Lancashire & Blackburn with Darwen
Shared Care for Substance Misuse

Shared Care Guide

Working in partnership to reduce substance misuse and make Lancashire a healthier and safer place.

Acknowledgments

Thank you to the following for their involvement and/or support in the development of this Shared Care Guide.

All members of the Lancashire County and Locality Shared Care Monitoring Groups.

All members of the Blackburn with Darwen Shared Care Monitoring Group.

All GPs providing Shared Care across the three Lancashire Primary Care Trusts and Blackburn with Darwen Primary Care Trust.

All Shared Care team members from Lancashire Care Foundation Trust and Greater Manchester West NHS Foundation Trust.

Lancashire Drug and Alcohol Action Team, with a special thanks to the Communications lead Ian Sprakes.

Blackburn with Darwen Drug and Alcohol Action Team.

A special thank you to Dr John Richmond, Delphi Medical Consultants and Dr Rebecca Lee, Greater Manchester West NHS Foundation Trust for their specialist clinical expertise and advice in the development of this guide.

Also a special thank you to Dr Jeremy Marriott, Chair North Lancashire Primary Care Trust, Dr Malcolm Ridgway, Professional Executive Committee Chair NHS Blackburn with Darwen, Dr Stephen Ward, Medical Director Central Lancashire Primary Care Trust and Dr John Haworth, Director of Health Standards and Medical Director for Primary Care, East Lancashire Primary Care Trust who on behalf of their respective Primary Care Trusts signed off this Shared Care Guide.

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Contents

Foreword page 04

Introduction to Lancashire Shared Care page 05

Lancashire & Blackburn with Darwen Shared Care Model

- Model Detail page 07
- Suitability Guidelines page 08
- Referral Process and Pathway page 09

Roles and Responsibilities

- Roles and Responsibilities page 15
- GP Do's and Don'ts page 17

Essential Elements of Treatment

- Comprehensive Assessment page 19
- Care Planning page 20
- Delivery of Treatment page 20
- Drug Testing page 20
- General Health Assessment page 21
- Regular Treatment Review page 21
- Treatment Options page 22

Prescribing Information

- Pharmacological Interventions and Prescribing Responsibility page 25
- Methadone Prescribing page 27
- Dose Commencement page 29
- Missed Doses page 31
- Buprenorphine Prescribing page 32
- Benzodiazepine and "Z" Drugs Prescribing page 36
- Naltrexone Prescribing page 37

Pharmacy Guide

- Supervised Consumption page 39
- Supervised Consumption Pathway page 40
- Missed Doses and Re-introduction Guide page 41

Psychosocial Interventions

- Formal Psychosocial Interventions page 43

Specific Treatment Situations and Populations

- Criminal Justice page 45
- Prisons page 46
- Pregnancy and Neonatal Care page 47
- Mental Health & Dual Diagnosis page 50
- Young People page 51
- Older Current and Ex-Drug Misusers page 52
- Pain Management for Drug Misusers page 53
- Hospital Admission and Discharge page 54
- Blood Borne Viruses (BBV's) page 56

Drugs and the Law

- Legal Status Table page 57
- Driving and Methadone page 57
- Taking Methadone Abroad page 58

Training & Development

- Training & Development - Training for Practice Staff page 59

Appendices

1 Sample Service User Rights and Responsibilities page 61
2 Incident Reporting page 62
3 Letter of Notification of LES2 Service Provision to Service Users Own GP page 63
4 Transfer from Specialist Service to Shared Care: Proforma page 64
5 Quarterly Clinical Review Document page 66
6 Service User Treatment Evaluation Form page 70
7 Summary of Locally Enhanced Service Level 1 Service Level Agreement page 72
8 Summary of Locally Enhanced Service Level 2 Service Level Agreement page 74
9 Performance Management Framework page 76
10 Prescribing Formulary page 78
11 List of Links and References page 79
12 Local Contacts page 80

Foreword

Drug misuse and its complications pervade every part of society and social class and is prevalent across the whole of the country. Offending and problematic drug and alcohol use are strongly associated with poor educational achievement, low literacy levels, mental health problems, dual diagnosis, poverty, deprivation, discrimination and unemployment. However, all the evidence suggests that drug misuse treatment can be effective in reducing the adverse consequences of drug misuse leading to improved health outcomes, reduction in inequalities, crime and social problems and improved access to services. These should be the overall aims of treatment provision.

Treating problem drug users in primary care affords drug using patients greater opportunities to access mainstream health services and "normalises" their drug misuse care. Primary care is ideally placed to provide the treatment for drug misuse and its associated problems, together with dealing with unrelated health issues, health promotion and illness prevention.

Much work has been undertaken locally over the past few years, to strengthen and develop Shared Care arrangements and the role of primary care in the treatment of substance misuse. The Lancashire and Blackburn with Darwen Shared Care model is based on a partnership approach primarily between GPs, Community Pharmacists and Specialist Substance Misuse Services, which provides comprehensive drug treatment in the community while reducing the harm caused by illicit drug use.

The following guidance has been produced to support clinicians who are involved in providing treatment to drug misusers in primary care, centred on the enclosed Shared Care model. These guidelines are not intended to be a comprehensive textbook or manual in treating drug misusers in primary care, but designed to aid and enhance the work currently being undertaken. It should be used in conjunction with the UK guidelines on clinical management of drug misuse and dependence.

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Introduction to Lancashire Shared Care

For the past two years the Lancashire and Blackburn with Darwen Shared Care Development Managers, Liz Jennings, Catherine Wickham, Kim Major and more recently Andrea Stead, have worked closely together to develop and produce this Shared Care Guide. The guide has been designed in order to gain consistency in treatment and service provision for individuals with drug misuse problems. This work has been undertaken across Lancashire and Blackburn with Darwen NHS Organisations and local Drug & Alcohol Action Teams working closely with Specialist Drug Treatment Services and Shared Care leads to establish a countywide standard model of Shared Care.

Shared Care is the term used to describe the provision of services to service users with substance misuse dependency issues in primary care, with support from specialist drug treatment services. Service Users managed within a Shared Care scheme normally have medium to low threshold management requirements, and would usually have been receiving treatment from the secondary care service.

There are many benefits for providing this type of service to substance misusing service users in a GP practice - it fits in with the Government strategy on bringing treatment closer to service users, improving access and improving health outcomes.

Additional benefits are:

- It provides increased routes of access to treatment.
- Practices providing Shared Care have their own dedicated keyworker provided by specialist drug services at no cost to the surgery.
- Shared Care clinics are run at the practices and integrated into the existing practice systems so this provides for better communication and continuity of care to this service user group.
- Service users are able to be cared for in a more holistic way, which includes their general health and social care.
- Shared Care clinics can be linked in with existing primary care clinics such as: practice nurse, health visitors, sexual health clinics etc which assists practices in meeting their QOF targets.
- It normalises the treatment process for the service user rather than contributing to the stigma associated with substance use.

The Shared Care model aims to promote joint working between GPs, Community Pharmacists, Specialist Substance Misuse Services and others to provide a comprehensive, primary care led and community based service which reduces substance related harm. *"Primary and secondary care should work together in collaborative partnerships within integrated care pathways to best meet the needs of drug users"* (NTA 2004)

Treatment for drug users in primary care through Shared Care arrangements is now viewed as a key feature of the drug treatment system nationally and locally.

Success of Shared Care is underpinned by:

- Specialist Drug Treatment Services – providing access to specialist treatment for service users with complex needs or who are not currently appropriate to be treated in general practice.
- General Practitioners treating service users in Shared Care arrangements providing drug treatment in primary care, supported by keyworkers and trained to deliver treatment effectively.
- GP Shared Care is a partnership between Specialist Drug Treatment Services and General Practitioners that aims to provide treatment in the most appropriate setting for individual service users.

These guidelines are intended to be followed, and used, across the whole of Lancashire and Blackburn with Darwen Shared Care schemes. However, although it is expected the guidance contained within will be adopted county wide, it is recognised that in each locality area there may be need for some adaptation in accordance with local need and resources. It is expected that any such adaptations will be negotiated and agreed locally through the Shared Care Monitoring Groups.

Some processes and systems are specific to Lancashire or Blackburn with Darwen (BwD), therefore this guide when referring to Lancashire is referring to the three Lancashire PCT areas and not BwD or Blackpool.

Lancashire & Blackburn with Darwen Shared Care Model

Lancashire & Blackburn with Darwen Shared Care Model

Lancashire & Blackburn with Darwen Shared Care Model

As indicated in the introduction to this handbook, Shared Care is a partnership arrangement. At the heart of the Lancashire model for Shared Care is the need of the service user, therefore the model is as follows:

Local Enhanced Service Level 1 (LES 1)

GP provides treatment to an agreed number of service users with support from the keyworker providing a package of care planned treatment which is reviewed by the GP at least every 3 months. The keyworker will manage the day-to-day running of the clinic sessions with the support of the practice and the worker's line management.

GP Training and development:

- Commitment to complete RCGP Certificate in the Management of Drug Misuse Part 1, within 12 months of joining the scheme.
- Attend at least one clinically focussed training update annually.

Local Enhanced Service Level 2 (LES 2)

Includes as Level 1 services, plus delivering treatment to service users from other practices that are not delivering Shared Care services.

GP Training and development:

- Commitment to complete RCGP Certificate in the Management of Drug Misuse Part 1, within 12 months of joining the scheme.
- Attend at least one clinically focussed training update annually.

GP with a Specialist Interest / National Enhanced Service (GPwSI/NES)

Involved in the development of community based Shared Care services. Provides specialist clinical support to service users in or transferred into Shared Care services. Provides specialist clinical support to GPs and keyworker where appropriate.

GP Training and development:

- GP to have gained RCGP Certificate in the Management of Drug Misuse parts 1 and 2.
- To provide training and support to all GPs providing Shared Care.
- Attend annually, at least 15 hours of Continuing Professional Development (CPD) in substance misuse.
- 2 years experience of working with service users with a substance misuse problem, either in secondary or primary care setting.

Guidelines of Suitability for Shared Care

Clinicians are required to work to their own level of confidence and competence; therefore the following criteria should be followed accordingly and should be implemented within a care planned approach to treatment provision.

As mentioned in the introduction, treating problem drug users in primary care rather than secondary care settings should be the preferred option, as it affords greater opportunities to access mainstream health services and normalises the experience of drug treatment. Primary care has the capacity to deal with a range of presenting problems and is experienced in the management of chronic relapsing conditions.

When looking at the suitability for Shared Care, it should be noted that in effect no-one should be excluded from being managed in Shared Care as long as the support systems are in place to aid the management of the more complex service users (such as GPwSI input).

In Lancashire and Blackburn with Darwen the management of particularly challenging or complex service users should remain within secondary services. This could include service users who have any, or all, of the following characteristics:

- Severe and enduring mental health problems
- Chaotic poly-drug use
- Pregnant
- Benzodiazepine reduction and detoxification
- Prescribed injectable opiates
- Complex pain management issues

Stability

Essentially, first and foremost the service user should be involved in the assessment and care planning process with a view to Shared Care as a progression in their treatment journey. If the service user has stabilised on a prescription and does not come under any of the above categories of complex need they should be moved into Shared Care.

Referral

It is important that the secondary service is able to respond quickly to referrals relating to chaotic and problematic drug users. Therefore it is vital that this service does not become congested with those service users who are stable and suitable for treatment in primary care (Shared Care) with the support from the keyworker.

It is essential that those with a substance misuse problem enter and receive a service that is tailored to their needs. It has been noted that one of the main “bottle-necks” for entering into Shared Care is the referral pathway which directs everyone through the secondary services which is time consuming and may be inappropriate to that person’s needs. Please see below and referral pathway flow chart.

Referral Process

Please note that there are two separate referral processes for Lancashire (see below) and Blackburn with Darwen (see page 12)

Referral to Shared Care - Lancashire

GPs involved in the Shared Care model as a Local Enhanced Service are likely to receive referrals from:

Specialist Drug Services that have stable service users in treatment that are registered at that practice:

Any service user that has been in treatment with Specialist Drug Services (Secondary Care, Criminal Justice Services, Young Persons Services etc) will have been assessed as suitable for treatment in primary care.

The referral would be discussed with the keyworker who would liaise with the GP and discuss the suitability of transfer.

GP appointment may be required to ensure there is no gap in drug or general medical treatment.

Service user, keyworker and GP – may meet at appointment and agree treatment plan.

Self referrals from service users registered at the practice

If a service user presents seeking treatment for heroin misuse, it is essential that a comprehensive assessment is completed prior to initiating treatment.

Comprehensive assessment will be completed by the keyworker or the Specialist Drug Service. This usually depends on whether the GP is signed up to Shared Care or not. Where possible it is hoped the service user can be referred into the keyworker at the surgery. The priority is to get the service user safely into treatment as soon as possible.

Although GPs may feel this delays access to treatment – and that service user needs can be identified and treated on the day – a comprehensive assessment will identify whether the service user is really suitable for treatment in primary care or initially requires specialist drug treatment.

In either case, the NTA target time from service user presentation to commencing treatment in Specialist Drug Treatment is 3 Weeks, and in priority cases one week.

At the end of a comprehensive assessment, including drug screening, the GP will be advised whether the service user is suitable for GP Shared Care or is to commence specialist drug treatment. This pathway ensures that service users receive treatment in the most appropriate setting.

If suitable for treatment in General Practice, keyworker would agree appointment to see GP and commence treatment in Shared Care.

Referral from Shared Care to Specialist Drug Treatment

As previously outlined in the guidelines of suitability, Specialist Drug Services should normally retain complex needs/ chaotic drug users in treatment unless there are support systems in place for treatment to be offered through Shared Care.

Some service users presenting to GPs for drug treatment, or who have previously transferred from Specialist Drug Service to Shared Care, will have (or may develop) complex needs or may be assessed as inappropriate for continued treatment in primary care.

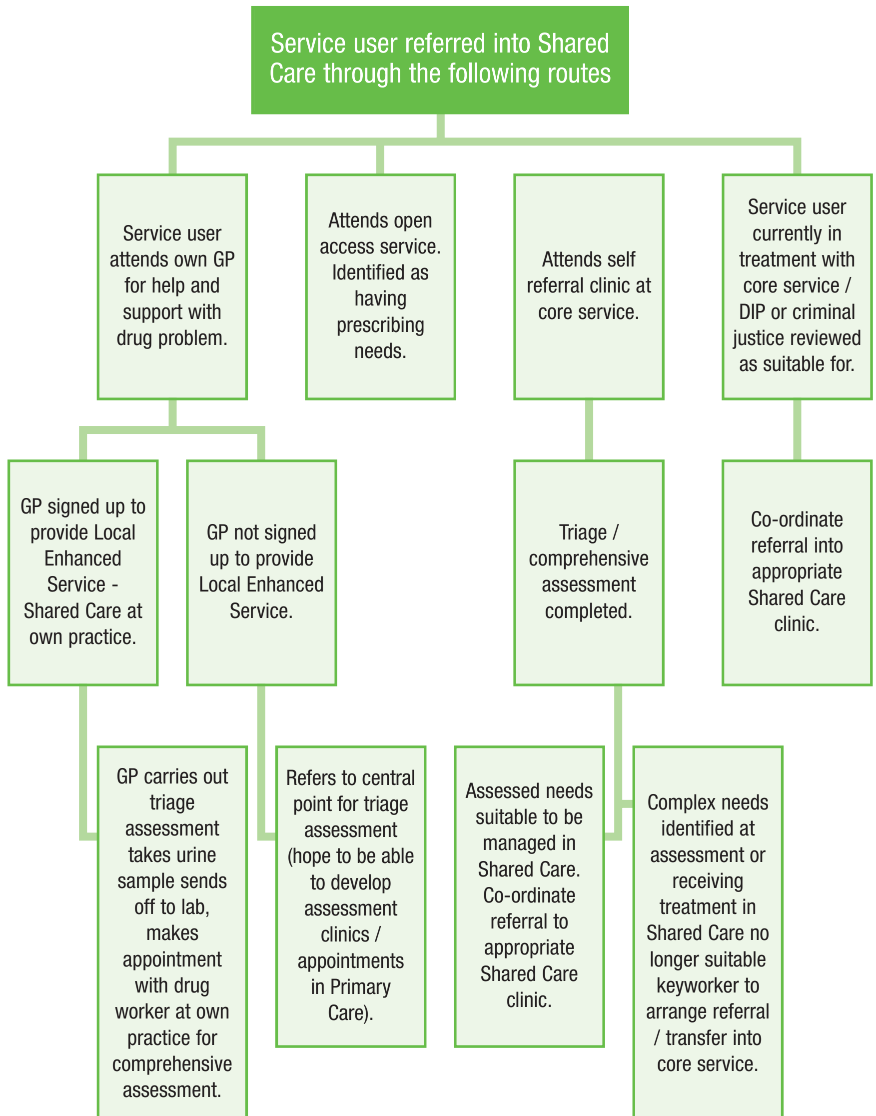
It is important for Specialist Services to ensure that these service users are transferred from Shared Care quickly, to enable service users to receive appropriate specialist treatment and management.

The keyworker should make a priority referral to Specialist Drug Services, with the aim of immediate transfer of the clinical care of the service user to specialist treatment.

The keyworker will confirm an appointment with the Specialist Drug Service and advise the service user of the transfer to specialist treatment.

If there is any doubt about the appropriateness of a service user commencing or continuing treatment in Shared Care the GP (or keyworker) should contact the prescribing doctor at the specialist service or their GP with a Specialist Interest for advice.

Referral Pathway into Shared Care



Referral to Shared Care in Blackburn with Darwen

GPs involved in the Shared Care model as a Local Enhanced Service are likely to receive referrals from:

Neighbourhood and Specialist Drug Teams

Any service user that has been in treatment with a Neighbourhood Drug Team or Specialist Drug Services (Secondary Care, Criminal Justice Services, Young Persons Services etc) will have been assessed as suitable for treatment in primary care.

The referral would be discussed with the keyworker who would liaise with the GP and discuss the suitability of transfer.

GP appointment may be required to ensure there is no gap in drug or general medical treatment.

Service user, keyworker and GP – may meet at appointment and agree treatment plan.

Self referrals from service users registered at the practice

If a service user presents seeking treatment for heroin misuse, it is essential that a comprehensive assessment is completed prior to initiating treatment.

In Blackburn with Darwen a comprehensive assessment will be completed by a keyworker from the substance misuse Neighbourhood Team. The Neighbourhood Team operate from a number of venues across the Borough which are advertised locally. The priority at this stage is to get the service user safely into treatment as soon as possible.

There are specific waiting time targets which drug treatment services are required to achieve, from when a service user presents for treatment to commencing treatment, which is 3 weeks, and in priority cases one week.

At the end of a comprehensive assessment, including drug screening, the GP will be contacted and advised on the treatment plan being put into place for their patients; this will indicate whether they are suitable to receive their treatment in primary care or whether they require further specialist drug treatment input. This pathway ensures that service users receive treatment in the most appropriate setting.

If suitable for treatment in General Practice, the keyworker will agree an appointment to see GP and commence treatment in Shared Care.

Referral from Shared Care to Specialist Drug Treatment in Blackburn with Darwen

As previously outlined in the guidelines of suitability, Specialist Drug Services should normally retain complex needs/ chaotic drug users in treatment unless there are support systems in place for treatment to be offered through Shared Care.

Some service users presenting to GPs for drug treatment, or who have previously transferred from Neighbourhood or Specialist Drug Teams to Shared Care, will have (or may develop) complex needs or may be assessed as inappropriate for continued treatment in primary care. It is important to ensure that these service users are transferred from Shared Care quickly and reassessed by a Specialist Clinician.

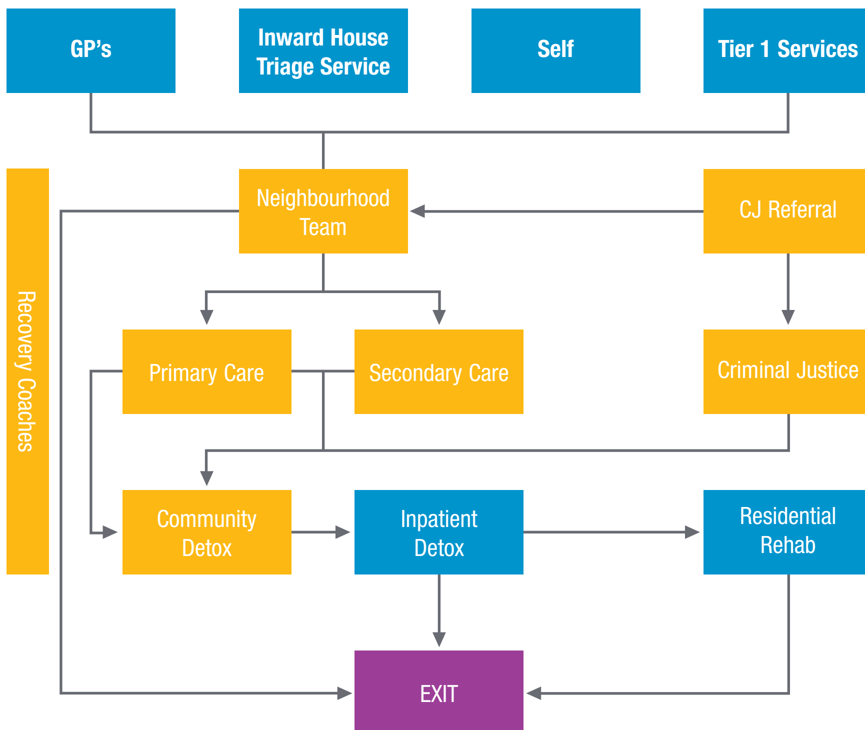
In the first instance these service users will be offered a review appointment with a clinician within the neighbourhood teams, whereby a new treatment plan will be formulated. It may be that the service user continues to be treated in Shared Care with extra support from the specialist clinician, or it may require the service user to stay with the Neighbourhood Team for a short term of stabilisation, transferring back into Shared Care once stabilised. If however, it is determined that the service user has more complex needs they will be transferred into specialist care enabling service users to receive appropriate specialist treatment and management.

The keyworker should make a priority referral to the Neighbourhood Team with the aim of an immediate review of the service users care.

The keyworker will confirm an appointment with the Neighbourhood Team and advise the service user of their appointment.

If there is any doubt about the appropriateness of a service user commencing or continuing treatment in Shared Care the GP (or keyworker) should contact the prescribing doctor at the Neighbourhood Team for advice.

Blackburn with Darwen Drug Treatment Service Model



Roles and Responsibilities

Roles and Responsibilities

Roles and Responsibilities within Shared Care

The GP will be expected to be able to:

- Agree, with the Keyworker, treatment options for service users who are registered at the practice.
- Meet on a minimum 3 monthly basis with the Keyworker to clinically review the caseload.
- Good practice guidelines recommend to undertake a face to face review with each service user twice per year, with an absolute minimum standard of once per year.
- To attend clinics with the Keyworker where there is clinical need.
- Take the lead on matters relating to prescribing practice including authorisation for changes to medication and/or dose regimes and sign the prepared prescriptions as agreed.
- Provide general medical services for drug users on a normal practice appointment basis if the service user is registered there.
- Ensure all prescribing is in line with current evidence based practice with reference to current NICE guidance and the DoH Clinical Guidance 2007.
- Ensure up-to-date records are kept at the surgery on the service users progress, this should include; summary of each consultation, prescribing details and any other relevant information pertaining to the service user.
- Provide the necessary data, as determined by the Performance Management Framework.
- Agree referral on to an appropriate agency for psychosocial interventions to include: regular reviews of care plans and treatment goals with the service user; provision of drug misuse related advice and information, interventions to reduce drug-related harm (especially risk of overdose and infections such as blood borne virus infections), psychosocial interventions to increase motivation, psychosocial interventions to prevent relapse, help to address social problems e.g. housing, financial and employment.

The Keyworker will:

- In consultation with the GP, agree the service users suitability for treatment within Local Enhanced Shared Care for those service users registered at the practice.
- Manage the clinic taking place at the practice and carry out regular urinalysis of service users attending (as per Urine Testing Policy).
- Ensure up-to-date records are kept at the surgery on the service users progress, this should include; summary of each consultation, prescribing details and any other relevant information pertaining to the service user.
- Provide the necessary data, as determined by the Performance Management Framework.
- Provide or refer on to an appropriate agency for psychosocial interventions to include; regular reviews of care plans and treatment goals with the service user, provision of drug misuse related advice and information, interventions to reduce drug-related harm (especially risk of overdose and infections such as blood-borne virus infections), psychosocial interventions to increase motivation, psychosocial interventions to prevent relapse, help to address social problems e.g. housing, financial and employment.
- Agree with the GP treatment options for service users.
- Meet on a minimum 3 monthly basis with the GP to clinically review the caseload.
- Attend clinics with the GP where there is clinical need.
- Ensure prescriptions are prepared, printed and available for signing in advance of the Shared Care clinic.
- Liaise regularly with community pharmacists.
- Organise referral to specialist services for service users who become inappropriate for treatment within Shared Care.
- Arrange referral on of service users to other services, for example, specialist Tier 3 services, detoxification and rehabilitation, hepatitis and HIV screening and testing, other statutory / voluntary sector services as required.
- Alert the GP, related primary care services and others as appropriate to changes in the service users healthcare or other emerging needs.
- Maintain accurate and up to date records of contact and content of consultation in line with Record Keeping Policy.
- Ensure practice is in line with current evidence based practice with reference to current NICE guidance and the DoH Clinical Guidance 2007.

GP Guidelines

DO's

Do refer to keyworker for comprehensive assessment as outlined in referral pathway.

Do refer on for comprehensive assessment for any temporary resident who presents for treatment for their drug problem. Confirmation of any existing prescribing levels with current prescribers should be established.

Do advise the service user that Benzodiazepines are not recommended for the treatment of drug misuse. Refer for comprehensive assessment.

Do assess priority: is the service user a young person under 18 years old, pregnant or have serious physical or mental health problems - and refer for comprehensive assessment and to other appropriate services.

Do refer to your local prescribing formulary and local and national guidelines re appropriate prescribing for the management of substance misuse in primary care.

DON'Ts

Do not initiate prescribing without confirming that service user has had a comprehensive assessment and full drug screen.

Do not prescribe to a temporary resident without a full comprehensive assessment and consultation with the health care professional responsible for their care

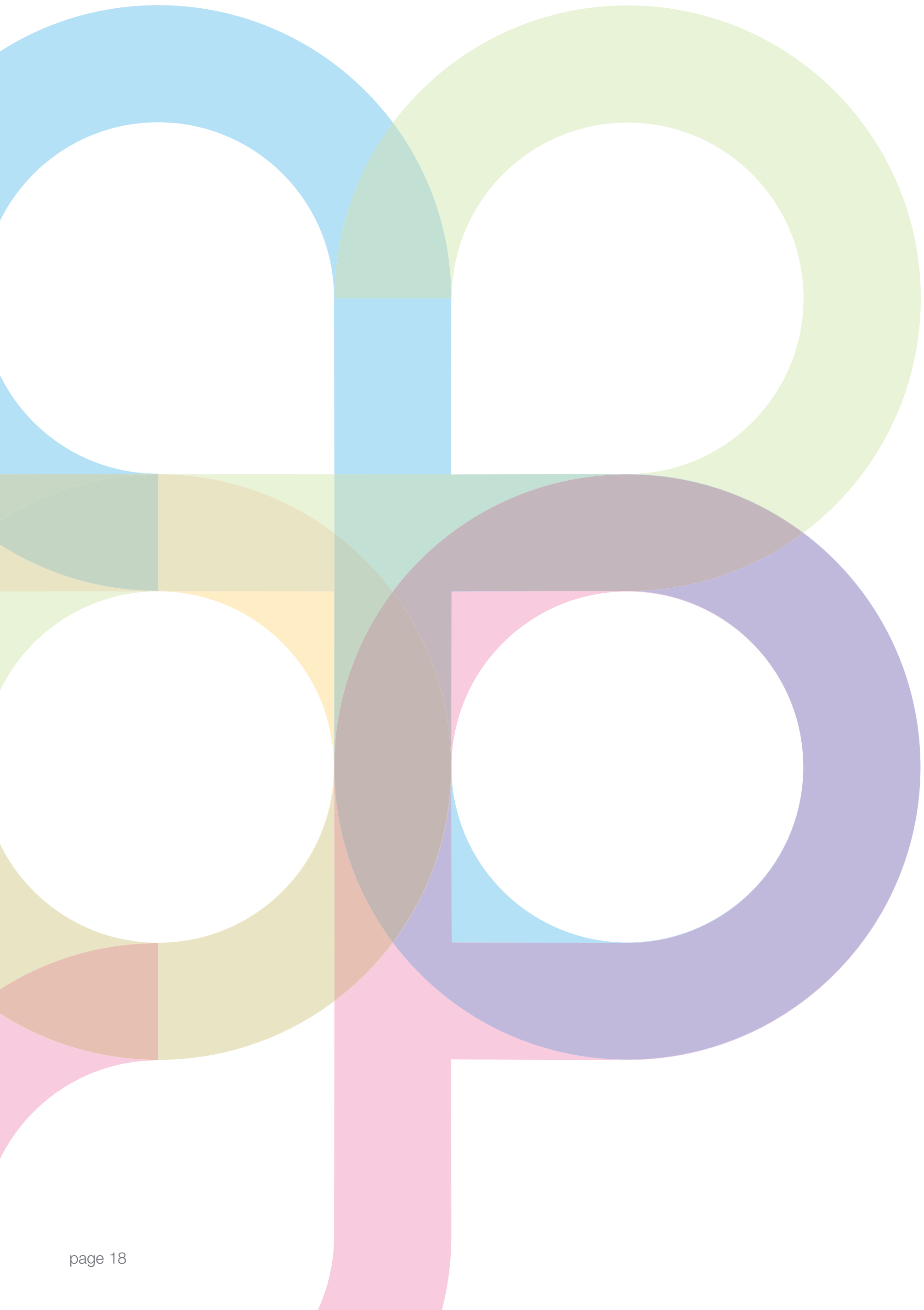
Do not prescribe benzodiazepines.

Do not initiate prescribing to problematic/chaotic drug user i.e. polydrug use, pregnant, severe and enduring mental health problems or continue prescribing to the above groups without the appropriate levels of clinical expertise and support.

Do not prescribe outside of national and local guidelines.

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.

Drug Misuse and Dependence - Guidelines on Clinical Management 2007.



Essential Elements of Treatment

Essential Elements of Treatment

Essential Elements of Treatment Provision

Comprehensive Assessment

Full and comprehensive assessment of this service user groups presenting needs is essential to the planning and delivery of the most appropriate package of care for each individual service user. It is important that treatment for drug misuse needs to be a care planned approach following a full assessment, and is not seen as a medical emergency which may lead to inappropriate prescribing.

In Lancashire, GPs providing Shared Care Services for Substance Misuse each have a keyworker attached to their practice who will arrange the assessment of service users approaching the surgery for management of their substance dependency issues.

A comprehensive assessment has three principal elements and includes a full risk assessment:

1. Give information

- Service rules/service user contract
- Confidentiality
- Effects of prescribed medication
- Storage of prescribed drugs
- Safer drug use/injecting advice

2. Collect information

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

3. Develop Care Plan for treatment

- Long and short term objectives
- Allocation to keyworker
- Initial prescription (if appropriate)

The assessor will also complete the following mandatory processes

- Complete a Treatment Outcome Profile (T.O.P.S.) at comprehensive assessment, quarterly review and upon discharge.
- Complete National Drug Treatment Monitoring requirements.
- Ensure urine samples are provided for full drug screen - to provide evidence of dependant drug use.
- Refer to other services if required.
- Ensure service user has understood and signed drug treatment service user contract.

If the service user is to commence treatment in Shared Care, it is important for the prescribing GP to confirm that a comprehensive assessment is complete and dependence has been confirmed.

Care Planning

Following comprehensive assessment of each service users presenting needs the keyworker will develop a plan of care alongside the service user in consultation with the clinician. All parties will agree and sign the care plan which will be reviewed every three months at each clinical review meeting.

Delivery of Treatment

The Keyworker is the primary contact for each service user managed in Shared Care in Lancashire and Blackburn with Darwen. Whilst the clinician retains responsibility for the prescribing of medication, the keyworker co-ordinates the care package delivered, delivers psychosocial interventions as appropriate, makes referrals to wrap around services, is the point of contact for the service user and is responsible for the ongoing review and delivery of the treatment plan.

Drug Testing

In Lancashire, drug testing is carried out using urine screening, this testing is carried out on a quarterly basis. The keyworker will facilitate this process and will ensure that results are recorded appropriately. Drug testing should be used as a mechanism for ensuring that the service user is taking their prescribed medication and must not be used punitively.

The routine mechanism for urine screening in Shared Care should be via normal practice arrangements.

General Health Assessment

GPs participating in Shared Care for Substance Misuse under a Local Enhanced Service **Level 1** Service Level Agreement are required to undertake general health assessment and management of their service users as they would routinely under their General Medical Service provision contract.

GPs participating in Shared Care for Substance Misuse under a Local Enhanced Service **Level 2** Service Level Agreement are required to refer their LES2 service users back to their own GP for assessment and management of general medical services required.

Regular Treatment Review

To ensure a consistent standard of care to all service users within Shared Care, it is an expectation that all service users will have their treatment progress reviewed against care plan goals with their keyworker as a minimum quarterly. It is acknowledged that in exceptional cases this interval may be shorter due the service users individual circumstances and needs. A quarterly review will always involve a face-to-face meeting between a service user and his/her keyworker. Depending upon service user presentation and level of need, the prescriber may attend the meeting with the service user where indicated. More usually medical involvement will take the form of a discussion of the service users progress between the keyworker and prescribing doctor as part of a Clinical Caseload Review. The Clinical Caseload Review is where the Keyworker and the prescribing Doctor meet on a quarterly basis to review all service users under their joint care, which will take the form of a formal discussion between the doctor and keyworker. This will invariably follow the keyworker review with the individual service users. It is expected that twice per year the quarterly review will involve the prescribing doctor and keyworker undertaking a face-to-face meeting with the service user. (Please see Appendix 05 - Quarterly Clinical Review Document).

Treatment Options

The most effective treatment for individual drug users is based on agreed treatment planning between the prescribing doctor, the keyworker and the service user. Harm Minimisation is the underlying ethos.

Treatment options include:

Cease or significantly reduce use of street drugs

Ensuring that the service user is able to cease or significantly reduce use of street drugs may involve prescribing optimum dosages. Titration and supervised consumption are features of the first stage of treatment. Please see Prescribing Information Section. Regular urinalysis for heroin will indicate the progress the service user is making.

Cease or significantly reduce injecting

If the service user is a regular intravenous or polydrug user, prescribing within the Specialist Treatment Service is recommended.

Stabilise drug use

Achieving stable use of prescribed treatment and maintaining stability may take some time. Service users may need support to determine the appropriate dose, while they address issues that will ultimately assist them in moving away from drug use e.g. personal relationships, physical and mental health, finance, employment.

Reduce prescribed treatment to nil

Reducing prescribed drug use to nil is a significant step that requires careful planning with the service user. Assessment of motivation and setting realistic goals is essential, along with an appreciation that plans may need to be changed. This is a time when service users may require increased support, with specific detoxification regimes being provided by Specialist Drug Services or within formal Shared Care arrangements.

Psychosocial Interventions

Prescribed treatment for drug misuse should always involve a psychosocial component. Service users often present for drug treatment with a myriad of health and social problems. Psychosocial interventions should encompass a wide range of actions from ‘talking therapies’, to supportive work and brief interventions.

Detoxification or longer term treatment?

The following factors should influence decisions regarding the most appropriate treatment option for an individual.

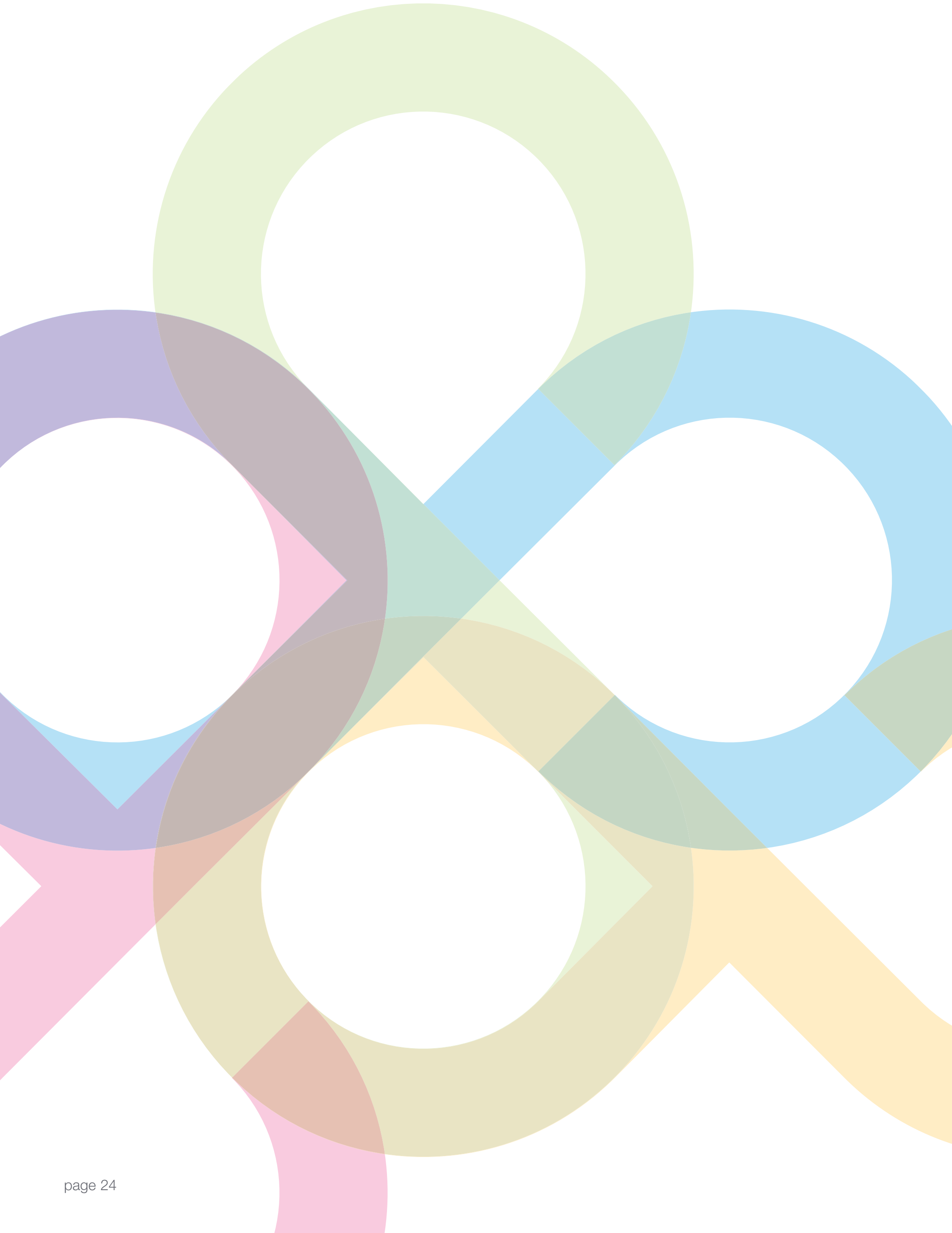
Detoxification Indicators

- Motivation to become drug free
- Good support network
- Detoxification requested by service user
- Clear aims from service user
- No intravenous drug use
- No polydrug use
- Low opiate use
- Short history of opiate use
- Previous period of stabilisation
- A clear care plan for maintaining a drug free lifestyle once abstinence has been achieved

Long Term Treatment

- Poor motivation to change
- Poor or no support network
- Service user cannot envisage becoming drug free
- Currently injecting drugs
- Polydrug user
- Long history of chaotic drug use
- No desire to address current lifestyle and drug use

The above indicators are not mutually exclusive, treatment goals should be identified, negotiated and agreed with the service user.



Prescribing Information

Prescribing Information

Prescribing Information

Pharmacological Interventions

Treatment planning prior to prescribing is essential in Shared Care. GPs, supported by the keyworker should be comfortable with the treatment plan and associated prescribing.

If at any point in a consultation you feel you need time to consider a prescribing decision, asking the service user to step-out will allow you to discuss any concerns you have with the keyworker, or where available will enable you to phone Specialist Drug Service or GPwSI for advice.

While the most commonly prescribed treatment for opioid dependence is Methadone Mixture 1mg/1ml, Buprenorphines are alternatives which are also used and may be continued within Local Enhanced Service Shared Care services.

The Responsibility of Prescribing

Prescribing is the responsibility of the clinician signing the prepared prescriptions. This includes non-medical prescribers, whether working as a supplementary or independent prescriber.

Prior to deciding to prescribe the clinician must be clear as to the desired outcomes for the service user as documented in the care plan.

Prescriptions for Controlled Drugs

Methadone is a Schedule 2 and Buprenorphine a Schedule 3 controlled drug.

Controlled drugs should not be prescribed on a repeat prescription basis.

Prescribers should use an installment dispensing prescription for methadone or buprenorphine treatment (FP10 MDA).

Prescriptions for controlled drugs are carefully monitored and the following requirements apply:

- Prescription must be completed in indelible ink and can be hand written or computer generated.
- All prescriptions must be signed in the prescribers own handwriting.
- A computer generated date on top of the prescription is now acceptable, or the prescriber can use a stamp or hand write the date.
- The prescriber must sign and date the prescription on the bottom of the prescription (a printed date is not legal and is no longer valid).
- Installment prescriptions must be written on FP10MDA prescription form. These cover a period up to 14 days.

- Installment prescriptions must state:
  - The daily dose
  - The amount to be prescribed per installment
  - The total quantity (milligrams / millilitres / number of tablets or capsules etc) in both words and figures
  - The days / dates on which the installments are to be dispensed
  - Installments due on days when pharmacy is closed should be dispensed on the day immediately prior to closure

Pharmacy Stamp

Avenham Pharma

Please don't stamp over age

Number of days' treatr

N.B. Ensure dose is stat

Endorsements

Methadone Mixture DTF
1mg / 1mL (One mg / One mL)
Take 120 mg daily (one-hundred twenty mg)
for 8 days (eight) only.
Dispense daily from 07/04/2009
with 240 mg on 09/04 and
with 360 mg on 11/04 for
three Pharmacy close days
Supervised except Sun & B/Hols

Supply in advance for days of closure

Total Dispensed = 960 mL
(nine-hundred sixty mL)

Last Day of Rx is 14/04/2009
--------No More Items---------
- x -
- x -
- x -

Dr John Richmond (South)

Signature of Prescriber | Date / /

For dispenser No. of Prescns. on form

NHS

FP10MDA0608

42191106000

Date	Item	Quantity supplied	Pharmacist's Initials

NOTE Details of items supplied - see notes overleaf

FP10MDA forms can only be used when a doctor wants to arrange for the installment dispensing of the drug Buprenorphine or any controlled drug listed in Schedule 2 of the Misuse of Drugs Regulations 1985 (as amended).

Prescribing Regulations

DRUGS WHICH CANNOT BE PRESCRIBED FOR ADDICTION WITHOUT A HOME OFFICE LICENCE FOR THE TREATMENT OF DRUG MISUSE

- Heroin (Diamorphine)
- Cocaine
- Diconal (Dipipanone)

The prescribing of the above should only be undertaken by Specialist Services

Methadone

Methadone maintenance treatment is internationally accepted as the main treatment for opiate dependence.

The main aims of methadone maintenance treatment are:

- Reduce or eliminate illicit opiates and other drug use
- Improve the health and well being of service users
- Facilitate social rehabilitation
- Reduce blood borne disease spread and injecting habit
- Reduce the risk of death associated with opiate use
- Reduce the levels of crime associated with opiate use

Oral methadone is the most commonly used prescription. Tablets may very infrequently be prescribed (i.e. nausea and vomiting in pregnancy or foreign holiday travel prescriptions). However, since tablets are not licensed for treatment of addiction and are not recommended to be used in the Department of Health Guidelines (2007) seeking specialist medical advice is recommended.

Drug Inter-Actions

The action of methadone is increased by many drugs especially Benzodiazepines and alcohol.

For further detailed information please see:
RCGP (2005) Guidance for the use of Methadone for the prescribing of opiod dependence in Primary Care DoH (2007) Drug Misuse and Dependence UK Guidelines on Clinical Management.

Indications for Entry into Methadone Maintenance Treatment

Methadone maintenance treatment is indicated for those who are dependent on opioids and who have an extended period of regular opioid use.

Service users must be able to give informed consent for treatment.

Contra Indication

Severe hepatic impairment

Caution should be exercised in the following categories:

- Higher risk polydrug use
- Concurrent dependence
- History of lessening opioid tolerance
- Psychiatric history
- Associated medical problems

For further information please see:
RCGP (2005) Guidance for the use of Methadone for the prescribing of opiod dependence in Primary Care DoH (2007) Drug Misuse and Dependence UK Guidelines on Clinical Management.

Commencement of Doses

No treatment for opioid dependence should be commenced without a full substance misuse comprehensive assessment, which should cover past and present drug use, physical and mental health status, social and criminal circumstance as well as evidence of opiate use (normally confirmed through drug screening and checking injection sites if applicable). Once these steps are established next steps should be followed:

Step One

The initial does of methadone should be 30 mgs or less.

Step Two

When commencing methadone treatment all service users should be started on observed consumption at a pharmacy for a minimum of 3 months. This is due to the greater risk of overdose for service users entering into treatment.

Step Three

Titration and Stabilisation of Dose

In the first 7 days Doses can be increased by 10 mgs twice a week as long as seen by a doctor at the end of the first and third weeks. Steady state plasma levels should be reached 5 days after the last dose increase.

Subsequent stabilisation period Doses can be increased by 10 mgs twice a week once over 50mg without specific review; up to a total of between 60 and 120 mgs. Stabilisation can be complete by the end of the 6th week of methadone treatment but this may take longer.

Safe Storage

It is important that all service users are given information of safe storage of medication, which includes keeping all medications in a safe, lockable child safe cupboard.

Poly Drug Use

A large proportion of opiate users also misuse benzodiazepine, alcohol, and cocaine. It is important when treating service users who are poly drug users that the risks are made explicit and appropriate harm reduction advice is given.

Slow Reduction Regimes

If service users are stabilised and wish to reduce their methadone, 5 to 10 mgs every week or fortnight can be considered, as long as the service user continues to abstain from illegal drug use. **We would recommend at least three months stability before starting to reduce the dose.**

Drug Reduction Regimes

- It may take months or even years for a service user who misuses drugs to reach a stage where a reduction in their prescribed drugs can be considered.
- For most service users, treatment options should be sensitively explored whether for Methadone Maintenance Treatment or detoxification.
- Service users should be followed up, once stabilised, at least 3 monthly with ideally seeing the prescribing physician at least twice a year, but a minimum of once a year.

Missed Doses and Re-introduction of Prescription

When service users miss medication doses they may use other drugs including other central nervous system depressants such as alcohol or Benzodiazepines. When medication doses are missed for 3 or more days, tolerance to opioids may be reduced placing service users at increased risk of overdose when medication is reintroduced.

The following steps needs to be adhered to with someone who has missed doses for both Methadone and Buprenorphine. The issue of precipitated withdrawal needs to be considered when recommencing Buprenorphine prescriptions.

Step One

Service user should be assessed for signs of intoxication and/or withdrawal before dosing is recommenced after missed doses. Assessment of service users current circumstance and reason for missed doses should be established.

Step Two

Depending on the number of doses missed the following actions are presumed safe and effective.

One dose: No change to dose: pharmacist to dispense as usual.

Two doses: Assessment by pharmacist, if no evidence of intoxication, administer normal dose. No need for drug screening.

Three doses: Pharmacist should contact prescriber/keyworker. Assessment by keyworker will be required, noting substances used over time missed with drug screen if indicated, discussion with prescriber and if no contra-indications, prescribe normal dose.

Four doses: Assessment by keyworker, discuss with prescriber and recommence 75% of dose. Titrate up to optimal dose.

Five doses: Needs to be regarded as a new induction and Initial commencement dosing should be followed.

Re-introduction (when dose titrating up) or if missed three or more doses of last seven.

One day: No change in dose

Two days or more: Re-assessment by keyworker. Keyworker to discuss with doctor.

Buprenorphine

Methadone substitute prescribing is one well-established treatment modality and is supported by a substantial body of research literature and clinical practice. However, methadone mixture is not suitable for, or popular with, all opioid users seeking treatment. The provision of a flexible menu of effective treatment options, and some degree of choice for those seeking treatment, is likely to optimise the outcomes and process of treatment.

Buprenorphine used in the treatment of opioid dependence is relatively new to the UK though it has had widespread use in other parts of the world. It was licensed for use in opioid dependency in the UK in 1999.

Indications, Contra Indications & Precautions for Use

Indications

Opioid dependency with informed consent to treatment with Buprenorphine.

Contra Indications

Buprenorphine should not be used for the following populations:

- Allergic or sensitive to Buprenorphine.
- Under 16 years.
- The license for Buprenorphine does not cover breast-feeding or pregnancy.
- Pregnancy is now a caution, not a contra-indication.

Precautions

Caution should be exercised in prescribing Buprenorphine for the following groups:

- Concurrent use of sedating drugs or medications.
- Transferring from Methadone when the Methadone dose exceeds 30mg daily.
- Medical conditions complicating opioid use (as with other opioids Buprenorphine should be used with caution in those with recent head injury, acute abdominal conditions or with severe respiratory, hepatic or renal disease).
- Service users with chronic pain.
- Service users with severe mental illness or other reasons to be unable to give informed consent.

Buprenorphine - Induction

The purpose of induction is to safely establish the service user on a dose of Buprenorphine that prevents opioid withdrawals, reduces the need to take additional illicit opioids and keeps side effects to a minimum. Induction can be effected for service users using heroin or methadone.

The key to understanding safe induction onto Buprenorphine is to understand the phenomenon of precipitated withdrawal as outlined:

Precipitated withdrawal

This occurs in someone commencing Buprenorphine who has recently used heroin (<6 hours previously) or methadone (<24 hours). It is caused by the high affinity of Buprenorphine displacing other opioids from opioid receptors, but having weaker opioid activity (partial agonist). This rapid reduction in opioid effects can be experienced as precipitated withdrawal, typically occurring within 1 to 3 hours, peaking over the first 3-6 hours, and then subsiding. If severe - offer lofexidine (e.g. 400-600mcg 8 hourly). Do not prescribe more Buprenorphine until the precipitated withdrawal symptoms have subsided.

Principles of safe induction

- Prepare service user for induction with information and agreed, signed care plan.
- Arrange, if possible, 3 consecutive days of appointments with the keyworker.
- Maximum licensed first dose is 4mg and this given only if service user experiencing features of opioid withdrawal.
- Increase by 4mg daily until desired clinical response.
- Mild to moderate opioid withdrawal symptoms are not uncommon in the first 3 days and steady state usually achieved after 5-8 days because of the long half life of Buprenorphine.

Dispensing and supervision

It is recommended that Buprenorphine is dispensed daily during induction and that consumption, if possible, is supervised by the pharmacist for a period of time which may, depending on the service user, be at least the first 3 months of treatment.

Option 1: Induction from heroin (can be undertaken in primary care if doctor has necessary support and experience)

- After full explanation to service user, the first dose of Buprenorphine should be administered at least 8 hours after the last use of heroin and preferably with mild withdrawals present.
- The dose can be increased by up to 4mg daily until the service user is stabilised, up to a maximum of 32mg daily. The most common effective dose is between 12 to 24 mg daily.

Option 2: Induction from methadone (can be undertaken in primary care if doctor has necessary support and experience)

- After full explanation to service user and with the methadone dose reduced to 30mg daily or less.
- Induction to Buprenorphine should be commenced after at least 24-36 hours after the last methadone dose and when there are mild to moderate signs of withdrawal.
- Dose guidance for days 1 and 2 are:

Last Methadone Dose	Buprenorphine Dose Day 1	Buprenorphine Dose Day 2
20-30mg	4mg	6-8mg
10-20mg	4mg	4-6mg
<10mg	2mg	2-6mg

Subsequent titration is as for induction from heroin.

For Further information please refer to:

DoH (2007) Drug Misuse and Dependence UK Guidelines on Clinical Management.

Addressing continued heroin and other drug use

Some service users may find it difficult to stabilise and be maintained on Buprenorphine, and this may be evidenced via:

- Urine screens positive for heroin or methadone
- Concurrent use of other drugs (such as alcohol, illicit benzodiazepines, cocaine or amphetamines)
- Frequent intoxicated presentations
- Overdoses and/or presentations to A&E, out of hours etc
- Frequent missed doses
- Physical or mental deterioration due to continued drug use

This requires a review of treatment that may encompass dose level, dispensing regime, psychosocial interventions, transfer to alternative pharmacotherapies (e.g. methadone), withdrawal from maintenance treatment, or use of non-pharmacological therapies.

Buprenorphine and liver disease

The presence of liver disease alters drug metabolism. In cirrhosis clearance of morphine is greatly reduced (by 60%). Cirrhosis would be expected to alter Buprenorphine clearance. Liver function tests (LFTs) and HIV and Hepatitis A, B and C screening should be undertaken at the beginning of treatment.

- If LFTs are normal monitor periodically (suggest after 6 months then annually) through treatment as Buprenorphine can cause an increase in aspartate aminotransferase (AST) and alanine aminotransferase (ALT).
- If the LFTs are abnormal the service user should be investigated for the underlying cause. This may commonly be due to alcohol misuse or Hepatitis C infection (HCV). If HCV positive and abnormal LFTs or HCV positive and HCV PCR reactive then the service user should be referred for specialist liver investigation and advice.
- There should be no problems with Buprenorphine in service users who have HCV as long as they have normal liver function tests and do not have cirrhosis. But there have been reports of significant deterioration in liver function in those with pre-existing liver disease (e.g. HCV) and who inject their Buprenorphine tablets or who take overdose of Buprenorphine so caution should be exercised.

Buprenorphine (or any opioids) should only be used with extreme caution (and on the advice of a specialist) in those with compromised livers, as the risk of respiratory depression is high.

Suboxone

This drug is currently awaiting PCT declaration regarding its use or inclusion in their prescribing formularies and this guide will be updated once statements are available.

Benzodiazepines and "Z" drugs

The Advisory Council on the Misuse of Drugs (ACMD) report: Reducing Drug Related Deaths, 2000 - indicated that benzodiazepines were implicated in 60% of drug related deaths.

"We have already remarked on the high proportion of drug-related deaths in which benzodiazepines are implicated. These statistics suggest to us that there is a need for doctors treating drug misusers, to consider very carefully the appropriateness of their prescribing benzodiazepines. We cannot sufficiently stress that these drugs are both dangerous to drug misusers and easily diverted". (pg 72, ACMD, 2000)

Service users presenting to General Practices with polydrug use, including the use of benzodiazepines should be referred to the Specialist Drug Service for assessment.

Be prepared to say no to prescribing Benzodiazepines and other similar drugs such as Zopiclone etc - advise the service user that these drugs are not prescribed for the treatment of drug misuse.

Prescribing benzodiazepines should only be considered following comprehensive assessment by specialist service providers and it is indicated that:

- Benzodiazepines are being taken daily.
- There is convincing evidence of dependence e.g. withdrawal symptoms, notes verifying previous history of prescribing.
- The service user is motivated to stabilise and reduce their drug use.

Be aware of the potential for diversion and abuse.

Prescribing should always be on a reducing basis - and dispensing arranged on a daily basis.

Although there is widespread demand for benzodiazepines, for use with illicit or prescribed drugs, polydrug misusers should be referred to Specialist Drug Treatment Services.

Service users within Shared Care arrangements should be in a stabilised condition and therefore it is reasonable to adopt a policy of not prescribing benzodiazepines to drug misusers.

Naltrexone

Naltrexone will be initiated in a specialist service but can be continued in Shared Care if the GP feels confident and competent to do so.

Naltrexone is an opioid antagonist which blocks the effect of opiate drugs (e.g. dihydrocodeine, morphine and heroin) and the body's own opioids which occur naturally in the brain. Naltrexone is used with other forms of treatment such as psychosocial interventions to help service users remain free from dependence on heroin, methadone and other similar opiate drugs of addiction. Cochrane Review of trials suggests that it can be successful when service users are HIGHLY MOTIVATED.

Prescribing Requirements

- Liver function tests, test result should be available to exclude moderate and severe damage.
- Service users should have been opiate free for a period of 5-7 days.
- High motivation of service user to remain drug free.
- Urine test taken to make sure there are no opiates in the system. (After a Buprenorphine detoxification, only 4 days drug free are required).
- Administer 25 mgs and observe for two hours on 1st day.
- Make service users aware that there is no effect on subjective feelings of craving for heroin and no psychotropic effect.
- If no adverse effects then start regular prescription of Naltrexone 50mg daily.
- Check LFT's in three months.
- Medical card to be carried by service user in case of an accident to ensure that correct pain relief i.e. non-opiate based is given.
- Information sheet given to service user about Naltrexone.
- Advice that some cough medicines and anti-diarrhoea medication and analgesics may lose their effect 'bought over the counter'.

Monitoring

- Stop treatment if service user starts using opiates.
- Follow up LFT's at 4 to 6 weeks.
- Not to be used by service users with acute Hepatitis or moderate disease of the liver.
- Unwanted side effects are infrequent. User to cease immediately if there are any signs of jaundice.
- Dispensing frequency decided by prescriber.
- Reviewed regularly (initially monthly) by Keyworker.

For further information please see NTA website

Supervised Consumption

As described in the section for Pharmacy, supervision consumption of methadone and buprenorphine, can be instrumental in supporting substance misusers in complying with their prescribed treatment, and in doing so reducing incidents of accidental death through overdose, and keep to a minimum the misdirection of controlled drugs, which may help to reduce drug related deaths in the wider community.

As directed by the 'Drug Misuse and Dependence - Guidelines on Clinical Management' (DoH. 2007), supervised consumption is recommended for the first three months of treatment. Supervised consumption can/may also be temporarily re-instated when service users are experiencing times of crisis or relapse. Whilst supervision is desirable when service users first enter into treatment, it is important that once the service user is stabilised that they are trusted to accept a degree of responsibility, and 'take home' doses are introduced, for example, from daily to twice weekly down to once weekly.

The clinical need for supervised consumption should be reviewed regularly and a decision as to when to relax it should be based on compliance and progress against the person care plan, the following are areas for consideration:

Considerations for Supervision

- When patient restarts Methadone or Buprenophine after a break.
- When patient is receiving a significant increase in medication.
- When treatment is failing or evidence of poly-drug use.
- When patient is struggling to reach stability.
- In cases of significant unstable psychiatric illness or threatening self harm.
- Where there is a suspicion of diversion of medications.
- Where there is risk of safe storage of medications.

Considerations to Cease Supervision

- Long term use of supervision my not be appropriate in cases where service user is employed.
- Compliance with treatment.

FOR PRESCRIBING FORMULARY SEE APPENDIX 10 on page 78

Pharmacy Guide

Lancashire & Blackburn with Darwen Shared Care for Substance Misuse

Shared Care Guide

Pharmacy Guide

Pharmacy Guide

Supervised Consumption

Supervision consumption of methadone and buprenorphine can be instrumental in supporting substance misusers in complying with their prescribed treatment and in doing so, reducing incidents of accidental death through overdose, keeping to a minimum the misdirection of controlled drugs, which may help to reduce drug related deaths in the wider community.

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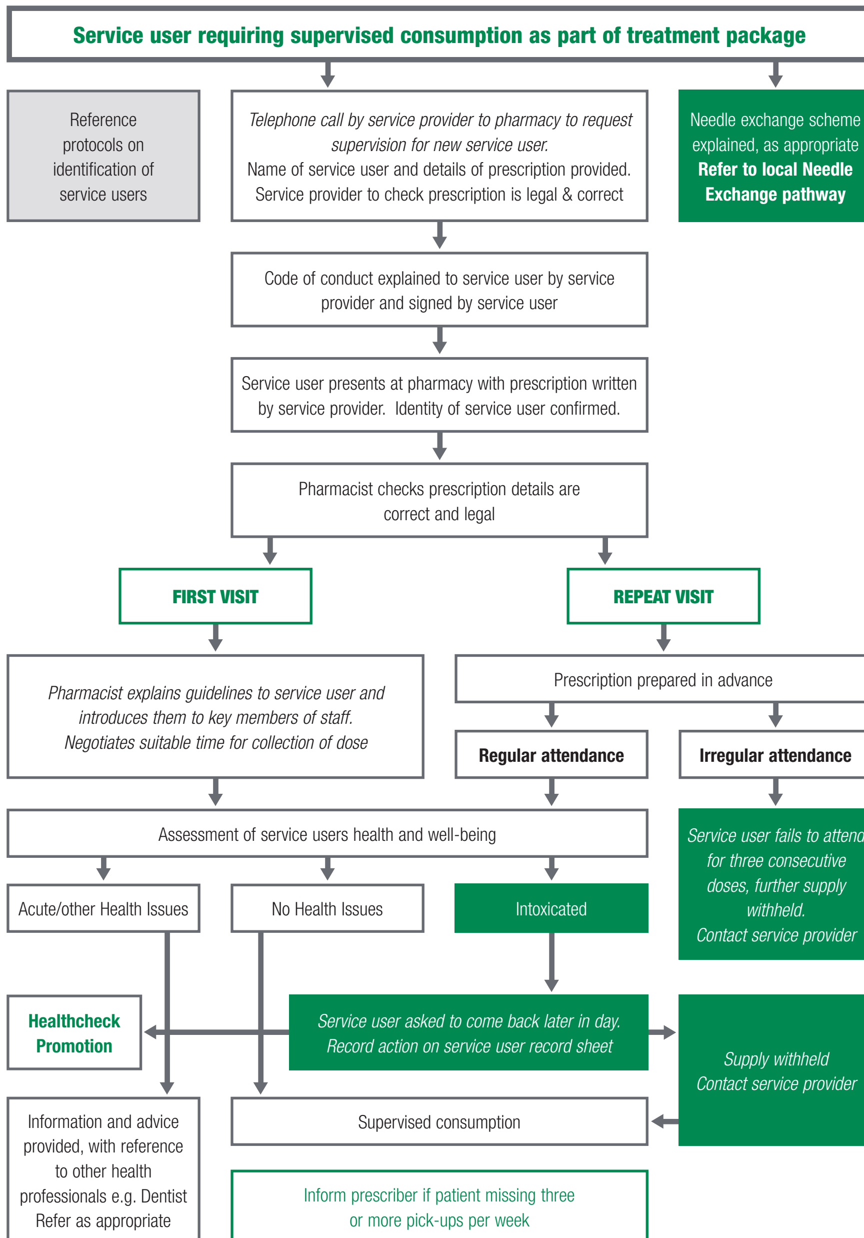
Therefore the main aim of supervised consumption is to ensure compliance with the agreed treatment plan by;

- Dispensing prescribed medication in specified installments.
- Ensuring each supervised dose is correctly administered to the service user for whom it was intended (doses may be dispensed for the service user to take away to cover days when the pharmacy is closed).
- Liaising with the prescriber, named keyworker and others directly involved in the care of the service user (where the service user has given written permission).
- Monitoring the service users response to prescribed treatment; for example if there are signs of overdose, especially at times when doses are changed, during titration of doses, if the service user appears intoxicated or when the service user has missed doses and if necessary withholding treatment if this is in the interest of service user safety, liaising with the prescriber or named keyworker as appropriate.
- Improving retention in drug treatment.
- Improving drug treatment delivery and completion.

Pharmacy Pathway for the Observed Consumption of Methadone and Consumption of Buprenorphine



Guide for Pharmacists

Missed doses and re-introduction

When service users miss opiate replacement doses they may use other drugs including other central nervous system depressants such as alcohol or benzodiazepines. When doses are missed for 3 or more days, tolerance to opioids may be reduced placing service users at increased risk of overdose when opiate replacement is re-introduced. The following guide has been produced to help guide the re-introduction of opiate replacement if doses are missed.

Re-introduction (in someone whose dose is stabilised or dose reducing)

- Service users should be assessed for signs of intoxication and withdrawal before dosing is recommenced after missed doses.
- In general the following schedule can be presumed to be safe and effective.

If the service user has missed:

- **One dose:** No change in dose, pharmacist to dispense as usual.
- **Two doses:** Assessment by pharmacist, if no evidence of intoxication, administer normal dose. No need for drug screening.
- **Three doses:** Pharmacist should contact prescriber/keyworker. Assessment by keyworker required, noting substances used over time missed with drug screening if indicated, discuss with prescriber and, if no contra-indications, prescribe normal dose.
- **Four doses:** Assessment by keyworker, discuss with prescriber, and recommence at 75% of the dose. A new prescription will be required.

Five doses or more: regard as a new induction

Please inform substance misuse service if service user has not picked up for more than five days as we will stop generating prescriptions until the service user has contacted their keyworker.

Re-introduction (when dose titrating up)

- One day: **No change in dose**
- Two days or more: **Re-assessment by keyworker. Keyworker to discuss with doctor**

Putting Scripts on hold

Occasionally, for a number of reasons, a keyworker may want to put a service users prescription on hold. This can be where the keyworker has not had contact with the service user despite repeated attempts to do so, the service user has gone into hospital/prison, or if they are being transferred to another area. The keyworker will contact you directly about this and should let Delphi know as well so that no further prescriptions are generated until the situation is clarified. When the script is to be restarted the keyworker should inform you of this.

Please do not restart a held prescription without confirmation from the keyworker.

Psychosocial Interventions

Psychosocial Interventions

Psychosocial Interventions

Formal psychosocial interventions to address drug misuse

Treatment for drug misuse should always involve a psychosocial component in line with current evidenced based practice as referenced in NICE guidance and the DoH Drug Misuse and Dependence: UK guidelines on clinical management (2007). This is a component of treatment which is now recognised as being highly significant in the treatment of drug users that will be delivered by your drug worker.

A good therapeutic relationship is crucial to the delivery of any treatment intervention, especially a psychosocial one. There is evidence to support that a good therapeutic relationship is known to improve treatment engagement, retention and service user outcomes. Therefore in the treatment of service users in Shared Care it is important that psychosocial interventions form part of their treatment plan.

For stimulant misuse, including cocaine, and for cannabis use, there is no effective substitution agent. Hence, the mainstay of treatment is evidence based psychological intervention. The range of interventions offered could include:

- Motivational Intervention Techniques
- Brief Intervention Therapy
- International Treatment Effectiveness Pilot (ITEP)
- Cognitive Behavioural Therapy

Other Psychosocial Interventions that may be available locally are:

Self-help and mutual aid approaches, especially 12-step e.g. Narcotics Anonymous and Cocaine Anonymous, have been found to be highly effective for some individuals. Service users should be signposted to them. These are typically provided outside formal treatment agencies but are nevertheless one of the most commonly travelled pathways to recovery.

The benefits of these groups can be further enhanced if keyworkers and other staff in services facilitate contact with them e.g. by making an initial appointment, arranging transport or possibly accompanying service users to the first meeting and dealing with any subsequent concerns. These interventions can be of benefit to a wide range of people at different levels of the care and treatment system.

Contingency Management (CM) operates by providing a variety of incentives in the form of vouchers, privileges, prizes or modest financial incentives to modify a person's drug misuse or to increase health promoting behaviours. Studies, many from the US, have found CM to be effective for people engaged in methadone maintenance programmes who are continuing to use illicit drugs and it is effective in promoting abstinence in stimulant misusers and has proved to be highly effective in promoting engagement with blood-borne virus testing and vaccination programmes.

The National Institute for Health and Clinical Excellence (NICE) published its final guidelines in July 2007 on Psychosocial Interventions for Drug Misuse (NICE, 2007a). Clinicians should refer to the full guidelines for the detailed findings and recommendations.

Specific Treatment Situations and Populations

Specific Treatment Situations and Populations

Specific Treatment Situations and Populations

The quality of treatment should be consistent regardless of how service users enter treatment. This includes treatment for those in the criminal justice system, including those in prison.

Appropriate communication and sharing of information between a wide range of professionals coming into contact with or providing interventions for drug users is vital to ensure seamless care.

Criminal Justice

The criminal justice systems of England and Wales, Scotland and Northern Ireland vary. There is considerable overlap between those misusing drugs and those committing crimes. Clinicians should make treatment decisions on clinical grounds but drug users - especially those who commit crimes to fund their drug misuse - may come into contact with, and increasingly be offered treatment in, the criminal justice system at various points and through a number of different arrangements. Clinicians need to understand the nature of these and where their involvement lies.

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

Upon completion of a criminal justice treatment order service users should be assessed for suitability for Shared Care and referred through where appropriate.

Prisons

There is a high concentration of people with a history of drug misuse in prison. The average pattern of drug misuse alters markedly when an offender enters prison, with reductions in drug misuse (NOMS, 2006) and injecting (Singleton et al, 1998). Research has found a seven-fold increase in overdose deaths in the fortnight after release from prison (Bird & Hutchinson, 2003). The principle objective in preparing a drug misusing prisoner for release should be to prevent overdose. Preventing relapse and facilitating continuation in treatment (if needed) or access to suitable aftercare provision or support are important in themselves and as a means of preventing overdose.

Service users approaching release from prison should be assessed for suitability for ongoing treatment and should be referred on to the most appropriate element of service provision - including Shared Care. Where prisoners are released without a treatment plan they should access services via the routine access pathways for assessment of need.

Work is in progress through recent government initiatives i.e. the Integrated Drug Treatment System (IDTS) to improve, amongst other things, the links between prison and community. As this work gets underway we will see an improvement in communication and liaison between prisons and the community, including GPs in primary care.

Pregnancy & Neonatal Care

The number of women misusing drugs has increased considerably in the past 30 years, and many are in their child bearing years. Though pregnancy may act as a catalyst for change and present a 'window of opportunity', drug users may not use general health services until late into pregnancy and this increases the health risks for both the mother and child.

Long term outcomes in women who enter treatment programmes during pregnancy are better in terms of their pregnancy and outcomes for the neonate. Engagement of drug using partners in treatment is also important in enabling pregnant women to achieve progress at the earliest possible stage.

At the time of writing, NICE is developing guidance on Management of Pregnant Women Who Misuse Drugs and/or Alcohol, and Their New Born Babies. This may change what services are recommended to do in this area of service user management.

Some women service users may be unaware that they are pregnant because amenorrhea is common in female opiate users and, if withdrawing, withdrawal symptoms can mimic signs of early pregnancy. All women of child- bearing age who give a recent history of substance misuse should therefore be encouraged to have a pregnancy test. Some women may know or suspect they are pregnant but may not have engaged with antenatal care and so their stage of gestation may be unknown. If a woman is considering or has had a termination of pregnancy, or miscarries, appropriate drug treatment should be maintained rather than any change considered, until the woman is fully recovered.

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

In Lancashire the Shared Care drugs worker will have access to specialist support and be familiar with procedures, protocols and clinical guidelines in working with pregnant drug users. A pregnant drug user does not require an immediate referral into specialist services but will require a risk and needs assessment as to her level of support and whether this support can be provided in primary care. Specialist advice can be provided whilst the service user remains in primary care as appropriate. Review of support required needs to be ongoing throughout pregnancy. If it is decided, through assessment, that the service user does require referral into specialist services then the referral will be undertaken and overseen by the keyworker.

Prescribing for pregnant drug users

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

Opioids

Maintenance, at a dose that stops or minimises illicit use, is most appropriate for ensuring continuity of management of pregnancy and aftercare. During the first trimester the focus would normally be on the service user becoming stabilised rather than on any request for detoxification as there is an increased risk of spontaneous abortion.

Detoxification in the second trimester may be undertaken in small frequent reductions - for example 2-3 mg methadone every 3-5 days - as long as illicit opiate use is not continuing and may continue throughout third trimester if service user remains comfortable.

If illicit opiate use continues, strenuous efforts should be made to stabilise the service user on a prescribed opioid, which may involve increasing the dose. If this is occurring, referral into the specialist service is indicated. Further detoxification should not generally be undertaken in the third trimester because there is evidence that maternal withdrawal, even if mild, is associated with foetal stress, foetal distress, and even stillbirth. However, for some, slow, carefully monitored reductions may safely be continued as long as there are no obstetric complications or resumption of illicit drug misuse. The metabolism of methadone is increased in the third trimester of pregnancy and it may occasionally be necessary to increase the dose or split it, from once daily consumption to twice daily consumption, or both.

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

If detoxification is unsuccessful and the service users drug use becomes uncontrolled at any stage of pregnancy, reduction should be stopped or the opioid dose increased until stability is regained.

Cocaine

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

Risks to the foetus include:

- Miscarriage
- Premature delivery
- Small for dates
- Genitourinary malformations
- Cleft pallet
- Placental abruption
- Antepartum haemorrhage
- Death in utero

Benzodiazepines

Pregnant women should be encouraged to cease all benzo use in a planned and controlled manner.

Women who are dependent on Benzodiazepines should be stabilised on Diazepam and, where this can be tolerated without restarting illicit use, the dose reduced. A woman being maintained on methadone should have her dose maintained during Benzodiazepine reduction.

Mental Health & Dual Diagnosis

There are high rates of psychiatric disorders among individuals using or dependent on drugs and alcohol. These service users present with a range of problems and disorders, chiefly anxiety and mood disorders. Others have personality disorders, some with significant personality traits that may negatively impact upon their presentation and compliance with treatment. Service users with coexisting mental health and drug (or alcohol) misuse problems are generally regarded as having a 'dual diagnosis' or 'co-morbidity'. The nature of co-occurring drug misuse and mental health problems is complex, with a number of interacting continuums such as severity, type of mental health problem, and type and amount of substance misused, as well as change over time. It is important that they receive appropriate assessment of need and risk and then relevant and evidenced treatments.

Service users with mental health problems of sufficient severity and risk need monitoring under the enhanced care programme approach and should have care plans that meet care programme approach (CPA) requirements. The CPA arrangements should normally sit within mental health services and should ensure that service users' care is planned and coordinated by individuals with the competencies to do so within sufficiently resourced service. The individual service user may also have a substance misuse care plan, which incorporates the CPA requirements and there must be adequate coordination. In addition, all those attending substance misuse services should have a care plan that identifies and plans management of their mental health needs.

Proper assessment is the key to establishing a comprehensive care plan. Adequate risk assessment of mental health should be undertaken at initiation of treatment and ongoing through the review system.

In regard to Shared Care for substance misuse in Lancashire it is the role of the keyworker to undertake the comprehensive assessment, which includes a risk assessment. Where mental health needs and/or risks are identified, the Shared Care worker will liaise with the GP and the mental health team as appropriate. It may be appropriate to conduct a joint assessment and formulate joint risk management plans between substance misuse and mental health services.

If it is determined through review that the service user cannot be managed in primary care then they can be fast tracked into secondary care specialist substance misuse treatment services. They may require an assessment by a consultant psychiatrist who would be able to advise the GP regarding appropriate treatment, including initiating prescribing of anti-psychotic drugs. Once stability has been achieved then the service user can transfer back to primary care. Many dual diagnosis service users are seen, and their care managed successfully, in primary care and they are able to achieve a level of stability.

Young People

It is not recommended that young people (under 18) are managed in Shared Care arrangements. This treatment population should be referred to specialist young person's substance misuse service providers. Specific information regarding locally based treatment services for young people is available within local service directories and online at www.ldaat.org

Young People's Substance Misuse Treatment Services (0-21 years)

The comprehensive young people specialist treatment services in Lancashire are provided by three main agencies;

- Young Addaction North (Lancaster, Morecambe, Fylde & Wyre).
- Young Addaction South (Preston, Chorley, South Ribble and West Lancashire.
- Early Break East Lancashire (Burnley, Pendle, Rossendale, Hyndburn and Ribble Valley).
- Lifeline (Blackburn with Darwen) this service also works with vulnerable adults up to the age of 25 years.

With smaller service provision delivered to young runaways by Street Safe Lancashire (formerly Young Runaways).

Access to Young People's Treatment System (referral routes into services);

- Youth Offending Team (YOT) and Criminal Justice
- Health
- Mental Health (including CAMHS)
- Education
- Looked After Children
- Children's Social Care (Social Services)
- Young People's Service (including Connexions)
- Sexual Health Services
- Self / Parent / Carer

Transfer of Service users between Young People's and Adult Treatment Services (transitional service users age is 18-21 years)

Young People and Adult Treatment Services work to the "Lancashire Integrated Transitional Referral Pathway" in relation to transfer of transitional aged service users from the young people's services into the adult services (NB: Shared Care has now been included in this treatment pathway).

Advice to GPs if a young person presents at their surgery with a substance misuse problem

- Refer any young person up to the age of 18 years for specialist treatment and support to the young people's substance misuse treatment service.
- Discuss and provide details to any young person between the transitional age of 18-21 years with their treatment options, i.e. Young People's Service, Adult Service and Shared Care (re latter, if young person meets the eligibility/criteria), etc. This will allow the young person to make a decision on which service they wish to be referred to (NB: GP to refer if decision is made at appointment, or if decision not reached at appointment, then a self referral can be made by the young person directly to their service of choice).

Where a GP is involved in Shared Care, the keyworker will be able to advise on Young People's Services and to make any necessary referrals.

Older, current & ex-drug misusers

It is not unusual now for clinicians to be caring for service users aged in their 40s, 50s and 60s receiving methadone or buprenorphine treatment. Older drug misusers need all the usual screening and monitoring that a non-drug misuser might be offered appropriate to their age and general health status. However older drug misusers may also have special health needs and it is important that clinicians are mindful of underlying problems caused either by complications of lifelong drug (and alcohol) misuse or by problems associated with substitute treatment. One of the most significant of these problems in the future is likely to be hepatic damage caused by Hepatitis C.

Complications related to long history of drug and alcohol misuse

Examples:

- Hepatic damage due to Hepatitis B or C and excess alcohol use (or a combination of these).
- HIV infection with or without antiviral chemotherapy.
- Chronic airways disease from cigarette and cannabis smoking.
- Chronic lung damage from inhaling drugs.
- Increased cardiovascular disease risk due to alcohol, smoking and lifestyle.
- Chronic venous and/or arterial damage making IV access difficult or impossible.
- Past cardiac valve destruction.

Pain management for drug users

Pain, both chronic and acute, is a complex biopsychosocial experience and both drug dependence and chronic pain are common conditions with long term consequences. Acute pain occurs commonly in drug users as they are at higher risk of physical illness and traumatic injury as a consequence of their lifestyle. Pharmacological interventions is only one aspect of pain management and non-pharmacological interventions, for example, CBT, should be considered for drug misusers although considerable support may be needed for these service users to engage in them.

Service users should have:

- a full joint assessment of their pain, incorporating either information from other professionals involved or joint assessment.
- a jointly agreed treatment plan including agreement by the service user.
- a lead agency to manage their treatment.
- a single prescriber to avoid multiple prescribing.
- prescriptions dispensed in ways which minimise over use and diversion.
- regular reviews.
- a plan for responding to non-compliance or if outcomes are not met.

GPs should seek specialist advice for further information.

Hospital admission and discharge

Admission

Drug users may attend A&E or be admitted to hospital for treatment of conditions common to other service users or directly related to their drug misuse. In either case, hospital medical staff should take proper account of any drug misuse and any treatment being provided in the community.

In Lancashire, where there is planned admission and discharge of a Shared Care service user, this will provide opportunity for preparation and effective transfer of care. The Shared Care keyworker will be able to liaise with the hospital and vice versa.

A&E treatment and emergency admissions may present greater challenges. Protocols should be in place for how hospitals will respond to drug misusers attending A&E or admitted onto wards. The admitting wards and departments should have the contact details of local drug treatment services to hand. For service users currently being prescribed methadone or buprenorphine for treatment of opiate dependency, good communication between hospital and community is essential for safe service user care. Service users will always have a named keyworker and a named pharmacy. They will be receiving treatment from either their GPs or local drug treatment services. Prescribing in these cases should be a relatively straightforward matter of continuing the usual dose while in hospital. The hospital doctor should ascertain by independent means (through communication with the service users specialist prescriber or GP, or with the community pharmacist or keyworker) the prescribed daily dose and, if possible, when the last dose of substitute medication was taken or, at least, when the last prescription was issued and how many days have been supplied.

Discharge

If the service user was admitted on an opioid prescription from the community, this should ordinarily be continued on discharge and prescribing responsibility transferred back to the local drug treatment service or GP.

Best practice:

- At least 24 hours before discharge - and preferably on admission - hospital staff should contact the local drug treatment service, or the service users GP, regarding discharge date and agree how much Methadone or Buprenorphine should be prescribed to the service user on discharge.
- On the day of discharge, confirm to the GP or drug treatment service:
    - whether or not that days dose has been administered at the hospital, and if so how much.
    - the number of days supply that the service user is taking home (minimising this usually to around one days supply depending on availability of appointment - larger amounts run the risk of overdose or being pressured to hand over or sell their supply).
    - any other drugs that the service user is being prescribed.
    - if the service users drug misuse is being treated by a GP and the GP cannot be contacted, contact the service users community pharmacist who should be able to advise what the service users prescription is and whether it is still current.

Where hospital patients are discharged without a treatment plan they should access services via the routine access pathways for assessment of need.

Blood Borne Viruses

In relation to drug misuse, four viruses are currently of particular concern: Hepatitis C, Hepatitis B, HIV and Hepatitis A (to a lesser degree). Tetanus has also been a concern for injecting drug users. The evidence suggests that risk can be reduced by providing an optimised range of drug services which includes:

- Access to needle exchange services
- Adequate doses of opiate substitute treatments
- Structured psychosocial interventions

In addition to this all clinicians should be giving information and advice on reducing risk behaviours which should include injection practices and sexual contact. All injecting drug users, and their partners, should be offered testing for Hepatitis C and B infection. For service users presenting in primary care this can be offered through their own practice.

Current evidence recommends that all drug users are vaccinated against Hepatitis A and B. This should be offered as soon after the initial presentation at a service, and should also be offered to sexual partners and children of injecting drug users, which can be done through the service users own GP practice.

All the evidence suggests that drug users engaging in treatment, receiving adequate doses of medication for the opiate dependence are more likely to make the necessary behaviour change which reduces/eliminates risk practices. Therefore, ensuring access and the right treatment is available is the key to reducing the potential harm caused through drug misuse.

Drugs and the Law

Drugs and the Law

Drugs and The Law

DRUGS BY PSYCHOACTIVE EFFECT AND LEGAL STATUS			
	LEGAL STATUS		
	CLASS A	**CLASS B**	**CLASS C**
Depressant	Heroin Methadone	Barbiturates Temazepam	Other Benzodiazepines
Stimulant	Cocaine/Crack	Amphetamines	Minor stimulants
Hallucinogen	LSD/MDMA/MDA	Cannabis	
ALL CLASS B DRUGS PREPARED FOR INJECTION ARE TREATED AS CLASS A			

Driving and Methadone

As laid out in Drug Misuse and Dependence - Guidelines on Clinical Management (Department of Health, 1999), it is the responsibility of the license holder to inform the Driver and Vehicle Licensing Authority (DVLA), not the prescribing doctor or drug service, therefore the following guidance should be followed:

- Advise the service user to inform the DVLA of the prescriptions.
- If the service user persists in driving without informing the DVLA, it should be explained to them that it is a legal duty to inform the DVLA, and every effort should be made to persuade them to do so.
- If you find that a service user is driving while intoxicated, and they haven't informed the DVLA of their treatment contrary to the advice given by the practitioner, relevant medical information should be disclosed, in confidence, to the DVLA medical officer.
- Before disclosing this information to the DVLA, where possible, the service user should be informed first.
- Once the DVLA has been informed, written confirmation of this should be sent to the service user.

Taking Methadone Abroad

When a service user is travelling abroad they will be required to have a Home Office Export Licence if taking more than 28 days supply of Methadone. Even with an export licence entry to another country is not guaranteed, as the document does not have legal status outside the UK.

It is always advisable that they carry a letter from their prescribing doctor to prove that they are in possession of a legitimate prescription.

Training & Development

Training & Development

Training & Development

Although some doctors may feel unprepared to manage substance misuse issues within General Practice there are national and local training and development opportunities available.

GPs wishing to provide LES1 or LES2 services in Lancashire and Blackburn with Darwen are required to complete the RCGP Part 1 Certificate in Management of Substance Misuse. This will be monitored via the annual Service Level Agreement review process.

The RCGP have developed specific certificated training (outlined below) and locally Specialist Drug Treatment Services will provide development support and placement opportunities.

The RCGP is now able to offer 2 different Certificate Level training packages:

Part 1

Part 1 is ideal for GPs working at a generalist level, as part of a Shared Care scheme, especially those intending to provide treatment to drug users as part of a locally enhanced service (LES1 & LES2).

The course will be delivered in 2 stages: 1) E-modules, 2) Face to face training.

The e-learning modules can be accessed at www.doctors.net.uk in the Education section by anyone who has a GMC number.

Part 2

Part 2 is a continuation of the existing certificate and is aimed at practitioners wishing to become GPs with a Special Clinical Interest or a Practitioner with Special Interest. There will be an expectation that candidates will have completed the Part 1 Certificate or equivalent training (recognised by the RCGP or sister organisations), or can demonstrate that they already have the generalist competencies.

Part 2 is open to GPs, nurses, pharmacists, user advocates, expert service users, psychiatrists, Shared Care workers, and others with appropriate background.

More information on the Part 2 Certificate can be found at www.rcgp.org.uk/drug/certificate.asp

Completion of the Part 2 certificate is a requirement for GPs in Lancashire and Blackburn with Darwen wishing to provide GPwSI/specialist services.

Training for practice staff

It is important for all practice staff to be aware of the benefits and discuss the challenges of primary care based drug treatment.

Practice staff will be able to access specific training sessions related to drug awareness and drug treatment. Details of training opportunities can be obtained from your local Shared Care development manager.

Furthermore, keyworkers will meet with practice staff and can provide specific advice regarding local delivery and how the service can work most effectively.

Appendices

Appendices

Appendix 1

Sample Service Users Rights & Responsibilities

As a service user of .... you will formulate a care plan with your keyworker and the doctor to meet your individual needs.

It is important that:

- You attend keyworker and doctor appointments as required
- You provide urine samples or oral mouth swabs for drug screening as requested
- You attend the chemist on the correct days to collect your medication
- You give two weeks notice if you need a holiday prescription

Please note

- We do not replace lost or stolen prescriptions
- We do not replace dispensed drugs which may have been lost, stolen or destroyed

Your treatment could be at risk if:

- Your drug screening test is negative for a drug that we prescribe to you
- You get a prescription from another doctor for drugs that we prescribe to you
- You alter your prescription
- You are intoxicated or use drugs whilst on the premises or in the pharmacy
- You are violent or threatening toward any person at the practice or any other associated service

Confidentiality

.... is a confidential service. However, information that we hold on you may be shared subject to Data Protection requirements. Information may be shared in the following circumstances:

- If there is a risk to yourself or others
- If there are child protection issues
- If you are a service user of Probation or Social Services
- You are involved with Mental Health Services
- Your GP will always be notified

Appendix 2

Incident Reporting

In order to promote high standards of care and make the working environment as safe as possible for all staff and service users, the reporting of adverse incidents or near misses is vital. In reporting these incidents we can learn from the events and ensure that policies are in place to achieve the highest standard of care for our service users. By meeting the requirements of Standards for Better Health core standards (DH 2004), systems need to be in place which enable quality assurance of services and promote quality improvement that enhances service user safety.

Things can go wrong even when best practice has been used, therefore if things do go wrong or do not go according to plan it is important to learn why, including identifying any mistakes that were made. In the event of an adverse incident, all incidents should be reported through the professionals existing organisational process, so that the risk can be assessed and investigated if necessary, in order to put systems in place to avoid other incidences in the future. Adverse incidents may include; lost prescriptions, threatening behaviour, communicating problems between clinicians or service user, needle stick injury etc. Each organisation will have its own process; however the following principles should be followed:

- INCIDENT OCCURS - TAKE NECESSARY EMERGENCY ACTION
- REPORT **IMMEDIATELY** TO PERSON IN CHARGE LOCALLY EG: - NURSE IN CHARGE, ADMINISTRATOR OR DESIGNATED PERSON.
- ASSESS THE INCIDENT, IS IT ACTUALLY/POTENTIALLY SERIOUS IN NATURE,
    - IF **NO** COMPLETE INCIDENT REPORT FORM AND SEND TO DESIGNATED WORKER USUALLY WITH 24HRS.
    - IF **YES** MAKE SURE AREA/SITUATION IS MADE SAFE, IMMEDIATELY CONTACT DESIGNATED INCIDENT REPORTING LEAD IN THE ORGANISATION. COMPLETE INCIDENT REPORT FORM WITHIN 24HRS

Individual NHS organisations may have slightly different specific policies/procedures - clinicians have a responsibility to familiarise themselves with their local policies.

Appendix 3

Letter of Notification of LES2 Service Provision to Service Users Own GP

Date ....

Dr ....

Address ....

Dear Dr ....

Re: Name .... D.O.B ....

Address ....

Your service user **(insert name)**, who has been receiving treatment for drug dependency, has now achieved the level of stability required to enable his / her transfer into Shared Care Services for Substance Use.

As your practice is currently not participating in the Locally Enhanced Service - Shared Care for Substance Use, your service user will be transferred into the Shared Care clinic at **(insert LES2 provider's details)** under a Locally Enhanced Service Level 2 Agreement.

(Insert service users name) will continue to be supervised and supported by a keyworker provided by the substance misuse service and their prescription will be managed by Dr **(insert LES2 provider's name)**. You will receive a summary of treatment provided on a quarterly basis and as and when significant changes are made to the treatment provided. Dr **(insert LES2 provider's name)** will only provide treatment for drug dependency and will refer your service user back to you for all general medical services.

Please do not hesitate to contact me should you require any further information regarding the treatment your service user is in receipt of.

If you would like information regarding Shared Care Services or how your practice could receive payment for participation in this Locally Enhanced Service provision please contact your local Shared Care Development Manager.

Yours faithfully,

(insert keyworker's name)
Keyworker

Appendix 4

Transfer of Service Users from Specialist Service to Shared Care: Proforma

Name	
DoB	Contact No.
Address	Town Postcode
GP Details	
Start this care episode	Previous care episodes
Substance misuse history	Current illicit drug use
Route Problems	Route Problems
Current prescription Dose Duration of prescription	Dispensing Chemist Frequency of Pick up
Medication prescribed by GP	Previous medical history

BBV Status	Immunisations
Hepatitis A	Hepatitis A ....
Hepatitis B	Hepatitis B 1st ....
Hepatitis C	2nd ....
HIV	3rd ....
Actions	

Alcohol use current	Alcohol use past

Mental health issues current	Mental health issues past

Social issues	Child Protection
Partner	
Housing status	
Employment status	

Most recent drug screen result

Appendix 5

Quarterly Clinical Care Plan Review

1. Introduction

1.1 Rationale

The purpose of this protocol is to indicate when treatment review should be undertaken, who should be involved and the expected topics to be covered.

1.2 Principles

The aim is to ensure a consistent standard of care to all clients within the Lancashire Care Foundation Trust Substance Misuse Network and also across Shared Care services within Local Enhanced Shared Care Services in the East Lancashire health economy.

1.3 Scope

The protocol applies to all members of staff, working within Lancashire Care Foundation Trust Substance Misuse Network and all General Practitioners operating Shared Care at locally enhanced service (LES), Nationally Enhanced Service (NES) or GPwSI levels.

2. Protocol

2.1 Frequency of review

It is an expectation that all clients will review their treatment progress against care plan goals with their keyworker as a minimum quarterly. It is acknowledged that in exceptional cases this interval may be shorter due the clients' individual circumstances and needs.

2.2 Personnel involved in review

A quarterly review will always involve a face-to-face meeting between a client and his/her keyworker. Depending upon client presentation and level of need the medical practitioner may attend the meeting with the client where indicated. More usually medical involvement will take the form of a discussion of the clients' progress between the keyworker and prescribing doctor as part of a Clinical Caseload Review.

It is expected that twice per year the quarterly review will involve the prescribing doctor and keyworker undertaking a face-to-face meeting with the client.

2.3 Clinical Caseload Review

As described above the prescribing doctor and keyworker will meet on a quarterly basis to review all clients under their joint care. This will invariably follow the keyworker review with the individual clients.

It is important that adequate time is allotted to the Clinical Caseload Review process to ensure all relevant information can be covered. The operational organisation of these meetings will be dependant on caseload sizes, which may require reviews to be carried

out over a number of sessions. This will be co-ordinated by the Team Managers working in conjunction with the medical practitioner within Lancashire Care Foundation Trust and by the Shared Care workers and the GP within Shared Care Services.

It is important to remember that clinical responsibility lies with the prescribing doctor whether this is in LES services or the Substance Misuse Services. It is important therefore that the medical practitioner takes an active role in the clinical review process to comply with good clinical governance practice.

2.4 Content of review

The review should include a number of standard documents:

- Treatment Outcome Profile (TOP)
- Consent to Information Sharing
- Risk Assessment Form
- Service User Treatment Evaluation

And to be accompanied by:

- Comprehensive Assessment
- Current Care Plan
- Prescribing Record Card
- Drug Screen Record

The review links closely to the original comprehensive assessment revisiting issues which have the potential to change over time i.e. contact with children, requirements for Hepatitis B vaccination and Booster, Hepatitis C / HIV screening etc.

Finally the review addresses the appropriateness of the clients' current treatment package and forms part of the development of the ongoing care plan.

2.5 Documentation

It is important to ensure both ongoing care and quarterly reviews are clearly documented in line with professional codes of conduct. This ensures continuity of care, good communication between staff members and facilitates the dissemination of appropriate information.

A copy of the review outcome should be recorded in all relevant treatment records e.g. Lancashire Care Case notes and Electronic Medical Record in Shared Care practices

National Treatment Agency 2006 -Models of Care for Treatment of Adult Drug Misusers: Update 2006.

National Treatment Agency 2006 - Care Planning Practice Guide.

Appendix 5 - continued

Review of Planned Care (Example)

<table>
<tr><th colspan="2">Client Name</th><th>D.O.B</th><th>NHS Number</th><th colspan="3">ID Number</th></tr>
<tr><td colspan="2"></td><td></td><td></td><td colspan="3"></td></tr>
<tr><th colspan="2">Date of Review</th><th colspan="2">Key worker</th><th colspan="3">Medical Practitioner</th></tr>
<tr><td colspan="2"></td><td colspan="2"></td><td colspan="3"></td></tr>
<tr><td colspan="7">TREATMENT REVIEW</td></tr>
<tr><td></td><td colspan="2">Date Completed</td><td colspan="2"></td><td colspan="2">Date Completed</td></tr>
<tr><td>TOP Form</td><td colspan="2"></td><td colspan="2">Information sharing consent</td><td colspan="2"></td></tr>
<tr><td>Risk assessment</td><td colspan="2"></td><td colspan="2">Service User Treatment Evaluation</td><td colspan="2"></td></tr>
<tr><td colspan="7">ACCOMPANYING DOCUMENTS PRESENT</td></tr>
<tr><td colspan="2">Comprehensive assessment</td><td colspan="5">YES / NO</td></tr>
<tr><td colspan="2">Current Care Plan</td><td colspan="5">YES / NO</td></tr>
<tr><td colspan="2">Prescription Record Card</td><td colspan="5">YES / NO</td></tr>
<tr><td colspan="2">Drug Screening Record</td><td colspan="5">YES / NO</td></tr>
<tr><td colspan="2">Other services currently involved in care</td><td colspan="5"></td></tr>
<tr><td colspan="2">Agency Identified as Care Coordinator</td><td colspan="5"></td></tr>
<tr><td colspan="7">SINCE THE LAST REVIEW HAS THE CLIENTS SITUATION CHANGED IN RELATION TO:</td></tr>
<tr><td colspan="7">DRUG & ALCOHOL</td></tr>
<tr><td colspan="7">Current patterns of drug and/or alcohol use and Current prescribed medication will be addressed in the accompanying TOP and prescription Record Sheet.</td></tr>
<tr><td colspan="6">Is the current medication package failing to meet the clients needs (level of opiate saturation etc)</td><td>YES / NO</td></tr>
<tr><td colspan="6">Is the client requesting changes in medication</td><td>YES / NO</td></tr>
<tr><td colspan="6">Number of Over Doses accidental / intentional in previous 12 week period</td><td></td></tr>
<tr><td colspan="6">Access to Tier 4 Inpatient detox and/or rehabilitation discussed with client</td><td>YES /NO</td></tr>
<tr><td colspan="2">If No please give reasons</td><td colspan="5"></td></tr>
<tr><td colspan="7">PHYSICAL</td></tr>
<tr><td colspan="2" rowspan="2">Hep B immunisation status reviewed</td><td>Immunisation requested</td><td colspan="2">Booster Due</td><td colspan="2">Client declines</td></tr>
<tr><td>YES / NO</td><td colspan="2">YES / NO</td><td colspan="2">YES / NO</td></tr>
<tr><td colspan="2">Hep C</td><td colspan="5">Screening requested YES / NO</td></tr>
<tr><td colspan="2">HIV</td><td colspan="5">Screening requested YES / NO</td></tr>
<tr><td colspan="6">Does the client require any input in relation to Family planning / Cervical smears</td><td>YES /NO</td></tr>
<tr><td colspan="6">Has the client developed any signs / symptoms of physical co-morbidity</td><td>YES /NO</td></tr>
<tr><td colspan="7">MENTAL</td></tr>
<tr><td colspan="6">Has the client developed any signs / symptoms of mental health problems</td><td>YES /NO</td></tr>
<tr><td colspan="7">SOCIAL</td></tr>
<tr><td colspan="6">Safe Guarding children – has the clients situation changed since the last review</td><td>YES /NO</td></tr>
<tr><td colspan="6">Carer issues – does the client now require support for children acting as young careers or adult family members</td><td>YES /NO</td></tr>
</table>

Review of Current Care Plan		
Care plan Goals	Outcome	Applicable
Review of current treatment modality does it still meet the clients needs		

Review outcomes **If you have answered yes to any of the above questions you must complete the following section**		
	Action taken	Date / Signature
Prescribed Medication		
Over dose		
Request for Tier 4 Services		
Hep B		
Hep C		
HIV		
Smear test / family planning		
Safe guarding Children issues		
Treatment modality		
Support for carers		
Physical health		
Mental health		

Referral to other Services required	Service referred to	Date/Signature

Key worker signature	Date	Medical Practitioner signature	Date
Date of next review			

Appendix 6

Service User Treatment Evaluation Form

As part of your continuing treatment you are entitled to and should receive a regular review of your care plan. These reviews should take place on a regular basis at least 3 or four times a year.

A care plan is the record of the treatment goals you have agreed with your keyworker. It should provide you with a record explaining how your care will be delivered and which service will provide it.

The Government has stated that all treatment services such as our own must ensure service users are fully involved in their care planning process and are fully informed of its content and any changes that might need to take place.

This form is designed so that you have an opportunity, before your formalised review with your keyworker/doctor, to highlight your own views on how you feel your treatment is progressing or if you would like to see changes made to your care plan. This will help to inform your forthcoming care plan review session.

Many thanks for your participation in this process.

Name	Date of Birth

1. In the past 3 months has your Care Plan been discussed with you?

   ☐ Yes ☐ No ☐ Don’t know ☐ Not sure

2. Have you been given the opportunity to have a copy of your Care Plan?

   ☐ Yes ☐ No ☐ Don’t know ☐ Not sure

3. Do you feel your current Care Plan accurately reflects your treatment goals?

   ☐ Yes definitely ☐ Yes to some extent ☐ No

4. Do you feel the current work you are doing with your keyworker is actively helping you to achieve your goals

   ☐ Yes definitely ☐ Yes to some extent ☐ No

If you have answered No to question 4, do you have any suggestions as to how this situation can be improved?

____

____

____

____

____

____

5. Are there any other services that you would like to see involved in your Care Plan e.g. Housing, Education, Employment etc?

____

____

____

____

____

____

6. Are there any other comments you would like to make that could help to ensure you receive the service you need.

____

____

____

____

____

____

Appendix 7

Summary of Locally Enhanced Service Level 1 Service Level Agreement

	LES Level 1
Criteria for participation in the scheme	1. Keep a register of service users 2. Effective liaison with Keyworker (SMP) 3. Arrangements for 3 monthly reviews by GP
Training	1. GP to make a commitment to completing the **RCGP Certificate in Drug Misuse (Part 1)** within 12 months of commencing service 2. Attend at least one **clinically focussed update event each successive year**
Minimum roles and responsibilities	1. Agree with the service user and SMP a range of treatment options 2. Meet 3 monthly with the SMP to clinically review the caseload 3. Undertake a face to face review with each service user twice per year, with an absolute minimum standard of once per year 4. To attend clinics with the SMP where there is clinical need 5. Sign the prepared prescriptions and complete authorisation for changes to medication and /or dose regimes 6. Advise the SMP on all matters relating to prescribing practice 7. Provide general medical services for drug users on a normal practice appointment basis 8. Identify and treat the common complications of drug misuse 9. Promote Hepatitis C screening and Hep A and B vaccination where appropriate 10. GPs to work to their own level of confidence and competence

	LES Level 1
Monitoring requirements	The LES will be subject to the following audit on a six-monthly basis: 1. Audit of prescribing of substitute medication if appropriate and adherence to the minimum standards laid out by the PCO / Shared Care monitoring group 2. An annual review of service will be made to include the following information which will be supplied by the clinic on a monthly basis using the agreed monitoring form • Attendance rates • Non-attendance rates • Clinic sessions provided • Hepatitis B screening • Review against outcomes • Referral on to other services • Progress towards completion of RCGP Part 1

Appendix 8

Summary of Locally Enhanced Service Level 2 Service Level Agreement

	LES Level 2
Criteria for participation in the scheme	1. Keep a register of service users 2. Effective liaison with Keyworker (SMP) 3. Arrangements for 3 monthly reviews by GP 4. Be prepared to provide substance misuse treatment to service users of other practices
Training	1. GP to make a commitment to completing the **RCGP Certificate in Drug Misuse (Part 1)** within 12 months of commencing service 2. Attend at least one **clinically focused update event each successive year**
Minimum roles and responsibilities	1. Agree with the service user and SMP a range of treatment options 2. Meet 3 monthly with the SMP to clinically review the caseload 3. Undertake a face to face review with each service user twice per year, with an absolute minimum standard of once per year 4. To attend clinics with the SMP where there is clinical need 5. Sign the prepared prescriptions and complete authorisation for changes to medication and /or dose regimes 6. Advise the SMP on all matters relating to prescribing practice 7. Refer service users back to own GP for any general medical services required 8. Identify and treat the common complications of drug misuse. 9. Ensure good lines of communication between yourselves and service users own GP re drug treatment plan and progression 10. Promote Hepatitis C screening and Hep A and B vaccination where appropriate 11. GPs to work to their own level of confidence and competence

	LES Level 2
Monitoring requirements	The LES will be subject to the following audit on a six-monthly basis: 1. Audit of prescribing of substitute medication if appropriate and adherence to the minimum standards laid out by the PCO / Shared Care monitoring group 2. An annual review of service will be made to include the following information which will be supplied by the clinic on a monthly basis using the agreed monitoring form • Attendance rates • Non-attendance rates • Clinic sessions provided • Hepatitis B screening • Review against outcomes • Referral on to other services • Progress towards completion of RCGP Part 1

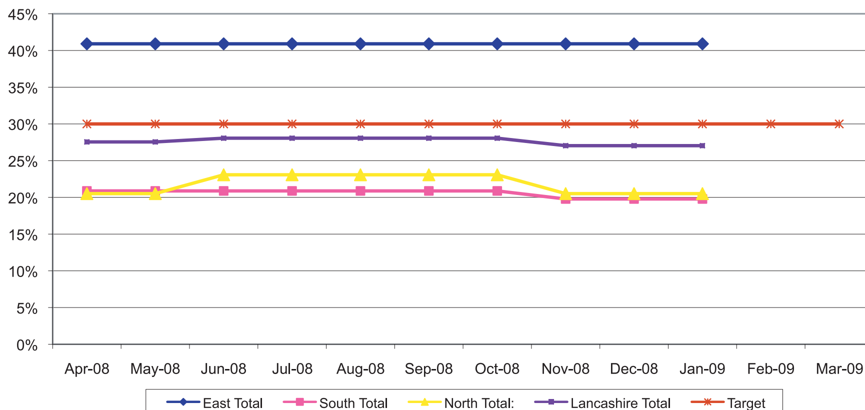
Appendix 9

Performance Management Framework

% GP's in Shared Care

% GP Practices Key <27% (red) 27-29% (amber) >=30% (green)

	2008									2009		
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
East												
BPR	46%	46%	46%	46%	46%	46%	46%	46%	46%	46%		
HRV	32%	32%	32%	32%	32%	32%	32%	32%	32%	32%		
East Total	41%	41%	41%	41%	41%	41%	41%	41%	41%	41%		
South												
Preston	43%	43%	43%	43%	43%	43%	43%	43%	43%	43%		
Chorley & South Ribble	14%	14%	14%	14%	14%	14%	16%	14%	14%	14%		
West Lancs	8%	8%	8%	8%	8%	8%	4%	4%	4%	4%		
South Total	21%	21%	21%	21%	21%	21%	21%	20%	20%	20%		
North												
Lancaster & MB	45%	45%	55%	55%	55%	55%	55%	45%	45%	45%		
Fylde	10%	10%	10%	10%	10%	10%	10%	10%	10%	10%		
Wyre	11%	11%	11%	11%	11%	11%	11%	11%	11%	11%		
North Total	21%	21%	23%	23%	23%	23%	23%	21%	21%	21%		
Lancashire Total	28%	28%	28%	28%	28%	28%	28%	27%	27%	27%		
Target	30%	30%	30%	30%	30%	30%	30%	30%	30%	30%	30%	30%



% Clients in Shared Care

% Shared Care Clients Key <45% 45-49% >=50%

	2008									2009		
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
East												
BPR	30%	30%	30%	30%	29%	30%	30%	30%	32%			
HRV	45%	45%	25%	49%	51%	46%	43%	43%	40%			
East Total	33%	33%	29%	33%	33%	33%	32%	32%	33%			
South												
Preston	23%	23%	26%	25%	28%	27%	26%	24%	24%			
Chorley & South Ribble	5%	6%	6%	6%	6%	6%	5%	9%	9%			
West Lancs	31%	31%	31%	28%	30%	29%	29%	29%	29%			
South Total	17%	17%	18%	18%	20%	19%	18%	19%	18%			
North												
Lancaster & MB	19%	19%	25%	25%	23%	24%	25%	24%	24%			
Fylde	55%	54%	49%	49%	52%	52%	49%	59%	61%			
Wyre	42%	42%	42%	43%	46%	44%	44%	41%	39%			
North Total	30%	30%	33%	33%	33%	33%	33%	33%	33%			
Lancashire Total	27%	27%	27%	28%	29%	28%	28%	28%	28%			
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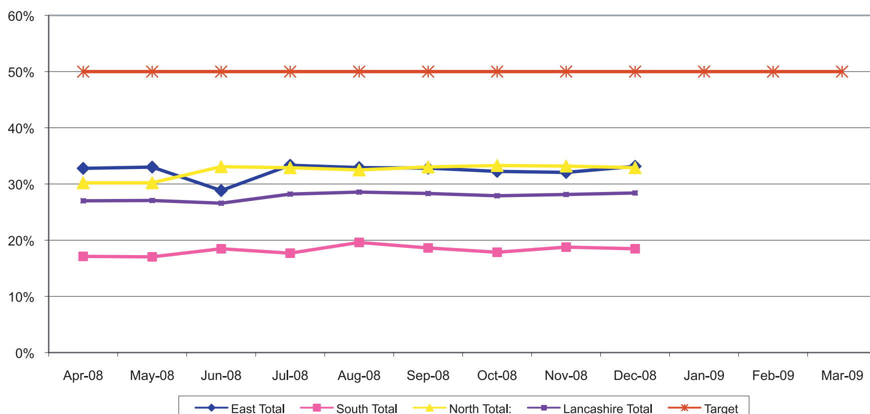

Appendix 10

Prescribing Formulary

Drug	Availability	Suggested Max Daily Dose in Primary Care	Comments
Methadone mixture	1mg/ml	120mg	Doses below 60mg are suboptimal and reasons for their use should be documented i.e. titration or patient request/side effects.
Buprenorphine	0.4mg; 2mg; 8mg	32mg	
Naltrexone tablets	50mg	50mg	
Lofexidine	0.2mg	2.4mg	
Diazepam	2mg; 5mg	30mg	
Hyoscine Butylbromide	10mg	60mg	For symptomatic relief during opiate detoxification.
Promethazine	25mg	50mg	
Loperamide	2mg	8 daily	
Paracetamol	500mg	8 daily	

Appendix 11

List of Links and References

Specific prescribing advice and information, which should be followed, can be found in:

- Drug Misuse and Dependence - UK Guidelines on Clinical Management 2008
- Department of Health, 2007
  www.dh.gov.uk/assetRoot/04/07/81/98/04078198.pdf
- A guide to good practice in the management of controlled drugs in Primary Care (England)
  National Prescribing Centre, 2005,
  www.npc.co.uk/publications/Controlled_Drugs_September_2005.pdf
- NICE, Drug Misuse: Opiate Detoxification Guideline 52, 2007
- NICE, Methadone and Buprenorphine for the Management of Opiate Dependence, Technology Appraisal 114, 2007
- NICE, Drug Misuse: Psychosocial Interventions, Guideline 51, 2007
- NICE, Naltrexone for the Management of Opioid Dependence, Technology Appraisal 115, 2007
  www.nice.org.uk

Specific Methadone and Buprenorphine prescribing guidelines are available on the RCGP website **www.rcgp.org.uk**

Additional useful references and resources:

- The National Treatment Agency's Clinical Guidance and Tools pages at:
  www.nta.nhs.uk
- Substance Misuse Management in General Practice provides discussion forums and responses to frequently asked questions:
  www.smmgp.org.uk
  www.ldaat.org

Specific sessional placements, observing and working alongside a GPwSI or with a Clinical Specialist within a Community Drug Team will also provide useful experience of how others make decisions and plan treatment interventions and can go towards fulfilling CPD requirements.

Appendix 12

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Working in partnership to reduce substance misuse and make Lancashire a healthier and safer place.