Forth Valley GP Guide to Managing Substance Use

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NHS Forth Valley
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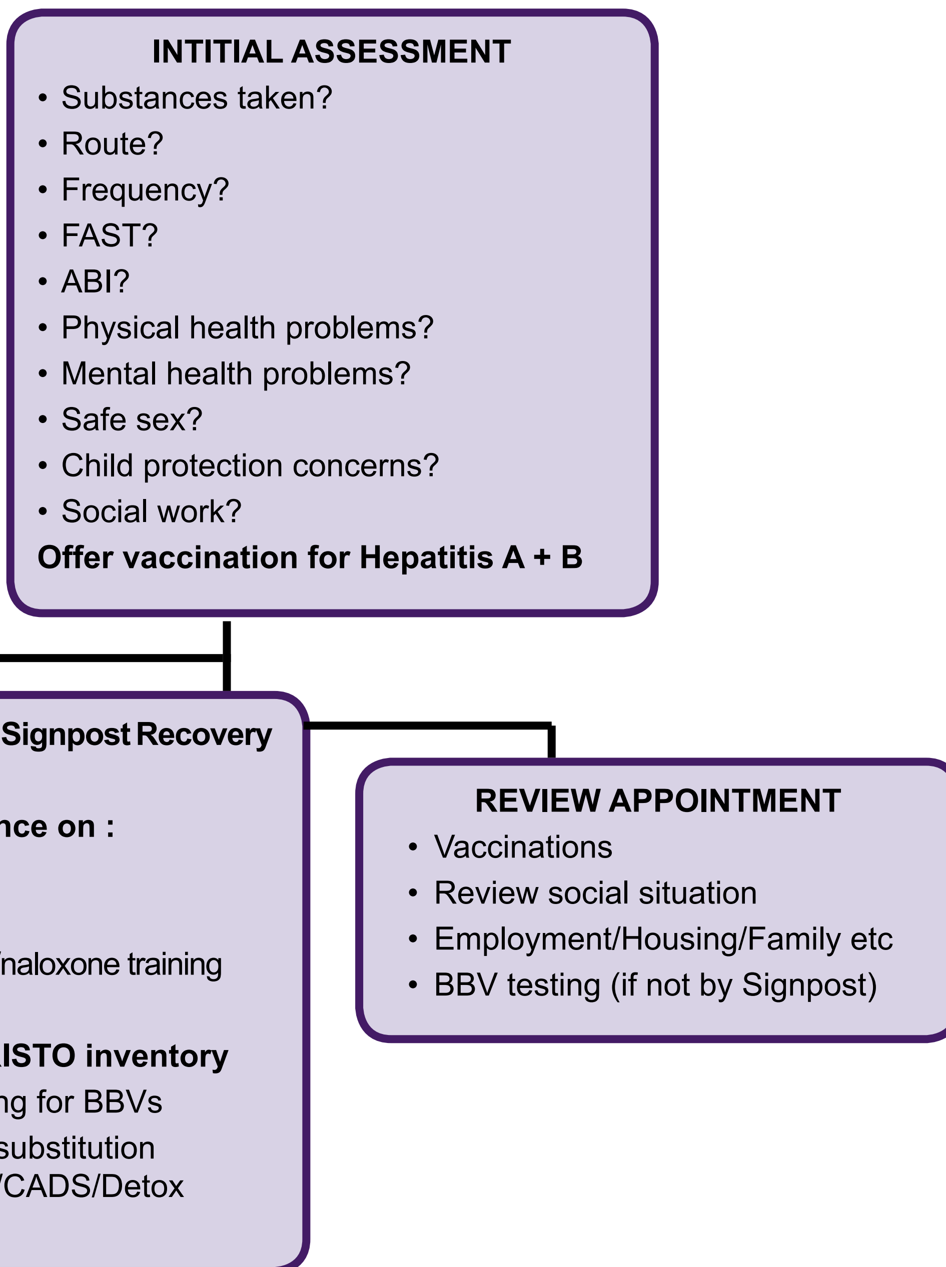
INTRODUCTION/SCOPE

This guide is a resource for general practitioners in Forth Valley engaged in the management of people with substance misuse problems. It seeks to promote best practice using both national and local guidance.

GP's can refer patients to Signpost Recovery by giving the client the SM Treatment Service Leaflet and phone number 0845 6731774 and an information leaflet for Signpost Recovery. The patient is expected to contact Signpost themselves by phone to arrange a suitable time to be assessed.

FVADP Service Directory – a useful resource which details all the services in Forth Valley which deliver care and support for substance misusers

1. INTEGRATED CARE FOR SUBSTANCE MISUSERS
All GPs should offer general medical services (GMS) and harm minimisation interventions for all substance users.



This care should include the following:

- Record substances, route and frequency of use.
- Screen using FAST and offer ABI if appropriate.
- Assess physical health – Drug misuse and dependence :UK Guidelines on Clinical Management

Assess mental health; **Drug misuse and dependence: UK Guidelines on Clinical Management**

- Advice regarding safer injecting and avoidance of blood-borne virus transmission – Guidelines for Services Providing Injecting Equipment.
- Refer to Injecting Equipment Provision services
- Referral for overdose awareness/naloxone training to Signpost Recovery (0845 6731774).
- Advice on safer sex and contraception, **CentralSexualHealth.org** (01324 613944)
- Offer vaccination for Hepatitis A + B.
- Testing for Hepatitis B, Hepatitis C and HIV, with pre and post test discussion.
- Referral to Single Point of Referral for substance misuse treatment either via SIGNPOST/CADS or SCI-Gateway (coming soon).
- Direct to peer support agencies, **AA**, **NA** etc
- Demonstrate progress in treatment through use of toxicology screening, recovery planning and **Christo**.
- Suitability for referral to Signpost for consideration for opiate detoxification programme (short duration and low level of use and supportive social situation).

2. GP PRESCRIBING SERVICE (GPPS)

The GP Prescribing model describes the shared clinical care of a patient between a GP, Signpost Recovery (key-worker) and community pharmacist. The overall quality and delivery of the service is coordinated by the GP Prescribing Coordinator.

"Medical practitioners should not prescribe in isolation but should seek to liaise with other professionals who will be able to help with factors contributing to an individual's drug misuse." (DOH, 1999)

The model also includes social care and recognises the importance of other professionals in the larger shared care team (social work staff, criminal justice staff, voluntary agency staff, and family support services).

The prescribing GP will typically be the individual client's own GP however on occasion an alternate GP prescriber may be sought. This may arise where an individual is assessed as suitable for GPPS but their own GP is unable to prescribe within GPPS.

Where an alternate GP is being considered the, GPPS key-worker will confirm that all parties, (client & both GPs), are fully aware and in agreement with the proposed treatment course. It is the responsibility of this prescriber to keep the client's GP apprised of their prescribing decisions. The client's own GP will retain the responsibility for the provision of General Medical Services, and should liaise prior to prescribing of any medicine with the potential for misuse, (see section 1.2).

2.1 GPPS ELIGIBILITY CRITERIA

- Opiate dependency where there is no problematic alcohol or poly-substance use.
- Stable accommodation
- Willingness to work towards recovery, reduction and a drug-free lifestyle.
- Good general health, (caution with significant co-morbidities).
- Good mental health, (caution with significant co-morbidities).
- Commitment to attending GP and regular key-worker sessions, and working towards positive outcomes.

Refer to CADS for opinion in substance misuse cases complicated by:

- Persistent chaotic or challenging behaviour.
- Complex poly-drug misuse.
- Pregnancy
- Severe and Enduring Mental Health.

2.2 GPPS ASSESSMENT

Prior to commencing GPPS comprehensive assessments, (GP and Signpost Recovery), will be undertaken. All parties, (GPs, Signpost & Service User), must agree to this treatment provision prior to commencement. GPs should ensure their assessment is in line with national guidelines: Drug misuse and dependence

The full drug assessment is a compilation of findings from the GP and the Signpost key-worker. Information from other involved professionals or reliable supporter may assist in completing the picture.

2.2.1 GP Assessment

Includes:

- Signs and degree of dependency/injection sites
- Signs of intoxication or withdrawal
- Reasons for accessing treatment now
- Social situation including considering the impact on children
- Legal situation/ forensic history
- Minimum of 2 results of urinalysis or salivary tests consistent with history.
- Risk factors for the patient, relevant others and professionals
- Enquire about BBV status and offer vaccination if appropriate
- Harm Reduction and overdose advice (refer to Signpost)
- Offer contraception and/or contraceptive advice.
- FAST and ABI as indicated.
- Smoking status
- **ESCRO GPPS Guide**

2.2.2 Signpost Key-worker Assessment

- see **Signpost Recovery Assessment** and **Signpost Key-workers Guidance**
- Initial assessments and drug screening will be completed prior to initial appointment with GP.
- Assessment will include initial full screen drug test and subsequently the **Forth Valley Alcohol & Drug Testing Guideline** will be followed.

2.3 TREATMENT GOALS

For some years now, "a range or a hierarchy of goals," for effective drug treatment has been identified in the UK **DOH, 1999** [1]:

- Reducing health, social, crime and other problems directly related to drug misuse.
- Reducing health, social or other problems not directly attributable to drug misuse.
- Reducing harmful or risky behaviours associated with the misuse of drugs (for example sharing injecting equipment).
- Attaining controlled non-dependent or non-problematic drug use.
- Abstinence from main problem drugs.
- Abstinence from all drugs.

The Road To Recovery (SG 2008) states that: *"Recovery is a process to which an individual is enabled to move on from their problem drug use, towards a drug free life as an active and contributing member of society. Recovery is most effective when service users' needs and aspirations are placed at the centre of their care and treatment."*

2.4 CONFIDENTIALITY AND INFORMATION SHARING

Please advise the patient that:

"when you are referred to the Substance Misuse Services your information will be shared with partner agencies to ensure the right service is offered to them which best meets their needs. If you do not agree to have your information shared like this, please ensure you make your GP or whoever is referring you aware of this. If you do not consent to having your information being shared Forth Valley may not be able to provide the best service for you."

All clients will be issued with NHS Code of Practice on protecting patient confidentiality.

2.5 TREATMENT AGREEMENT

The Four way Treatment Agreement clearly establishes guidelines for all parties relating to expected standards of behaviour/care. The document defines any local policy within the practice/pharmacy with regard to appointments/ prescriptions.

The agreement will be completed by the client, key-worker and GP at the first GP appointment. The key-worker will then attend the pharmacy, with the client, where the pharmacist will sign the agreement.

2.6 RECOVERY PLAN

A recovery plan will be developed by GP and key-worker in partnership with the patient. It must serve as a basis of shared understanding between the client and treatment providers. All parties must be aware of what is expected of them regards program commitments and attendance.

The recovery plan is a comprehensive set of tools and strategies and interventions that address the client's problems and deficits. It provides an approach for sequencing resources and activities, and should identify benchmarks of progress to guide evaluation.

The **Christo Inventory** is quick and simple validated treatment evaluation tool to assist, assessment, clinical audit and evaluating treatment outcomes. The CHRISTO should be used at the baseline assessment and at, quarterly, clinical review.

- Toxicology: effects, withdrawal and detection of drugs of misuse can be found in the extract from The Maudsley Prescribing Guideline 11th Edition.

2.7 DRUG MISUSE DATABASE

All patients will be notified to the Scottish Drug Misuse Database using an online SMR25 (a&b) by Signpost at assessment.

For further information see 'SMR25: Guidance Notes' at:

http://www.drugmisuse.isdscotland.org/sdmd/sdmd.htm

3. PHARMACOLOGICAL INTERVENTIONS

All prescribing in GPPS must adhere to both national and local guidelines:

- Methadone Assisted Treatment (MAT)
- Buprenorphine Assisted Treatment (BAT)
- SMMGP Guidance for the use of substitute prescribing in the treatment of opioid dependence
- **Drug Misuse and dependence** – UK guidelines on clinical management

3.1 SUBSTITUTES FOR OPIOID DEPENDENCE

Methadone and buprenorphine are both licensed for the treatment of substance misuse. Dihydrocodeine is not licensed for the treatment of opioid dependence and not recognised as a treatment option in NHS Forth Valley.

Only methadone oral solution 1mg/1ml should be prescribed. Sugar free methadone mixture should only be prescribed for diabetic patients.

Guidance for the use of substitute prescribing in the treatment of opioid dependence in primary care.

Induction onto methadone and buprenorphine treatment is the process of starting a patient on a suitable dose of a substitute opioid and optimizing the dose. Induction should be monitored by a doctor or specialist drug worker. It may take several weeks (or more) to achieve an optimal dose with methadone, less with buprenorphine.

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, falls to very low levels.

Clinicians therefore need to balance three competing pressures in prescribing for opiate-dependent drug misusers.

- To prescribe an effective and appropriate dose.
- To minimise the risks of overdose or precipitated withdrawal during induction onto appropriate medication.
- To rapidly respond to the patients' needs for appropriate treatment in order to retain them in treatment and prevent harm from illicit drug misuse.

For further information on titration see Prescribing Guidance (**MAT** & **BAT**)

No substitute medication should be considered until the patient has provided two drug screening tests and has shown positive for opiates.

3.1.1 Methadone Induction

It is very difficult to calculate the starting dose for methadone. Guidance and regimes are detailed in the Methadone Assisted Treatment (**MAT**). Caution is urged, probable starting does are around 10-30ml of methadone supervised daily. Caution is also recommended in community titration with local protocols suggesting increases of 10mls per week up to the target dose. The target dose should be discussed with the patient and based on the history of use, previous treatment experience and monitored on a weekly basis by the key-worker.

The risk factors for overdose during induction are:

- Low opioid tolerance
- Concurrent use of CNS depressant drugs, including alcohol
- Too high an initial dose
- To rapid dose increase

3.1.2 Buprenorphine Induction

It is advised that prior to buprenorphine induction GPs consult the Buprenorphine Assisted Treatment (BAT) guideline. In brief, for buprenorphine induction, clients must present in marked opiate withdrawal to avoid precipitating withdrawal by the administration of buprenorphine. In general clients are given one 4mg dose under supervision in the clinic. If there are no signs of precipitated withdrawal, a second 4mg dose is supervised in the clinic. The next day, in most cases, the treatment dose of 16mg will be given supervised in the pharmacy. The target maintenance dose should be calculated based on the history of use and previous treatment experience.

The risk factors for overdose during induction are:

- Low opioid tolerance
- Concurrent use of CNS depressant drugs, including alcohol.

With buprenorphine there is a risk of precipitated withdrawal. The risks are increased where insufficient time is left before administering buprenorphine in patients who have:

- Recently used heroin, particularly at higher doses.
- Recently consumed long-acting opioids such as methadone.

3.2 MAINTENANCE PHASE

Objectives	How	Duration
• To put in place lifestyle and behaviour changes to maintain abstinence from heroin. • To initiate or continue interventions to reduce other drug and alcohol use. • To prepare for reduction off methadone i.e. phase 3.	• Engage in effective keyworking. • Appropriate referrals to other agencies and services. • Other interventions e.g. complementary therapies, engagement in meaningful occupations or other activities.	Maintenance should continue as long as it is of continuing benefit to the client

3.3 REDUCTION PHASE

Objectives	How	Duration
• To detoxify off methadone • To prepare for abstinence i.e. 'life post-methadone'	• Structured methadone dose reduction regimen (alternatively, buprenorphine assisted detoxification may be used). • Engagement in relapse prevention work - group and/or individual. • Clients should have a medical review 2 to 3 months after initiation to ensure dose optimisation.	Weeks to months, reduction should be entered into with a clear plan, and where possible, an end date.

3.4 PRESCRIPTIONS

Prescription form (GP10) is used in General Practice. This permits a methadone or buprenorphine prescription to extend for a period of 28 days.

See Examples of standard prescription in BNF/Controlled Drugs and drug dependence

3.5 DISPENSING AND SUPERVISION

In most cases, new patients being prescribed methadone or buprenorphine should be required to take their daily doses under the direct supervision of a professional for a period of time that may be around three months, subject to assessment of patients' compliance and individual circumstances.

In patients whose treatment is failing, a period in supervised consumption can improve treatment concordance and facilitate interventions to improve outcomes. A good example is to enable daily breathalyser readings or monitoring of other indicators of alcohol intoxication in patients who are drinking heavily while taking methadone.

Remember to clearly specify **DAILY DISPENSING** and **SUPERVISED CONSUMPTION,** for the first period of prescribing.

3.6 STOPPING SUPERVISION

Relaxation of requirements for supervised consumption and for instalment dispensing is a stepped process. A patient first stops taking doses observed by a professional but remains on daily dispensing. Later, after further progress, the frequency of dispensing may be gradually reduced. The relaxation of supervision can be an important component of recovery.

Supervised consumption should only be relaxed where the prescriber has good reason to believe that compliance will be maintained. In general the prescriber needs to assess the following:

- changes in drug-taking behaviours (such as IV use),
- compliance with prescribed drug treatment,
- abstinence from illicit drug misuse,
- engagement in other elements of a care plan, e.g. attendance at appointments.
- storage of take home doses

Take-home doses should NOT normally be offered where:

- a patient has not reached a stable maintenance dose.
- there is continued illicit drug misuse.
- there is evident alcohol use
- there is significant, unstable psychiatric illness or threat of self-harm
- there is are concerns of diversion or inappropriate use
- there are concerns about the safety of medicines stored in the home and possible risks to children.

Refer to MAT & BAT

3.7 MISSED DOSES

Refer to MAT & BAT

3.8 STOPPING PRESCRIPTIONS

Refer to MAT & BAT

4. PRESCRIBING PRACTICE POINTS FOR SUBSTANCE MISUSERS

4.1 BENZODIAZEPINES

Toxicology findings from analysis of drug deaths in Forth Valley show wide spread non-compliance to and diversion of prescribing regimes. Substances particularly implicated include benzodiazapines, anti-depressants and gabapentin. Caution is urged when considering one of these prescriptions.

The prescribing of benzodiazepines to patients, who have problems with illicit use of benzodiazepines, is of no proven effectiveness.

Benzodiazepines should not be routinely prescribed to those who are known or suspected to be illicit drug users.

Refer to **Guidance on Benzodiazepines: Prescribing and Management of Dependence in Primary Care.**

4.2 PRESCRIBING IN THE TREATMENT OF DEPRESSIVE DISORDERS

Refer to NHS Forth Valley **"Guidance for the Management of Depression"**

Substance misusing populations have a higher incidence of depressive illness than the general population. The treatment of choice would be an SSRI, such as fluoxetine or sertraline, as documented in the local formulary. Evidence based guidelines suggest that stabilisation and treatment for substance use is an essential part of the package, and that antidepressant treatment is unlikely to help substance use per se. (Lingford-Hughes,2004 [7]). If patients are attending daily to pick up methadone, consideration should be given to also dispensing the anti depressant daily. Any patient who has failed to respond to 2 antidepressants, at adequate dose for the required time frame should be referred for specialist assessment.

The co-prescribing of escitalopram or citalopram and methadone is contraindicated.

Specialist advice is available from CADS Psychiatrists, if required.

4.2.1 Amitriptyline and Tricyclic Antidepressants

Special consideration should be given to the use of amitriptyline and other tricyclic antidepressants in substance misusing and methadone maintained populations. They are very dangerous in overdose both due to respiratory depression and cardiac arrhythmias, risks increased by a concurrent methadone prescription. Amitriptyline has a street value in Forth Valley and is often substituted for diazepam. Recent guidelines suggest reviewing tricyclic antidepressant prescriptions in substance using patients, and changing to safer alternatives. There may be rare cases where a previous severe mood disorder requires continuation of tricyclic prescribing, in these cases psychiatric review and daily dispensing should be considered

A small dose of amitriptyline is unlikely to aid long term insomnia, it must be recognised that patients that misuse drugs, and even those stabilising on methadone often have sleep disruption. Generally this is more likely to respond to routine and lifestyle stabilisation than pharmacotherapy.

4.3 OTHER PRESCRIBING CONSIDERATIONS

A number of other prescribed medicines are liable to mis-use. These include opiate analgesics, tramadol, gabapentin and pregabalin. See **Guidelines on Management of Pain in Substance Misuse.**

5. MANAGING DRUG PROBLEMS IN GENERAL PRACTICE

5.1 TREATMENT POLICY

The rules and boundaries adopted by a particular Practice will vary dependent on local conditions and the system in operation. However, it is important that the rules and boundaries are explicit and observed by all concerned.

It may be of advantage that each Practice could have a written Treatment Policy for the management of problem drug users. Assistance in the development of such policies is available from the GP Prescribing Co-ordinator.

5.2 CRIME PREVENTION AND SAFETY

Advice on personal safety is available from Learn-Pro and:

- Violence and Aggression Coordinator/advisor Tel: 01324 614337
- Police/Health Service Liaison Tel: 01324 567655:
  Mob: 07881 883745.

5.3 TRAINING

For GPs who are interested in participating in GPPS please contact GPPS coordinator (07770 816 140, email: **grahamnisbet@nhs.net** .

GPs are recommended to undertake Part 1 and Part 2 of the **RCGP Certificate in the Management of Drug Misuse** is available via RCGP (Scotland). Details available via RCGP contact GPPS coordinator to discuss funding.

STRADA provides substance misuse modules, see **www.projectstrada.org/v1/**

Child Protection Training is mandatory for all NHS staff basic awareness is available via Learn Pro

Staff working directly will vulnerable families should seek additional training to meet their needs Modular training is provided and should be sources via the Child Protection department
Tel:01786 477420.
email - nhsfvchildprotect@nhs.net

6. LEGAL ISSUES

6.1 DVLA

- Road Traffic Act requires drivers to declare 'any disability likely to affect safe driving'. DVLA consider drug use a 'disability'.
- It is an offence to be in charge of a vehicle if "unfit to drive through drink or drugs" (DOH 2007). The General Medical Councils Guidance 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)
- Further information can be found on the **DVLA website**.

6.2 TRAVEL TO ENGLAND

- The Prescription Pricing Authority confirms that pharmacists in England should accept Scottish prescriptions.
- Instalment dispensing on prescriptions issued in England is now available for benzodiazepines as well as for controlled drugs.
- Prescriptions written in Scotland on a GP10, but dispensed in England, should be dealt with in the same way as they would be in Scotland. This includes prescriptions for instalment dispensing of diazepam or other drugs: separate daily prescriptions are not required.

6.3 TRAVEL ABROAD

When travelling abroad for any length of time, controlled drugs are carried at the risk of the individual, who is subject to the legal requirements and restrictions of the country or countries of transit and destination. See Home Office website for current information

Further information is available from:

Home Office
Drugs Licensing and Compliance Unit
4th floor Fry Building
2 Marsham Street
London, SW1P 4DF
Tel. 020 7035 3731

7. GUIDELINES FOR PHARMACISTS

Guidelines for Dispensing and Supervised Patient Administration of Treatments for Substance Misuse by Community Pharmacists were prepared by members of the East and Central Scotland Addictions Services Managed Clinical Network. These guidelines are primarily for pharmacists who dispense and supervise substitute opiates. The information is also useful to those prescribing opiate substitutes and other agencies involved in providing services. It is hoped that the guidelines will encourage all pharmacists to engage in providing holistic pharmaceutical care to this important group of patients.

The guidelines also take into account the requirements within HDL (2007) 12: Safer Management of Controlled Drugs: Guidance on Strengthened Governance Arrangements

7.1 INITIATION

- Signpost Key-worker will identify from the client their preferred community pharmacy and contact the pharmacist to ensure there is capacity within the service.
- The client will visit the pharmacy with their key-worker prior to or with their first prescription, to confirm the client's identity to the pharmacist.
- The pharmacist will discuss and complete the 4 –Way Treatment Agreement.

7.2 QUALITY ASSURANCE

Pharmacists participating in this service will comply with the NHS Forth Valley Service Specifications for methadone and buprenorphine.

7.3 COMMUNICATION

Refer to Substance Misuse Services Communication Guideline.

7.4 INCORRECT DOSE ADMINISTERED

Refer to Guidelines for Dispensing and Supervised Patient Administration of Treatments for Substance Misuse by Community Pharmacists