TOP provides patients and clinicians with an additional way of seeing whether their current care plan is working and provides commissioners with suitable information to assess the impact of treatment

Clinicians should complete TOPs at the start of a patient's treatment, then every 26 weeks as part of the care plan review process, and finally when the patient exits treatment.

When completing TOPs, it is important to remember that "NA" means "not answered". Use NA when the patient cannot remember a particular detail or refuses to disclose information relating any or all items in the TOPs.

Section 1 of the TOP should be reported as illicit drug use. This includes methadone and Buprenorphine (Subutex) that the patient has obtained on the street rather than prescription and should be recorded in the opiate section.

Information gathered about patients via the TOP is subject to the same confidentiality safeguards as all other drug treatment and health data. It is important that patients feel reassured of this fact, as it will encourage them to report their behaviour accurately.

The Treatment Outcomes Profile (TOP) has been developed by the National Treatment Agency (NTA) and, since 2007, is being implemented throughout the drug treatment system in England. The tool was developed with three aims in mind:

- *To provide a tool that is clinically useful, that can add value to the important work that is done between the patient and the drugs worker.*
- *To enable the NTA to monitor and assess the effectiveness of the national drug treatment system.*
- *To support commissioners and treatment providers in making improvements where necessary in the local treatment system.*

The TOP is a 20 item measure that focuses on four important treatment domains as defined in the NTA care planning practice guide:

- *Substance use*
- *Injecting risk behaviour*
- *Crime*
- *Health & social functioning*
- *Unlike proxy indicators, these domains reflect the problem areas that can make a real difference to patients' lives and that of wider communities.*

TOP information is submitted to the National Drug Treatment Monitoring System (NDTMS) where quality assurance and analysis are undertaken.

ALCOHOL

- *Alcohol may be the primary drug at presentation*
- *Alcohol is used excessively in an attempt to alleviate symptoms of withdrawal*
- *Alcohol increases the risks associated with Heroin, Methadone, Buprenorphine and Benzodiazepines especially in overdose*
- *Assess before initiating substitute medication*

25% British adults drink hazardously.

If detoxification is requested with dual dependency alcohol detoxification should occur first.

When people stop using Heroin or Cocaine, alcohol use can be problematic. It is important to identify and offer brief interventions. Problematic alcohol use can seriously compromise recovery.

Use AUDIT to screen for alcohol problems

Follow the Rotherham Alcohol Treatment Pathway

Brief Interventions are useful and appropriate

The Care co-ordinator/ key worker may deliver extended brief interventions

CANNABIS

- *Relaxant and has a euphoric effect*
- *Unusual to present as main drug of choice - users may be unaware of its connection to symptomatology*
- *Dependency develops in a tenth of users - 75% experience withdrawal on cessation*
- *Causes respiratory symptoms*
- *Associated with psychosis*

Over 2.5 million people used cannabis in the UK last year.

Skunk is currently the preferred variety of cannabis and its effects are is highly potent.

It affects cognitive function, mood, memory, sleep and appetite.

Nicotine dependency can be treated as normal. It's advisable to withdraw from one addictive substance at a time.

- *No substitution therapy is available*
- *Brief interventions and advice can improve outcomes*
- *Behavioural approach to management of withdrawal gradual reduction allied with relaxation, sleep hygiene, relapse prevention*
- *If depression is the presenting complaint an ideal approach would be to stop cannabis and review after two weeks*
- *Don't forget that cannabis users are likely to be nicotine dependent too*

CRACK COCAINE

The patient may present in a medical crisis and receptionists and other staff should be made aware that these users may need to be seen as an emergency. Less acutely, they might be presenting with a specific set of symptoms such as asthma, chest pains and weight loss, which could be a result of their Crack/Cocaine problem. Patients who are already known to have another drug problem e. g. opioid dependence, and be currently in treatment at the surgery may present with symptoms of Crack/Cocaine use as a new problem.

There are currently 3 forms of treatment that are best used in conjunction:

- *Psychological interventions, such as Cognitive Behavioral Therapy (CBT) and Motivational Interviewing (MI): - Which are arguably the most useful of the treatments, but will for the most part be conducted outside of the surgery. All treatment is improved by a positive, non-punitive, relationship with a key person, such as the GP or drug worker.*
- *Prescribed medication - which should never be used in isolation from a whole package of care, including relapse prevention. In light of the results of trials on a large number of drugs, it would seem reasonable to conclude that drug therapy is only effective for the most part in treating individual symptoms such as depression or insomnia (short-term only) after Crack/Cocaine or other stimulant use has ceased. There is no substitute medication, although many have been tried.*
- *Complimentary Therapies – Such as auricular acupuncture may sometimes help*

It is recommended that regular health checks, including monitoring of weight, nutrition and peak flow rate, take place to monitor progress and provide appropriate interventions, (e.g. on a 3-4 monthly basis).

When discussing harm reduction with an individual, encourage them to bring their paraphernalia in to the surgery. Get them to show you what they do and work together to minimise the harm caused by using the drug in that way.

The drug comes in two main forms: Cocaine Hydrochloride powder, which is usually snorted, but also injected - and Crack, which is usually smoked, but also can be injected if converted back to base. Crack/Cocaine is a powerful stimulant whose effects wear off quickly, prompting the user to repeat the dose. Many users do not get into problems but high dose users, especially of Crack, are likely to need treatment for a large range of physical problems and it is important that GPs and other primary care practitioners, have a working knowledge of the problems faced by Crack/Cocaine users, while at the same time not working in isolation or outside their level of competence.

The published evidence base is small and much from the US, but there is an increasing wealth of experience both in people who use the drug and professionals. Crack/Cocaine is extracted from the leaves of the coca plant and processed into Cocaine Hydrochloride powder. To transform Cocaine into Crack, the Cocaine base which has to be freed from powder is heated up in a microwave with bicarbonate of soda and water. Crack is easily melted and vaporized, so can be smoked, but it can also be injected by adding acid.

Crack/Cocaine is a stimulant drug. Users feel more alert and energetic, confident and physically strong and frequently believe that they have enhanced mental capacities. When smoked as Crack, it has more intense and immediate effects because in this form the drug is delivered to the brain much more quickly. Excessive doses can cause severe medical problems, and even death, from pulmonary oedema, heart failure, myocardial infarction, cerebral hemorrhage, stroke and hyperthermia. The after-effects of crack use may include fatigue, depression, paranoid ideation and de-personalisation as people 'come down' from the high

- *There is no completely safe way to take Cocaine/Crack but much advice can be given about how to use the drugs more safely.*
- *Explain about possible health risks: local burns, damage to the lungs, heart and liver.*
- *Because Cocaine/Crack needs to be injected frequently and acts as a local anaesthetic to the skin this increases the risk of damage to the tissues, local and systemic infections and DVT.*
- *Always advise about sharing any injecting, piping or snorting equipment, particularly injecting equipment.*
- *Advise pipers to switch from using plastic bottles or cans to glass pipes, and to avoid inhaling ash, paint, dust, water and other particles into the lungs.*
- *Encourage the move towards non-injecting routes of use, such as chasing or piping.*
- *Get the patient to set themselves rules and stick to them. For example put off the first pipe of the day for as long as possible.*
- *Overdose - Understand the signs of overdose, which may be: sudden rise in body temperature, flushed face, hot skin, muscle cramps, stiffness in arms and legs, know how to manage it and always call for an ambulance early.*

PSYCHOLOGICAL TREATMENT AND APPROACHES FOR ANXIETY AND DEPRESSION

All patients should be informed by the key-worker/GP about the following interventions which should be considered in relation to anxiety and depression:

- *Self help, AA and NA should be discussed with the patient.*
- *Guided self help for anxiety and depression. This should be discussed and used as part of a keyworking session.*
- *Computerised CBT (especially where the patient likes to use computers).*
- *Exercise this is beneficial to all patients but particularly recommended for depression.*
- *Relaxation and holistic therapies should be offered to all patients but particularly helpful for anxiety.*
- *Motivational interventions is useful when the patient is ambivalent and needs to connect their anxiety and depression symptoms with their substance use.*
- *One to one key-working focusing on changes in substance misuse where patients choose to make changes.*
- *Medication for anxiety and depression may be considered by GP and this decision is taken by the GP.*
- *CBT approaches such as node link mapping may be useful to make changes before a more formal therapy route is considered.*
- *One to one key-working to identify issues and to work towards addressing and making lifestyle changes in areas such as diet, exercise, offending patterns. Domestic violence and homelessness can contribute significantly to anxiety and depression symptoms.*

The main symptoms of depression are losing pleasure in things that were once enjoyable and losing interest in other people and usual activities. A person with depression may also commonly experience some of the following: feeling tearful, irritable or tired most of the time, changes in appetite, and problems with sleep, concentration and memory.

People with depression typically have lots of negative thoughts and feelings of guilt and worthlessness; they often criticise themselves and lack confidence. Sometimes people with depression harm them selves, have thoughts about suicide, or may even attempt suicide. Occasionally a person with severe depression may have hallucinations and delusions. People with depression may have feelings of anxiety as well. (NICE 2007)

Everyone feels anxious sometimes but having anxiety disorder means someone feels anxious at inappropriate times and finds it difficult to control their worries. People with anxiety disorders may feel apprehensive and tense. These feelings may be experienced not as emotions but as physical symptoms such as butterflies or cramps in the stomach, trembling, a fast heart beat and /or sweating. Often the cause of the feelings both physical and emotional is unclear and people may think they are going mad, losing control or fainting. Other people fear they are having a heart attack or stoke which although is understandable such fears are groundless. (NICE 2007)

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