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Drug misuse and dependence

UK guidelines on clinical management

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Preface

Professor Sir John Strang

It has been my great honour and pleasure to chair the independent expert working group updating the 2007 Clinical Guidelines. I am immensely grateful to the many colleagues who have served on the working group, or who have prepared documents and given evidence to us, and to the officials who have so actively supported us in our work. I am satisfied that this 2017 edition of the 'Orange Book' will help providers and commissioners to optimise the reach and effectiveness of the interventions they have the responsibility to deliver.

The right treatment at the right time can be life-saving. It can also make a huge difference to the wellbeing and recovery of people with problems related to their drug use. Well-delivered treatment is greatly more effective than less competently delivered treatment. The Clinical Guidelines are designed to support you in meeting your responsibility to ensure evidence-based treatments are available and competently delivered.

Guidelines guide – they are not intended to dictate the precise treatment for each patient. Rather, they are designed to guide the clinician and the commissioner in the provision of the right balance of interventions, which have the greatest likelihood to produce individual benefit and public good.

The Clinical Guidelines also enable the clinician to assess whether a proposed treatment plan departs, and to what extent it departs, from evidence-based guidance on the specific treatment. As a general principle, the greater the extent to which a treatment plan departs from evidence-based guidelines, the greater the need to ensure that this departure from orthodox clinical practice is appropriate. Since my first involvement with the Clinical Guidelines more than a quarter of a century ago, the world of drug treatment has matured greatly, and so too has the manner in which we examine the available evidence. This is evident in the substantial and evidence-informed nature of the new 2017 Clinical Guidelines.

Some of the problems individuals experience are new and require their own consideration, although many of the underlying principles of the provision of best care remain valid from previous iterations of the Clinical Guidelines. This is as we would expect it to be, since our knowledge grows incrementally with regard to the problems people experience and the ways in which we can help them to address these problems. Thus, some sections of the 2017 Clinical Guidelines contain new material, others echo earlier editions and others present updated revisions of earlier guidance.

Psychosocial and pharmacological approaches are considered within the Clinical Guidelines, as is the social context in which people experience their problems and are helped with their treatment and recovery. Pharmacological approaches remain extremely important and of clearly demonstrated efficacy and effectiveness for those with problems related to use of heroin or other opiates. But this approach is of limited relevance to treatment for those with problems related to use of other types of drug. For many who make contact with treatment services, it is also important to look broadly at the opportunity to address their psychological problems and the impact of past traumas, and to provide support to gain meaningful employment, stable housing, alongside family and other social support.

There have been positive developments in the greater availability of community-based psychosocial interventions and peer support and mutual aid for those in drug treatment. However, there are also areas of marked weakness, including inadequate provision of effective support for social integration, including for employment and housing, which are still poorly provided for this group. There have been major advances, including with some of the associated health complications such as the greatly improved treatment of chronic hepatitis C infection: it is our privilege to bring you updated guidance of these new treatments, and it is our collective responsibility to ensure that these new treatments are used to deliver health benefit.

The systems and services to serve these needs may be vastly different. Earlier versions of the guidelines were written when the system was mostly divided between NHS secondary care prescribing and voluntary sector advice and support. Today the situation is very different, with NHS specialist providers much diminished and with major independent or third-sector agencies being the main providers of treatment in a variety of collaborative arrangements. But there is considerable variation between localities and between the different countries of the UK. Whatever the composition of commissioning and provision, the fundamental principles of the Clinical Guidelines remain crucial and will require careful attention to ensure improved reach, better quality and proper monitoring of benefit from the various evidence-based treatments which must be commissioned to address the clinical needs of the populations with healthcare problems.

Despite success with falling numbers of young people currently developing heroin dependence, the morbidity, mortality and long-term needs of an ageing cohort of patients with long-term heroin dependence problems means that treatment is increasingly complex and that coordination between services is vital. This includes ever greater integration with mainstream physical and mental healthcare. Furthermore, the huge number of new psychoactive substances with little-known long-term effects poses fresh challenges for clinicians.

There are additional challenges such as the need for training of addiction specialists outside of, as well as within, the NHS. If adequate training of addiction specialists is not achieved, then it will be harder for policy makers and commissioners to deliver adequate care for patients with more severe and complex problems.

In conclusion, I would like to re-state my immense gratitude to colleagues on the working group, to the advisory groups that supported the service user and carer representatives, and to the officials who supported us in this important preparation of the 2017 Clinical Guidelines.

Finally, I am grateful to the Chief Medical Officers of England, Scotland, Wales and Northern Ireland for commissioning and supporting the update, and to Public Health England for providing secretariat support.

A handwritten signature in black ink that reads "John Strang". The signature is written in a cursive style with a horizontal line underneath the name.

Professor Sir John Strang
National Addiction Centre

Chapter 1: Introduction

1.1 About these guidelines

1.1.1 Who are the Clinical Guidelines for?

Drug Misuse and Dependence: UK Guidelines on Clinical Management – hereafter referred to as the 2017 Clinical Guidelines – are intended primarily for clinicians providing drug treatment for people who misuse or are dependent on drugs. Clinicians in this context are psychiatrists and other doctors, nurses, psychologists, pharmacists, keyworkers and other workers providing drug treatment, as well as health and social care professionals who provide limited periods of support for the treatment of drug misuse and dependence (such as during hospitalisations).

The guidelines will also be useful to those commissioning drug treatment and to those considering or undergoing drug treatment, their family, friends and carers.

1.1.2 What are the 2017 Clinical Guidelines?

This document updates and replaces the 2007 edition of Drug Misuse and Dependence: UK Guidelines on Clinical Management (DH & devolved administrations 2007) – hereafter referred to as the 2007 Clinical Guidelines. It has the same status across the UK as the 2007 Clinical Guidelines.

The 2017 Clinical Guidelines provide guidance on the treatment of drug misuse and dependence in the UK. They are based on current evidence and professional consensus on how to provide drug treatment for the majority of patients, in most instances.

The 2017 Clinical Guidelines do not provide rigid protocols on how clinicians must provide drug treatment for all in their care. Professionals are expected to take the recommendations in the guidelines fully into account when exercising their judgement, alongside the individual needs, preferences and values of their patients or service users. The guidelines do not override the responsibility of clinicians to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient (and guardians and carers, if appropriate). However, where clinicians decide to operate outside the specific recommendations within this guidance, they should be able to demonstrate (and should record) the rationale for their decisions.

Local commissioners and providers have a responsibility to develop services that enable the guidelines to be applied. They should do so in the context of local and national priorities for funding and developing services, and in light of their duties to have due regard to the need to eliminate unlawful discrimination, to advance equality of opportunity and to reduce

health inequalities. Nothing in these guidelines should be interpreted in a way that would be inconsistent with compliance with those duties.

1.1.3 Why update the Clinical Guidelines?

UK guidelines for the clinical management of drug misuse and dependence were last revised in 2007. Since then there have been developments in the evidence for drug treatment, in the demands on services and in the treatment delivered. These developments include:

- an ageing cohort of those with heroin dependence in treatment needing a focus on improving their morbidity and mortality
- legislative changes to allow non-medical prescribers to assess, diagnose and independently prescribe for the treatment of drug dependence
- emerging risks from new psychoactive substances and changing patterns of drug use, and the need to address new needs of diverse populations
- a more explicit focus on individually defined recovery journeys with an enhanced focus on keyworking and care planning that integrates support for pharmacological and psychosocial interventions, and peer engagement and mutual aid.

1.1.4 The 2017 Clinical Guidelines and other published guidance

The 2017 Clinical Guidelines take account of the evidence underpinning authoritative guidance, such as that from NICE, but they are intended broadly to integrate the evidence on the management and treatment of drug misusers for all the UK. These Clinical Guidelines should be taken together with any other authoritative guidance to provide a comprehensive picture of current best practice in the treatment of drug misuse and dependence.

1.1.5 The status of the Clinical Guidelines

The 2017 Clinical Guidelines replace the previous 2007 Clinical Guidelines. They have no specific statutory status. However, the standards and quality of care for the appropriate treatment of drug misusers that the guidelines set out will be taken into account when the performance of any service or clinician in this clinical area is inspected or assessed.

There are separate, defined legal obligations in relation to the prescribing of controlled drugs that clinicians should act in accordance with. In addition, doctors need to ensure that they act within Home Office licensing arrangements for the prescription of diamorphine, dipipanone or cocaine for the management of drug misuse.

The General Medical Council states (GMC 2013), among other things in its guidance on good medical practice, that doctors must:

- be familiar with guidelines and developments that affect your work
- keep up to date with, and follow, the law, our guidance and other regulation relevant to your work
- provide effective treatments based on the best available evidence.

1.1.6 The process for developing the 2017 Clinical Guidelines

In 2014, the Chief Medical Officers of the UK tasked the Department of Health and, through it, Public Health England (PHE) with supporting an independent working group to update Drug Misuse and Dependence: UK Guidelines on Clinical Management (DH & devolved administrations 2007). It was agreed that it would still be sensible to issue a single set of guidelines for the whole of the UK that would provide a skeleton framework of best practice upon which locally appropriate policies and procedures could be based. The terms of reference of the working group were to update the 2007 Clinical Guidelines.

The chair of the 2007, 1999 and 1991 guidelines working groups, Professor Sir John Strang, was invited to chair the group. PHE convened and provided a secretariat for the working group and for separate user and carer advisory groups.

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

Development of the updated guidelines included the commissioning of reviews, presentations and draft sections to advise the working group on the current evidence base for a range of drug misuse treatment-related issues. These are listed in the sections on *Reviews and synopses* and *Other contributors*. Reviewers were asked to make explicit the strength of the published evidence for their recommendations and this was scrutinised by the working group.

The working group also considered the evidence from relevant current guidance and other research. The working group then, by a process of consensus, came to a view of the best available evidence from whatever source. As in 2007, the working group considered rating its recommendations and the evidence supporting them in line with common current practice for guidelines. However, it decided against this on the basis that the Clinical Guidelines have traditionally – and usefully – provided consensus opinion which draws extensively on clinical experience as well as on published research. By doing this it is able to make recommendations on important subjects beyond those with a substantial research evidence base and in a way that is of practical use to clinicians. The strength of the working group's recommendations and its opinion on the quality of the supporting evidence is mostly indicated by judicious wording of the recommendation and of the accompanying text.

1.1.7 Consultation on the update

A draft of the guidelines update was published for public consultation in August 2016. A substantial number of responses was received and reviewed.

Members of the Clinical Guidelines working group were fully involved in the consultation process, which was conducted by PHE. All consultation responses were collated and fed back to the group during the consultation period. The group was asked to comment on key issues arising and their advice taken into account when redrafting the document. Meetings of the working group were held to discuss topics that were the focus of most consultation comment, or where more discussion or consensus was required before finalising the clinical guidelines.

1.1.8 Some evidence lacking

The evidence base for drug misuse treatment has improved considerably and forms the basis for much of the working group's advice. However, as in previous editions of the guidelines, the working group found that, in many areas of drug treatment, evidence was still either lacking rigorous reviews or was based on research from countries other than the UK.

1.2 About drug misuse and its treatment

1.2.1 Drug treatment is effective

The effectiveness of well-delivered, evidence-based treatment for drug misuse is well established. UK and international evidence consistently show that drug treatment – covering different types of drug problems, using different treatment interventions, and in different treatment settings – impacts positively on levels of drug use, offending, overdose risk and the spread of blood-borne viruses. For a significant proportion of those entering treatment, drug treatment results in long-term sustained abstinence.

1.2.2 Drug misuse prevalence and drugs misused

The UK has comparatively high rates of heroin and crack cocaine misusers compared to many other western countries. However, the proportion of these drug misusers in treatment is also very high compared to many other countries.

Most adult drug misusers in treatment in the UK still report opiates (primarily heroin) as their main problem drugs.

Significant and increasing minorities report their main problem drugs to be stimulants or cannabis. However, most adult drug misusers report problems with a range of illegal drugs and alcohol.

The majority of young people in treatment report cannabis as their main problem drug (often with alcohol). The misuse of Class A drugs like heroin and crack is much less common among young people who misuse drugs.

1.2.3 Drug-related morbidity and mortality

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

Recorded rates of drug-related death due to overdose in the UK continue to be among the highest in Europe. After drug misuse deaths levelled in the 2000s, and fell around 2010, there were significant increases in most countries of the UK in the three years before 2017, and concerns about further future rises. Reasons for the recent dramatic fall and subsequent rise are not clear but have been ascribed in part to changes in heroin availability but there is also a longer-term rise as opiate users of the 1980s and 1990s get older and more ill, and more susceptible to overdose deaths.

People in treatment or in the criminal justice system, who have used opiates are six times more likely to die prematurely than people in the general population (Pierce et al 2015). They are particularly at risk soon after leaving treatment (Cornish et al 2010) or prison (Farrell and Marsden 2008). Some people who use opiates and have never been in treatment are at greatest risk of drug-related death (PHE 2016).

1.2.4 The impact of drug misuse on families and communities

Protecting children from the potential impact of drug misuse is an important issue across the UK.

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

Problem drug use in parents can, and does, cause serious harm to children at every age. Reducing harm to children from parental drug misuse is a main objective of policy and practice. Effective treatment of the parent can have major benefits for the child, and services and clinicians need to work together to protect and improve the health and wellbeing of affected children. Drug treatment can also improve the quality of life for families and carers.

Drug-related crime has been estimated to inflict a major cost on local communities and the national economy. There is good evidence that drug treatment significantly reduces drug-related crime.

1.2.5 Models of drug treatment

Major changes to the delivery of health and social care have been made in the past decade. The devolution of responsibility to local areas, especially in England, continues to present risks and opportunities for drug treatment.

The involvement of primary care in drug treatment varies substantially from area to area. General practitioners are a vital part of the provision of healthcare in the UK and still have a responsibility to provide general medical care to people who use drugs even though they may only provide specialist drug treatment if this is commissioned directly.

There are new opportunities for non-medical prescribers, and increasing numbers of pharmacists and nurses have acquired the training required to prescribe for their patients.

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

1.2.5.1 Local drug treatment systems based on local need

Local commissioners and providers need to work together to ensure drug treatment systems are available to meet the changing needs of local drug-misusing populations.

1.2.5.2 Partnership

Many drug misusers have a myriad of health and social problems, which require interventions from a range of providers. Therefore, joint working across health and social care and between hospital, prison, primary care and community drug services is a key feature of effective

treatment partnerships. It is seldom the case that one clinician or provider will be able to meet these needs in isolation.

1.2.5.3 Staff with a range of competencies

Each local system will need to have a cohort of doctors providing treatment for drug misusers, ranging from those able to provide general medical services to those with specialist competencies in treating drug dependence. Other health and social care professionals with a range of competencies are also needed. See [annexe A2](#).

1.2.5.4 Involving patients

Involving patients as active partners in their drug treatment and recovery is essential and is associated with good outcomes. Patients should be fully involved in the development of their plans for treatment, care and recovery, in setting appropriate goals and reviewing their progress. It is also good practice to involve patients in the design, planning, development and evaluation of services, and in advocacy and support groups linked to local drug treatment systems. Patients may also be involved in providing peer support and education.

1.2.5.5 Involving carers

The families and other carers of drug-misusing patients are a valuable resource in drug treatment and can be involved wherever possible and agreed by the patient. However, they are often in need of information and support for themselves, and their needs should not be overlooked. See [section 2.7.12](#).

1.3 References

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Chapter 2: Essential elements of treatment provision

2.1 Key points

- The needs of all drug misusers should be assessed across the four domains of drug and alcohol misuse, health, social functioning and criminal involvement.
- Risks to the individual, to at-risk adults and to potentially affected children should be assessed.
- All drug misusers receiving structured treatment should have consented to their treatment and recovery care plan, which should be regularly reviewed.
- A keyworker – usually a consistent, named keyworker – should develop and review the care plan and may deliver elements of care.
- Drug testing can be a useful tool in diagnosis and assessment and in monitoring compliance and outcomes of treatment.
- Drug misuse treatment involves offering a range of psychosocial treatment and support interventions, not just prescribing.
- Identifying and responding to general healthcare needs is increasingly important and means working in partnership with primary and secondary care services.
- A proactive, flexible organisational ethos that actively involves service users and carers can support an effective and engaging therapeutic milieu, and can address stigmatisation and help promote positive service developments.
- All drug services need competence in identifying and addressing the effects of trauma on service users and the effects of intimate partner or other domestic violence.
- Aftercare support and pathways for rapid re-engagement in treatment are important to address risks of relapse and harm, and support recovery in the period after leaving treatment.

2.2 Assessment, planning care and treatment

2.2.1 Introduction

Commonly, particularly in primary care and emergency care settings, patients consult a clinician for a medical problem without mentioning their drug use or the full extent of any problem use. By maintaining an empathic, non-judgemental attitude, a clinician can encourage appropriate disclosure of what is often a stigmatised health problem. Early assessment and identification of need provides an opportunity to provide information about

available treatment and recovery support options and about what treatment can offer, and to encourage engagement in further assessment.

Good assessment is essential to the continuing care of the patient. Not only can it enable the patient to become engaged in treatment but it can begin a process of change even before a full or comprehensive assessment is complete. Assessment skills are vital for everyone providing drug treatment. Clinicians need competencies to be able to assess patient need. These competencies are detailed in relevant professional and other appropriate standards. It is essential that all those assessing service users can identify need themselves or can refer on for further assessment to those with additional assessment competencies (for initiation of prescribing, for more complex physical or mental health diagnostic assessments or for other complex assessments such as of complex polypharmacy).

For those managing assessment and treatment for drug dependence, core skills in assessment and planning are needed to:

- identify and manage drug (and alcohol) dependence
- identify and manage risks
- identify and manage coexisting physical health, mental health and social problems
- deliver effective harm reduction interventions
- support psychosocial interventions and effective prescribing
- deliver holistic, person-centred, treatment and recovery care planning.

Core psychosocial skills, including skills in building a therapeutic alliance and patient motivation, and a range of other specific psychosocial interventions underpin structured treatment for all patients. This treatment may be delivered by the patient's keyworker and/or by others, and is commonly integrated within the processes of keyworking and of treatment and recovery care planning. These core competencies also support the effective pharmacological management of patients.

2.2.2 Assessment

2.2.2.1 Introduction

Assessing substance use problems and the need for drug treatment is described in some detail in this section. Context-specific and additional elements of assessment are discussed in the following sections:

- drug testing – [section 2.4](#)
- assessment of general health – [section 2.5](#)
- assessment for psychosocial interventions – [section 3.7.1](#)
- assessment for initiating opioid substitution treatment – [section 4.2.2](#) and [section 4.3](#)
- assessment for opioid detoxification – [section 4.8.1](#)
- assessment within the criminal justice system – [sections 5.4.5](#) and [5.4.6](#)
- assessment of opioid dependent patients within general hospital settings – [section 7.5.4.1](#)
- assessment of young people – [section 7.10.6](#).

Comprehensive assessment may need to be conducted over several sessions and is then ongoing.

With patient consent, it may be appropriate for one or more concerned friends, carers or relatives or other professionals already involved with the patient to attend the assessment. With patients under 16 years, this may be required.

An extensive approach to assessment should not lead to any unnecessary delays in the initiation of treatments that can be started at an early stage, including at the first assessment appointment. Such early access to treatment may improve early engagement. Needle and syringe provision, blood-borne virus screening, guidance regarding safer injecting and even opioid substitution treatment may be initiated promptly and safely, while a more comprehensive recovery plan is being developed.

After an initial assessment in which risks are identified, clinicians may find it useful to develop brief, initial plans of care with patients that address immediate concerns. These may include improving access to clean injecting equipment, reducing the risks of overdose and of contracting blood-borne viruses, and supporting safe use of any prescribed medication.

For patients with severe problems, the assessment process may involve input from several professionals. Such patients may have treatment, care and support needs in all the domains of drug and alcohol misuse, health (physical and psychological) and social functioning (including housing, employment, and crime and criminal justice).

2.2.2.2 Assessment of risk

Assessing risk is an important part of assessment. Drug misuse may present specific risks related to overdose, polydrug and alcohol misuse, mental health, unsafe injecting practices, and unsafe sex. Risks may include self-harm or harm to others. Assessing the need for any safeguarding or other protection actions for at-risk adults or children is an important ongoing expectation on professionals. Risks to dependent children should be assessed as soon as possible after contact with services. At initial assessment, all service users should be asked about their own children and other children in the home and otherwise in close contact, the ages of the children (with some service protocols requiring date of birth) and the level of contact. Any important current risks should be clarified and reflected in a risk management plan.

2.2.2.3 Aims of full or comprehensive drug assessment

Comprehensive drug assessment underpins the identification of treatment needs and the agreement with the patient of the goals for their treatment and recovery. It also underpins risk assessment and risk management planning.

A drug misuse assessment should include:

- identifying, and responding, to any emergency or acute problem
- confirming the patient is taking psychoactive substances (based on history, examination and drug testing, and through accessing any relevant additional information from clinical records)

- identifying degree of problem use or dependence, including:
 - types of psychoactive drugs used (including prescribed and over-the-counter medicines and tobacco), quantity and frequency of use, pattern of use, routes of administration (including any injecting), sources of drugs obtained and evidence for harmful use or dependence (including any experience of withdrawal syndromes)
 - types of alcohol consumed, quantity and frequency of use, pattern of use, and whether there is evidence of hazardous drinking (above recommended levels for low risk drinking), or of harmful or dependent use (including experience of alcohol withdrawal syndrome)
- identifying physical and mental health problems, including:
 - current or previous physical complications of drug and alcohol use such as infection with blood-borne viruses or continuing related risky behaviours, liver disease, abscesses, overdoses, enduring severe physical disabilities and sexual health problems
 - risks related to pregnancy
 - current or previous psychological problems, such as personality problems and disorders, self-harm, history of abuse or trauma, depression, anxiety and severe psychiatric comorbidity (details of contact with mental health services should be recorded)
- identifying social problems, including:
 - problems in personal relationships (including with partners) and of social integration, including domestic violence and abuse, family, housing and living arrangements, education, employment, benefits and financial problems
 - childcare issues, including parenting, pregnancy and child protection
 - criminal involvement, offending and other legal issues, including arrests, fines, outstanding charges and warrants, probation, imprisonment, violent offences and criminal activity, and involvement with workers in the criminal justice system
- assessing the family history for substance use and dependence and relevant medical, psychiatric or psychosocial factors
- determining the patient's understanding of treatment options and motivation for change
- exploring and identifying strengths, including:
 - personal, family, social and other strengths and positive networks that the service user can use to achieve their treatment and recovery goals
 - past successes and difficulties in achieving stability or in making improvements (e.g. what helped in the past and what didn't help or what caused any relapse?)
- determining any need for substitute medication or other prescribing for dependence

- assessing risk behaviours, including those associated with injecting:
 - for drug-misusing parents or other adults with dependent children, obtaining information on the children and any drug-related risks to which they may be exposed (see [box 1](#))
 - if risk of significant harm to a young person is found, involving other professionals in line with local child protection requirements and child safeguarding procedures
 - if risk of significant harm to a vulnerable or at-risk adult person is found, responding professionally and in line with local adult safeguarding procedures
- with young people, assessing competency to consent to treatment (if required) and involving those with parental responsibility as appropriate
 - local assessment proformas or processes specifically designed for young people may also need to be used and different professional competencies may be required (assessment of young people may require additional components such as comprehensive educational needs and developmental needs assessment).

Box 1: Full or comprehensive assessment of drug-using parents

Comprehensive assessment of drug-using parents or others with dependent children

Assessment should take into consideration:

- effect of drug misuse on functioning, for example, intoxication, agitation
- effect of drug-seeking behaviours, for example, leaving children unsupervised, contact with unsuitable characters
- impact of parent's physical and mental health on parenting
- how drug use is funded, for example, sex working, diversion of family income
- emotional availability to children
- effects on family routines, for example, getting children to school on time
- others supporting the children, for example, family, and their fitness to provide that support
- ability to access professional support
- storage of illicit drugs, prescribed medication and drug-using paraphernalia.

With consent, information should be gathered from other professionals as appropriate.

If a patient has a serious drug misuse problem or unmet needs in a range of domains, one clinician will rarely be able to meet all the patient's needs. A patient may need prescribing interventions plus psychosocial interventions and help with housing or benefits. The assessment needs to collect sufficient information to identify these needs and to facilitate input from, or referral to, a range of other professionals and services.

It is also important to assess the most appropriate level of expertise required to manage the patient (this may alter over time) and to refer to, or liaise with, others (for example, with clinicians who have more competencies in treating drug misuse or in delivering appropriate psychosocial interventions).

Clinicians will also need to collect and notify relevant assessment information about the patient to local, regional or national drug treatment monitoring systems using the appropriate local reporting form or system.

The assessment process should result in an initial plan of care that can be referred to and used as a basis for discussing with the patient their goals and objectives and the plans for delivering on these goals. This plan will be the patient's 'treatment and recovery care plan', or it will underpin the fuller care plan that is developed subsequently at a clinically more appropriate time.

The assessment process will also inform the clinician's and clinical service's initial risk assessment and initial risk management plan, which may present a need for urgent action.

The assessment and initial planning process also provides an excellent opportunity for clinicians to provide brief interventions to reduce immediate harm from substance misuse and, if needed, access to sterile injecting equipment or other suitable equipment, testing for hepatitis and HIV, and immunisation against hepatitis B. Individuals who may need rapid or immediate access to opioid substitution treatment, due to severity of current harm or due to the level of risk identified, can also be responded to appropriately.

2.2.2.4 Use of screening, assessment and monitoring tools

Screening, assessment and monitoring tools are sometimes used to support the assessment and review process. These tools may help standardise assessment and care when used in the context of clear local protocols. Tools used for substance use include:

- the Alcohol Use Disorders Identification Tests (AUDIT or AUDIT-C) for screening for risky or dependent alcohol use
- the Severity of Alcohol Dependence Questionnaire (SADQ) for assessing severity of alcohol dependence
- the Clinical Institute Withdrawal Assessment for Alcohol – revised version (CIWA-Ar) for measuring alcohol withdrawal severity
- the Clinical Opiate Withdrawal Scale (COWS) or the Short Opiate Withdrawal Scale (SOWS) for severity of opioid withdrawals
- versions of the 'Grubin tool', a general health screening questionnaire used for prison reception assessments, which are made up of various health elements including for identification of substance use problems.

2.2.3 Treatment and recovery goals

Following completion of a suitably comprehensive history and assessment, treatment and recovery goals should be agreed with the patient in the early stages of treatment. Immediate goals might already have been agreed following a brief or urgent assessment. However, more

considered goals are usually needed that lie across multiple domains of recovery, along with the actions to achieve them, and clarity about who is responsible for doing them.

Drug treatment has a range of goals that aim to reduce dependence and improve health, wellbeing and recovery. The keyworker will explore these with the service user over time. The treatment and recovery care plan can be an important mechanism for reflecting on, and recording, informed consent to treatment and the goals agreed with the service user. However, the main role of clinicians is to assist patients in making their own, informed, choices about their treatment goals and priorities, and to agree the actions to try to best achieve them. Initially, treatment goals tend to be more focused on problems and harm but then, as treatment progresses, they become more focused on building recovery and resilience. Goals and treatment and recovery domains commonly include:

- reducing various health, social, crime and other problems directly related to drug misuse
- reducing various health, social or other problems not directly attributable to drug misuse
- achieving abstinence from main problem drugs
- reducing harmful or risky behaviours associated with the misuse of drugs (for example, sharing injecting equipment)
- attaining controlled, non-dependent or non-problematic drug use
- optimising personal physical and mental wellbeing; building social networks, including family and community network; building strengths; and developing resilience in recovery
- achieving specific personal goals
- achieving abstinence from all problem drugs (and perhaps alcohol)
- avoiding all non-prescribed psychoactive drugs, perhaps including alcohol
- coming off all pharmacotherapy for drug use disorders (whether substitution treatments or relapse prevention medications).

Some of these goals can be regarded as milestones or as stages in recovery. Some milestones may be achieved quickly, other stages may last for prolonged periods. However, while some individuals may never progress through all the stages they may still be successfully sustaining or continuing to develop their recovery.

It is important that the goals of psychosocial interventions are consistent with the goals agreed with the prescriber where there is prescribing for dependence (whether continuing on maintenance opioid substitution treatment (OST) or undergoing detoxification) so that the support provided is coherent. This is particularly relevant where more than one agency is involved.

2.2.4 Treatment and recovery care planning and keyworking

Building an effective therapeutic alliance with the patient, begun at assessment, is supported by keyworking and collaborative, person-centred treatment and recovery care planning. The treatment and recovery goals agreed with the patient (and the actions to address them) need to be reflected in the treatment and recovery care plan.

There may be several clinicians or others involved in helping to address the patient's goals and they should be named in the plan, along with the keyworker who is the clinician responsible

for developing, monitoring and supporting the plan. The plan needs to be a document that can be shared with the patient and used as a basis for ongoing discussion.

The keyworker needs to integrate any plans made with other clinicians (e.g. for prescribing or for engaging with psychosocial interventions). It is important that there is no fundamental discrepancy in goals and actions agreed with the patient, including prescribing goals, and that the keyworker supports communication with colleagues to avoid this, taking advice when needed from senior clinical colleagues.

Keyworkers need to bring to the process of treatment and recovery care planning their skills in developing a therapeutic alliance and their core assessment, motivational, clinical and planning skills.

In some cases, the plan may be initiated by the clinician who was first involved in treatment or assessment taking on the initial keyworking functions. The keyworker may be a nurse, an NHS or voluntary sector drug worker, or a doctor and is often the clinician in most regular contact with the patient. It is particularly important that the keyworker is a single, named individual in cases of complex need. The intention should normally be for the same keyworker to provide support for a time, with good handover communication whenever a change of keyworker is needed.

The work of the keyworker normally involves regular meetings with the patient to support their care. At these meetings, the treatment and recovery care plan can be reviewed and revised, as appropriate. In some cases, or at certain times, the primary therapeutic work with the patient may be delivered by one or more other clinicians but the plan will still be monitored and supported by the keyworker.

2.2.4.1 Content of keyworking

The content of keyworking sessions will depend on a patient's needs but would normally include:

- developing, agreeing and reviewing the treatment and recovery care plan with the patient, identifying the goals, strengths and challenges, identifying actions to be taken and by whom, and checking progress against milestones
- discussing risks and ensuring actions to address identified risks are recorded in risk management plans (and/or, by agreement with the patient, within their treatment and recovery care plan)
- providing information and advice on drug and alcohol misuse
- providing or promoting harm reduction interventions
- delivering interventions to prevent relapse
- using motivational interventions and planning tools such as mapping
- delivering other psychosocial and medical interventions depending on the competency of the keyworker
- helping to address social needs (e.g. providing support, or referring to support, for accessing welfare benefits)

- for drug-misusing parents, monitoring the family situation, supporting parenting, helping patients access resources, managing the interface with social services, antenatal services and other relevant professionals, and formally monitoring child protection risk.

2.2.4.2 Treatment and recovery care planning

A treatment and recovery care plan is a constantly evolving record that has four core components:

- the service user's agreed treatment and recovery goals
- specific, clear actions to be taken to assist in achieving the goals
- clarity about who is taking those actions
- monitoring of progress with achievement of the actions and goals.

While agreed goals and actions may appropriately include management of identified risks when these are agreed by the service user, risk management planning is not, of itself, a core component of an agreed or collaborative care plan record. Such risks can be, and often are, addressed in a separate risk management plan, and this is a necessity for some such risks. Care is needed not to confuse the concept of 'agreed' care plan goals with any plans for managing risks that are needed by a service or keyworker to meet their duty of care but may not be agreed by the service user.

Good treatment and recovery care plan goals are usually SMART (specific, measurable, agreed-upon, realistic and time-limited) and should reflect patient preference. At the start of the treatment process, care planning can usefully focus on highly relevant goals or more immediate actions that, where possible, include ones that can be achieved in a reasonable time scale. This allows for early success by the service user and positive reinforcement by the worker, building both therapeutic alliance and service user confidence.

Treatment and recovery care planning is an ongoing and dynamic process of reviewing the achievement of goals and re-setting them if needed, linking the service user to other agencies, where appropriate, and integrating management of identified risks where the patient agrees such goals as part of their care plan.

Different services users will have different frequencies of review of their plan with the keyworker. The focus of keyworking sessions with the service user will vary. For example, the session time may be spent, for a time, just on delivery of psychosocial interventions or support activity, on more general review of the service user's situation, or on a formal review of the agreed plan, or a combination of these.

However, monitoring and review of progress with the plan is an essential task for the keyworker. The review will take account of reflection with the service user and others, the results of any investigations, and the use of mapping or outcome monitoring tools. This process can inform decisions to optimise or otherwise change treatment plans.

For the kind of treatment and recovery care plan needed for suitable person-centred and holistic management of drug dependence, the keyworker clearly needs to be competent in multidisciplinary and multi-agency working, including liaison with primary care, social services, mental health teams and family support services. It may also be necessary to make

appropriate supported or facilitated referrals to other services such as healthcare, financial and legal advice, housing, employment, education, training and peer support, and these should be followed up.

The keyworker can often play a crucial role in encouraging and persisting with delivery of harm reduction advice and support.

2.2.4.3 Review of treatment and recovery care plans

Reviews of the plan during structured treatment take place as:

1. Ongoing reviews, arising during monitoring of care.
2. Specific reviews planned for a certain date.
3. Planned 'strategic reviews'.

The planned reviews may involve communicating with others involved with the treatment and recovery care plan, as appropriate.

1. The ongoing monitoring of care and progress is part of every one-to-one structured keyworking appointment. Discussions with the patient will include reflections on, and monitoring of, their changing goals or actions and their achievements and challenges to date. The process may require an immediate, or early, update of the care plan.
2. Keyworkers should schedule regular reviews of the treatment and recovery care plan to reflect on progress and to update the plan, if necessary. These may occur every 3-6 months but such reviews may be brought forward for patients who are:
 - receiving short-term treatments and expected to progress quickly
 - displaying complex, comorbid or problematic conditions
 - apparently not benefiting from treatment
 - undergoing a significant transition in life circumstances or in their treatment and recovery plan.
3. Higher level, sometimes less frequent, 'strategic reviews' of the treatment and recovery care plan are also recommended as part of the core treatment and recovery process. They enable the keyworker to step back with an experienced and suitably competent clinical supervisor or colleague(s), and consider the overall progress and direction of the recovery path and the mix of interventions provided. A strategic review provides an opportunity to consider whether the current balance of pharmacological, psychological and social interventions needs adjustment. It is intended as an important opportunity for the service user and keyworker to reflect on overall progress in treatment and recovery and to enable broader consideration of possible alternative goals or direction of treatment.

Where treatment includes opioid substitution treatment (OST), strategic reviews should be within three months of treatment entry (and no later than six months). They can then be repeated at six-monthly intervals, although this frequency may be increased or reduced based on individual need. For stable service users on OST, subsequent strategic reviews should occur at least annually.

Strategic reviews can also be important for service users staying in treatment for a sustained period but not in receipt of OST. In some cases, where service users are progressing rapidly or where there are concerns about managing complexity, a strategic review may be requested relatively early in treatment. This could help in cases where important decisions on the recovery path to pursue are required.

The organisation of strategic reviews may differ with different care and staffing structures. Possible structures include:

- using routine clinical supervision sessions
- discussion at a multidisciplinary team meeting
- special slots for a full treatment and recovery care plan review at a multi-agency meeting.

Whether the service user is present at the discussion between the keyworker and senior clinician or colleague(s) will depend on patient need and practical feasibility. However, before the review can be considered complete, the service user must be involved in updating their progress and in any potential changes to their plan.

The frequency of the strategic reviews can be reduced when the patient is deriving clear benefit from the interventions being provided and no relevant change to treatment direction is envisaged before the next review.

Where the treatment and recovery care plan identifies high-risk behaviour and complex interventions involving multiple contributors, a full multidisciplinary or multi-agency strategic review meeting may be appropriate. Such reviews are likely to be the norm in inpatient and residential settings.

A review should also take place to plan aftercare as a treatment episode ends (e.g. after community detoxification and relapse prevention work or following conclusion of a period of inpatient care or residential rehabilitation). After this, pre-scheduled recovery check-ups should be arranged to monitor recovery, adjust recovery supports and to support rapid access back into treatment at early signs of relapse risk if appropriate.

The treatment and recovery care plan is typically a record of the plan of care agreed with the service user at a particular time. An acute or urgent problem, or important change in clinical circumstances, may need to be addressed as a matter of priority, and should be appropriately recorded in the patient's clinical record. It would not always need an immediate change to the care plan record as other issues may be of greater priority or urgency. However, the keyworker would normally maintain sight of the service user's overall goals and would look to update the care plan with their service user in due course to maintain its relevance (and to change agreed goals or actions, as appropriate).

2.2.5 Risk management and actions to reduce harm

The initial assessing clinician, the prescriber, the keyworker, and sometimes others, all have responsibilities for identifying risks and planning actions to mitigate them.

Where possible, addressing risks with the patient will be incorporated, by agreement, in the goals and actions of the treatment and recovery care plan. However, clinicians' and service

providers' responsibilities for risk management will often extend beyond those risks that can be agreed within the framework of collaborative, consensual care planning.

Some identified risks are not accepted by the service user as valid, or they may not agree with actions identified as being needed to address risks (such as in some cases of child safeguarding). In some exceptional cases, the service user may not even be entitled to know certain risks have been identified (such as if this could impact on the safety of another person).

Separate, dedicated, risk management plans are common. However, unless for exceptional reasons, such risk management plans should always be discussed with the service user. The keyworker will need to use their skills to try to maintain a good therapeutic alliance in cases when their responsibilities for managing risk to the patient (or others) creates a discrepancy with the patient's perspective on the risks identified, or where the service user is not happy about planned staff actions (such as required information sharing of what would normally be their confidential information). This is usually best managed by transparency about the issues and explanation of actions taken or planned. It is important that the patient's autonomy is fully supported, except in certain cases (such as where there are concerns about serious risk to others in disclosure of the risk plans), and that appropriate advice and advocacy support for the patient is provided or signposted by the keyworker in cases when the patient does not accept the plans.

Risk management planning and collaborative treatment and recovery care planning will usually be complementary elements in providing and monitoring safe and effective care.

A decision to incorporate risk planning actions with which the service user did not agree (or which did not reflect their goals) in to their treatment and recovery care plan could interfere with the maintenance of a good therapeutic alliance and could affect patient engagement with treatment. It would therefore be important to clearly articulate the rationale behind such a decision and to address the implications for all workers involved.

2.2.6 Discharge from treatment and support to prevent relapse

If a patient has successfully completed a period in drug treatment, they still may have needs to prevent relapse into drug and alcohol misuse. Many people with a history of drug misuse relapse and it is important that they can gain speedy access back to treatment if they do. Patients may also require a package of aftercare, which may include psychosocial support. Some high-risk individuals with heroin dependence, recently abstinent and leaving prison, may be particularly vulnerable if not assessed rapidly after release to explore their support needs. Others, such as those recently discharged from inpatient care, may have similar needs. See also [section 3.7.4](#), [chapter 5](#) and [section 6.3](#).

Support from a GP to maintain health and wellbeing may be vital to success, together with support from social care providers (such as housing, education or employment access schemes).

Advocacy and support may also be provided through local health advocacy support networks. Service users should be facilitated to link with mutual aid organisations such as Narcotics Anonymous, Cocaine Anonymous, Alcoholics Anonymous and SMART Recovery groups. See [section 3.7.4.1](#).

2.3 Delivery of treatment

2.3.1 Delivering drug treatment in different settings

In addition to supporting patients who attend drug treatment services (see [section 2.6](#)), GPs and pharmacists play a pivotal role for patients who opt to receive their drug treatment in primary care. In these cases, the GP may be the keyworker or that role could be provided by a drug worker supporting the GP in a shared care arrangement. The keyworker should still work within the recommended treatment and recovery care planning framework. The treatment and recovery care plan will describe how the specific roles, responsibilities and actions of the GP, the shared care worker and any others involved, will be shared in delivering coordinated care in this setting. Shared responsibilities will often include monitoring of compliance and ensuring communication and continuity of care. The GP is likely to lead on prescribing interventions, changes and additions to medication, and addressing other healthcare needs. A shared care worker is likely to lead on monitoring progress against treatment goals, developing a holistic treatment plan and ensuring multidisciplinary discussion when appropriate. For GPs working at a more specialist level (for example, a GP with a special interest) the role may be somewhat different but in all cases this should be clear in the treatment and recovery care plan. The role of any pharmacist delivering enhanced services to a patient should also be appropriately reflected in the plan.

In secondary drug treatment services, the keyworker is usually a nurse or drug worker. Doctors may be the keyworker for some patients and will have an advisory or supervisory role for others, depending on local arrangements. In specialist drug treatment services, the keyworker is often part of a multidisciplinary team and responsible for coordinating patient care when more than one clinician or service is delivering treatment to a patient (for example, when a patient is receiving psychosocial interventions from a psychologist to address specific issues, is being prescribed methadone or buprenorphine by a prescriber and is having regular keyworking sessions). The treatment and recovery care plan should reflect the respective contributions.

2.3.2 Care planning for those with externally coordinated care and support

Patients with mental health and substance misuse comorbidity need coordinated care planning shared by services and in line with national and local practice. There are specific systems for such care planning, risk management and care coordination (such as the care programme approach in some parts of the UK). Structured drug treatment providers usually contribute to elements of the mental health plan of care and, if also providing care in parallel to the mental health provider, will normally maintain a drug treatment and recovery care plan. It is crucial that, where there is a mental health service care plan and a drug treatment provider care plan, they reflect each other appropriately and there is clarity of communication and responsibility for action and review. Clinicians need to keep up-to-date with the relevant good practice guidance on managing care planning and coordination within mental health services locally and within any national arrangements for care. Assessment and management of care for individuals with coexisting mental health and substance use problems is discussed in [section 7.9](#) and specific interventions are discussed in [section 3.7.3.2](#) (coexisting substance use and mental health problems).

Those who are under supervision or treatment orders from the criminal justice system will need careful integration of planning of their structured treatment to optimise outcomes (for example, in the case of those on community sentences requiring drug treatment). The probation service (or Criminal Justice Social Work in Scotland) may have information (particularly regarding risk issues and offending behaviour) that may need to be considered for incorporation for goals or actions of the treatment and recovery care plan or may need to be addressed in risk management planning. They may also offer additional support groups that may impact on care planning.

Patients receiving community care funding (for example, someone in residential rehabilitation) may have the coordination of their care and case management provided by a community care manager.

For young substance misusers, the primary responsibility for delivering a holistic treatment and care plan may be located with child and adolescent mental health services, a social services team or young offenders team. In these situations, drug treatment clinicians may need to work closely with other professionals and participate in multidisciplinary meetings that focus on all the young person's needs and which coordinate care.

2.4 Drug testing

2.4.1 Introduction

Illicit and prescribed drugs and medication can be detected in a variety of biological samples using different testing methods. Selection of appropriate testing methods can complement the treatment of people who use drugs.

The sensitivity and windows of detection of different drug tests can result in false negatives or false positives. Inconsistent or unexpected results should always be interpreted in the light of other clinical information and should not be treated as definitive in themselves.

Staff performing tests should be competent in taking samples and, if appropriate, in reading results. Laboratory testing must be done in appropriately accredited (or competence otherwise assured) laboratories.

2.4.2 Uses of drug testing

Drug testing can be used for:

- initial assessment and confirmation of drug use (although testing does not confirm dependence or tolerance and should be used alongside other methods of assessment)
- confirming treatment compliance – that a patient is taking prescribed medication
- monitoring illicit drug use, including as a drug-specific treatment goal (for example, as part of a psychosocial intervention).

Clarity and consistency about the rationale for any drug testing, and about the uses to be made of the results, by those requesting the tests and by those acting on the results, is crucial for its effective and cost effective use.

Drug testing when a patient in treatment has already admitted to using, is generally not cost-effective (except when the testing is used to detect non-compliance with prescribed medication).

2.4.3 Biological samples used in drug testing

Urine remains the most versatile biological fluid for drug testing and has the advantage of indicating drug use over the past several days. As well as being physically non-invasive, drugs are present in relatively high concentrations and large samples can quickly and safely be collected.

Oral fluid has the advantage of being easier to collect and harder to switch or adulterate samples, although drugs are present in lower concentrations and the sample size is usually much smaller than for urine. The detection window for oral fluid testing is normally 24-48 hours for most drugs, so only very recent drug use can be detected.

Hair testing is poor at detecting very recent use, but can be used to look at drug use over the preceding few months. Since hair grows at a relatively constant 1cm a month, the detection window can be several months or more. Normally, hair testing can detect drug use at some stage during a preceding month, and can be used to compare months, but cannot differentiate continual from sporadic use. Hair testing is usually restricted to specialist laboratories.

2.4.4 Types of drug test

Most drug testing processes consist of two separate types of analysis: a screening test and, if warranted, a confirmation or classification stage.

Screening tests are quick, cheap and easy to complete, and useful in clinical practice. With these tests, however, there is a higher risk of false positive or false negative results, so the results should be interpreted with a clear understanding of the limitations. Such qualitative screening tests are available for urine and saliva, using an immunoassay system, either in the laboratory or at the point of care. Where substantial weight is to be placed on a test result or if any significant decision will be based on the result, a confirmatory testing method, usually conducted by a laboratory, should be used.

A confirmatory test is normally only done on samples that have shown positive on a screening test. It is almost always laboratory based, and frequently uses either gas or liquid chromatography coupled to mass spectrometry (GC/MS or LC/MS). These methods will detect drugs and their metabolites with greater accuracy than screening tests but are usually slower and more expensive. Their use is essential when testing is for forensic purposes or may otherwise have serious consequences for patients or their families (for example, child protection).

2.4.5 Choosing an appropriate drug test regimen

Random intermittent drug screening is probably the most practical and cost-effective option for providing reliable information about an individual's recent drug use. It is likely to be used more frequently in the assessment and engagement phases of treatment when there is still an active focus on stabilisation of illicit and problem drug use.

Many patients will admit to continued drug use without the need for repeat testing, especially if they are clear that this information is welcomed positively with concern rather than with any disappointment or frustration. Unnecessary testing for drug use can then be minimised (though it may still be needed to assess compliance with medication).

Drug testing can be used as part of a specific intervention using contingency management principles, when the testing regimen should be determined in line with the principles of that intervention.

2.4.6 Procedures for drug testing

It is normal practice to have written procedures for the collection and storage of biological samples, their dispatch to a laboratory and the discussion and management of reported results.

Standard operating procedures should include, where relevant, instructions on storage of point-of-care test devices, calibration of equipment, recording of results, infection control procedures and disposal of biological fluids. Appropriate facilities should be available for sample collection and, if conducted, for testing on site.

Collection procedures should aim to ensure the integrity of specimens. The time of sample collection should always be noted along with reported consumption of relevant prescribed and illicit drugs over the previous few days.

Samples such as urine can be prone to problems of adulteration, substitution, non-compliance and pre-collection abstinence. A negative interference can be achieved by specimen dilution, drinking large volumes of fluid, addition of chemicals (salt, soap, bleach) or direct substitution with another sample. A positive result can be achieved by direct addition of a drug to the sample or by substitution with one provided by a known positive misuser. Alternatively, pre-sample abstinence may produce a misleading negative result, while ingestion of drugs obtained lawfully may be used to mask those taken illicitly.

In routine clinical practice, strict supervision, including observation of urine specimen collection, is rarely necessary but steps should be taken to limit the opportunities to tamper with specimens and to check their integrity, such as examining sample colour and temperature.

Where serious consequences might follow a positive (or negative) test, procedures should be more rigorous and might include greater security of the specimen collection site, further steps to reduce tampering or adulteration, and secure packaging for delivery to the testing site.

It will only very occasionally be necessary or appropriate to directly observe a urine specimen being given, and then only with informed patient consent.

In clinical practice, sampling under a 'chain of custody' protocol may very occasionally be required for confirmatory testing, especially in forensic situations such as testing in relation to court orders or sentences when all appropriate required procedures should be followed.

2.5 General health assessment at presentation and in treatment

2.5.1 Introduction

The main elements of assessment of drug misuse and dependence are described in [section 2.2.2](#) above.

The aim of a general health assessment is to identify any unmet healthcare needs and to take account of other health problems that could interact with drug treatment. The assessment presents an opportunity to attract individuals who have previously not benefited from supported contact with health services to improve their health and wellbeing. This may also improve the outcomes of drug treatment and recovery. Health problem(s) may be directly connected with drug taking, a complication of drug misuse or drug misuse lifestyle, or an incidental comorbid finding.

As an increasing number of older people present for the first time or return to drug treatment services, medical assessment becomes increasingly important. Screening opportunities may have been missed in the past and premature presentation of diseases associated with increasing age need to be considered in this population, who have higher than usual risk due to lifestyle, neglect or drug use. Those in drug treatment have high levels of morbidity and mortality and, potentially, several remediable risks and conditions.

This responsibility on drug services does not replace the normal responsibility of primary care and other secondary care health services for providing such assessment and care. It simply recognises the opportunities for drug treatment services to contribute to the identification of health problems and to liaise with primary care and other services to complete required assessment or treatments.

Early initial assessment of the general health status of an individual revealing a drug problem may, therefore, be best carried out by the person conducting the initial assessment of the problem. This is not always a GP or even a clinician in a drug treatment service. Increasingly the entry point into treatment, or the route by which individuals are directed into specialist care, begins with non-specialist staff such as a generic counsellor, community pharmacist, non-statutory care agency, midwife or community or practice nurse. This may lead to early encouragement to engage with their GP and community pharmacist for advice.

The prescriber within the drug service needs to be satisfied that an adequate health assessment is being provided for each patient for whom they will prescribe, and whether further assessment is needed from primary care or secondary care drug or other specialist services.

It is good practice for the clinician assessing for drug treatment to complete a sufficient general health assessment that is within their own competency and to decide whether a further assessment (or other intervention) is needed arising from this, and whether this should be considered urgent or not. It is important for services to achieve a balance that focuses on the needs of the patient, while not attempting to supplant the role of primary care.

Sometimes it will be obvious that an identified health problem requires further and more detailed examination and perhaps laboratory or clinical testing. The most appropriate action then may be to refer to a medically qualified practitioner such as a GP or, in some cases, to

support referral from primary care (or from the substance misuse service itself) to a relevant specialist medical clinic (such as one dealing with infectious diseases, liver problems, cardiac and vascular abnormalities or respiratory diseases). In other cases, primary care may have referred to the drug or alcohol service in the first instance because of the urgency of supporting engagement and stabilisation in treatment but will have already identified other health needs.

Given the common conditions that affect people who use drugs, some questions and potential further examinations that may help in assessing these conditions are listed in the next section. It is not intended to suggest that all drug services should always pursue these themselves and it may be that primary care services are asked to pursue some of them.

Possible additional examinations and tests that can be discussed with patients and can be carried out on selected individuals, according to need and decisions of the patient, are also listed.

Clinicians should also be alert to sometimes important but infrequent health hazards connected with drug taking.

Where a health assessment or concern is not urgent, clinicians and patients may prefer to cover these in a series of consultations rather than attempting to unearth complex and sometimes long-standing problems in a short consultation. One of the advantages of having patients in treatment is the ongoing contact and opportunities for medical and social interventions.

2.5.2 Health questions, examinations and tests

2.5.2.1 Questions and medical history

There is some overlap between the questions asked specifically in relation to health needs and those addressed as part of a drug assessment.

History-taking in relation to health should include questions about the following, asked at an appropriate time in relation to circumstances and patient priorities (so that some may be urgent or essential prior to treatment initiation, while others may be completed more appropriately on a subsequent occasion):

- presenting symptoms of a physical health concern
- any past medical history including operations, injuries and periods in hospital
- any current mental health concerns or symptoms, or psychiatric history
- for women, relevant contraception history and cervical screening, menstrual and pregnancy history
- sexual health and sexually transmitted infections history (including any partners with HIV or hepatitis C)
- any current oral health problems and recent dental attendance
- any current problems with respiratory or cardiac health
- current prescribed and non-prescribed medication including over the counter medicines

- cigarette, cannabis and alcohol consumption
- any allergies or sensitivities.

2.5.2.2 General health examinations and assessments

Suitable, private and confidential facilities for physical examination are essential in all services involved in prescribing or that offer physical examination. Any services that may need to examine injecting sites also need accessible, suitable, private and confidential facilities that respect the dignity of service users being examined.

Patients who are known to have injected in the past should be considered as at risk from injecting-related complications. Patients who have smoked tobacco or drugs such as crack cocaine should be considered as exposed to risks to their respiratory and cardiovascular health.

The following general health assessments or examinations should be carried out early in the assessment process, especially before prescribing. They may be done by clinical drug treatment staff but elements may be carried out by another suitable clinician, such as the GP. They include:

- assessment of injection sites in all limbs and inguinal areas, particularly if injecting (or injected in the past)
- a general assessment of mental health
- a general assessment of respiratory, cardiovascular and other body systems, paying attention to any symptoms offered and complaints described (which can lead in some services to a basic medical examination of body system or signposting of the patient to their GP for this)
- measurement of weight and blood pressure – while not routinely required prior to initiating substitute prescribing, baseline measurements can be useful in monitoring progress and may be needed in cases where there are concerns.

2.5.2.3 Special examinations and testing that may be required

Access to the following specific investigations and physical examinations may be needed in some patients with drug problems. Whether these are provided within the drug service, by primary care or by others will depend on local arrangements.

Based on the presence of history, risks, symptoms or findings of previous general physical examination, further physical examinations and testing that may be required include:

- detailed examination of cardiovascular and respiratory systems, including ECG, chest X-rays and pulmonary function tests such as peak flow and FEV/FVC
- detailed examination of gastrointestinal system including dentition and liver
- pregnancy testing
- testing for the presence of HIV, hepatitis C (including PCR testing for the presence of HCV RNA) and hepatitis B infection

- other blood tests to assess liver function, thyroid function, renal function and haematological indices
- neurological examination (indications include loss of sensation, organic causes of confusion, forgetfulness, convulsions, blackouts)
- urine testing for markers of conditions such as diabetes and infection.

2.5.3 Initial management of general health and drug-related problems

There are occasions when an opportunity should not be missed to initiate a healthcare intervention as contact can be transitory and interrupted by events in a patient's life. The following tasks and interventions might be commenced or discussed with a drug-misusing patient (delivered directly or preparatory to referral to a specialist worker or colleague or to the patient's GP):

- treatment of acute episodes of illness
- information and advice about, and immunisation against, hepatitis B (and possibly hepatitis A) – see [section 6.2](#)
- advice and testing for blood-borne virus infections, with referral for treatment if required
- cervical cancer screening
- general health information
- treatment of direct complications of injecting, including deep vein thrombosis and abscesses
- safer injecting advice and provision of injecting paraphernalia
- contraception advice
- safer sex advice and referral to sexual health service
- information about local NHS dental services or direct referral to special care dental services if appropriate.

People who use drugs are at risk from the same diseases as others and should be included in appropriate screening programmes and health assessments. They are also susceptible to an increased range of problems and perhaps early onset of some degenerative diseases because of their lifestyle and risk activities. Consideration needs to be given to repeating relevant tests and investigations in those who continue to inject.

People who use drugs may suffer from poor nutrition but should only receive oral nutrition support if there are clear medical reasons. Provision of dietary supplements should usually be assessed by the GP who typically takes account of their clinical assessment and the patient's BMI. Patients should, however, be given advice on diet and nutrition, especially if drinking heavily. Thiamine supplements should be recommended if clinically indicated in the context of problem drinking.

2.6 Effective communication with primary and secondary care services

The GP and pharmacist have pivotal roles in the safe and effective delivery of care. The GP, pharmacist and wider primary care team can identify problems, provide harm reduction support and brief interventions, manage complex comorbidities in an ageing drug treatment population and can provide drug treatment in shared care arrangements. They can be an invaluable resource in assessment, in linking access to other support and secondary care services, and in coordinating the management of multiple comorbid problems.

Drug treatment provided by primary care and shared care arrangements is discussed in [section 2.3.1](#) but the central role of the GP and primary care team in managing complex health problems and multiple prescribing for many patients will necessitate adequate and ongoing communication and collaborative working between secondary drug treatment providers and the GP and pharmacist.

In addition, the care received from emergency care services by those in drug treatment may be enhanced by active communication from drug treatment providers. This may also help with the planning of care and aftercare, such as following urgent admission to hospital.

Drug services need to be able to allocate resources to urgent and planned liaison work on behalf of their service users. Some of those attending drug treatment services will need to be under the care of other secondary care services such as mental health, pain management, antenatal, respiratory care, palliative care or other specialist services. These other secondary care services may benefit from expert advice, advocacy and communication from drug treatment providers. This may be important to improve diagnostic clarity, plan for admission, clarify the need for medication for drug dependence (as distinct from medicines for coexisting problems), or identify respective clinical roles for future care. Working with some services, such as antenatal, sexual health and mental health services, can often be enhanced by developing agreed protocols or locally defined pathways that support patient access, risk management, treatment and support.

2.7 Organisational factors for effective drug treatment

2.7.1 Introduction

A positive and successful service user and carer experience, and the effectiveness of the clinician and the keyworker, can be facilitated by a range of organisational factors that support competent, caring, evidence-based provision, and that promote a consistent and positive therapeutic milieu (particularly important in providing care for a stigmatised and disadvantaged group).

Essential core elements of effective treatment and recovery support include:

- good penetration of, and availability to, the in-need population
- timely assessment
- support for reduction of harm
- effective sustained engagement in appropriately planned care.

A healthy organisation will have good clinical leadership, engaged staff and clear management direction. In addition to the effect of a patient's attributes on later outcomes, organisational features also have distinctive, complex influences. A positive staff ethos and staff competence in managing support for patients and their often-complex needs (including comorbid mental health problems), support for carers and support for those affected by trauma are important considerations for the effective management and organisation of services. The service's ethos can be strongly influenced by the service's clinical and quality governance framework, informed by the clinical leadership.

How administrative and clinical staff interact with service users on the telephone or face-to-face at reception or in clinical interactions, how the service ethos is portrayed in literature and communications with service users, and how the environment within which assessment and treatment take place is organised, all have a role in engaging and supporting service users and in avoiding or limiting stigmatisation and stereotyping. This also applies to the carer experience of services.

Positive, respectful staff attitudes, provision of options that aid access and accessibility, and flexibility of provision to meet changing needs can all be potent factors in effective engagement and care.

First impressions of a treatment service can have a lasting impact, and the following organisational steps can enhance the assessment and engagement process:

- Train all staff, including reception and administration staff who interact with service users, in customer service and encourage them to greet service users in a warm and friendly manner and to be able explain the process of assessment in line with the service ethos and approach.
- Make opportunities for assessment sufficiently frequent to avoid undue delays.
- Provide adequate waiting areas, and pleasant confidential spaces, and ensure any physical examination can be carried out in suitable, sensitive and confidential settings.
- Provide sufficient peer support to enable adequate access to more informal support to service users.
- Ensure staff undertaking assessments and acting as keyworkers understand their role in developing therapeutic alliance and using motivational styles of working.
- Ensure staff undertaking assessments and monitoring progress are sufficiently skilled and supported to identify varied needs and to respond appropriately to service users who have difficulties with engagement or more severe and complex problems.
- Develop a flexible and responsive approach to those attending for assessment for the first time and for those with differing substance use problems (for example, elderly patients with dependence on therapeutic benzodiazepines or new patients presenting with problems with club drugs may not be best assessed in the middle of a busy clinic attended predominantly by those stabilising on OST).
- Provide flexible appointment times, including early morning or evening appointments, which may suit people who work.

- Avoid peremptory discharge from treatment if appointments are missed and consider better ways of accommodating individual needs (for example, when patients may be limited in their ability to engage due to phobic anxiety).
- Address problems of geographic accessibility of appointments, especially in some rural areas (for example, by providing venues close to the person's domicile or by taking account of the known inadequacy or unreliability of public transport with flexibility in appointment slots).
- Consider preferences for physical siting of a service's entrance (a degree of helpful anonymity for some may need to be balanced with attention to lighting, signage and providing an adequate sense of security approaching the service for others).
- Consider the welcoming nature of reception areas and waiting rooms. Appropriate security measures should be kept as discrete as possible. Essential warnings about unacceptable behaviour or 'Do not' notices should be balanced with suitably welcoming messages and signposting of options available to assist treatment and recovery.
- Ensure reception and waiting areas show the welcome and support available from the service to meet the needs of its diverse local population, including LGBT people, people who use stimulants, and people with disabilities.
- Provide flexible arrangements for appointments, particularly for patients not yet stabilised on medication, for those who are homeless, for those who have issues of safeguarding and for individuals with comorbidities that affect their ability to engage.

Other organisational factors that have been identified as important in the effective organisation of clinical care are described in the following sections.

2.7.2 Avoid arbitrary delays in initiation of prescribing

Services should avoid unnecessary steps in the assessment process, particularly to reduce the risk of harm for those who need to stabilise on OST. Initiation of OST needs comprehensive assessment of new patients. However, it is possible to make a diagnosis of dependence and collate sufficient information for a prescribing decision at first appointment if the relevant information is available. There is no justification for an arbitrary requirement to attend multiple appointments before prescribing, though further appointments may be necessary to gather information needed to inform a prescribing decision. Patients already well-known to the service can, in many cases, be safely re-assessed and re-started on treatment rapidly (if the prescriber is satisfied they have all the information they need for that decision).

2.7.3 Provide welcoming reminders about treatment appointments

There is some evidence that attendance at initial and later sessions can be improved, in the interests of the patient and for service efficiency, by personal reminders sent before the appointments. Services need to consider the best way of providing such reminders. For many patients and situations, SMS/text messages are preferred to traditional letters. Reminders will be more effective if made as personal as possible, the aim being to make the service user feel welcomed and convey optimism about the process of treatment.

2.7.4 Set appointment frequencies to reflect clinical need and good use of resources

Safe and effective provision of OST, particularly in the early stages of treatment, can be best delivered by frequent attendance at the pharmacy and at the service for prescribing reviews, support and keyworking. Using regular appointments to provide opportunistic interventions (such as hepatitis interventions, injecting equipment, and overdose and naloxone training) can be crucial to maximise engagement in potentially life-saving interventions.

More stable service users, who do not have a clinical need for such frequent attendance, can be over-treated or over-supervised. This can have a detrimental effect on their ability to return to, or sustain, a more conventional or stable lifestyle. There will be some stable patients who still feel they benefit from the structure of close supervision. It is important, therefore, that attendance requirements are not arbitrary and that they respect individual circumstances.

2.7.5 Ensure there is a visible positive service ethos

Service ethos should be apparent from initial entry to care, supporting individualised treatment and recovery goals, supporting patient choice and access to the variety of recovery paths and options, and sensitive to the needs of diverse populations.

The range of treatment options available (in-house or through referral) should be visible at treatment entry and during assessment. It should include pharmacotherapies (OST for both maintenance and detoxification, and medications for relapse prevention) and psychosocial interventions (for those on maintenance medication and as abstinence-oriented or abstinence-based interventions).

2.7.6 Provide an approach that supports whichever recovery path is chosen

Positive feedback should be provided for individuals successfully engaging on maintenance OST and for those engaging in abstinence-oriented or abstinence-based treatments. In addition, opportunities to change approach should be clear and reviewed appropriately, as part of treatment and recovery care planning and keyworking, whether that change is to move to the path of abstinent recovery or to the path of recovery on maintenance OST. The benefits and risks of the treatment options should be discussed as for any other health condition. These discussions should not be driven by a pre-existing preferred orientation of the clinician or service but the discussion should be a professional one, reliant on the clinician providing the best advice they can to enable the patient to make their own, informed choices, which are underpinned with information about the risks, benefits and known outcomes of the options.

It is inappropriate, in providing ethical, evidence-based treatment, for services to create a sense that those opting for OST maintenance are making a poorer choice than those opting for an abstinence-oriented or abstinence-based treatment. Equally, prescribing services should not discourage a patient who wishes to pursue detoxification, but should provide the best information on benefits and risks, and support the patient's considered decision. Staff should convey all the options suitably optimistically and realistically, and with sensitivity to the service user's personal situation and risks.

2.7.7 Develop adequate peer support and good visibility of peers in recovery

The visibility of peers, both in abstinent recovery and in recovery on OST, is likely to facilitate engagement as well as acting as a bridge to recovery resources. Services should consider

how peer supporters may facilitate engagement by, for example, being part of the treatment induction process and by involvement around clinic times. Peer mentors can also be involved in group support (e.g. SMART Recovery).

2.7.8 Give attention to people who are homeless or at risk of disengagement

Homelessness is associated with multiple complex needs. This may require a different clinical response including by engaging in assertive outreach and where possible working with specialist teams. It may be useful to set up satellite clinics in hostels so that care is taken to the service users.

Services may be able to identify individuals with a propensity to disengagement. It is recommended that the treatment offer takes account of such a risk. Incentives, flexibility, engagement of social support and peer mentoring may be indicated.

2.7.9 Address equity of access, vulnerable groups and cultural considerations

Services should consider the extent to which their services, and the way in which they are delivered, are accessible to all people who use drugs, how they address people's vulnerabilities and whether they are culturally sensitive.

Where there are known drug use issues in specific ethnic or cultural groups, efforts should be made to consult with relevant community groups and agencies to establish a culturally-relevant service offer.

Depending on local circumstances, particular consideration may need to be given to service users from black and minority ethnic groups, LGBT groups, traveller communities and club drug users.

Consideration should be given to sensitively and flexibly engaging with people who may be particularly vulnerable. This may include sex workers, young adults, and people with mental health problems.

Services may wish to consider adaptations to treatment induction processes such as women-only sessions, parent and child-friendly spaces, in-reach to non-drug-specialist services or providing booked appointments and drop-in sessions.

2.7.10 Contribute to a wider recovery community

Services need to consider the recovery communities available or needed locally, and the organisation's potential role in developing or supporting these, as well as the effective links with the recovery support available from other agencies.

Recovery planning should form part of the treatment from the outset, with a shift over time to enabling service users to become maximally self-reliant (whether continuing on a stable, established maintenance treatment, attending for abstinence-oriented or abstinence-based treatment, or following discharge from treatment drug-free).

Recovery is often described as a process rather than a state easily or quickly achieved. Progress to recovery is a useful concept when considering and supporting treatment options. Progress is sometimes slow or can even halt or regress in various dimensions, while other elements of recovery may still be sustained. Support services need to recognise this complex pathway of recovery and the need for a range of support options across a network of providers.

Integrating maintenance support and aftercare pathways within mainstream treatment makes both maintenance and abstinent recovery visible as well as exposing service users who may be earlier in their recovery journey to those further ahead.

Services should establish themselves within their local community and promote themselves as contributing to community cohesion and resilience. For instance, this could include, where feasible, providing free space for community groups or space for mutual aid groups.

Service users of working age sometimes get involved in related social enterprise initiatives as part of their process of recovery. Where such initiatives are available, it may be useful for treatment services to develop links.

2.7.11 Involve service users

Involving service users through well-developed structures that allow input to programme design and provide rapid feedback on service changes can be influential in maintaining and improving care (also see [A2.1.9](#)).

In some cases, good service user involvement can facilitate local understanding of emerging drugs (including experience of novel new psychoactive substances, use of image and performance-enhancing drugs, and the inappropriate use of over-the-counter and pain medications).

Consideration should be given to creating a balanced and wide treatment team, with representation from both professionals and people in recovery.

Service users and people who use drugs can help provide insights, expertise and access into the needs and requirements of their communities. They can create valuable opportunities for services through, for example:

- active collaborative involvement in their own care or treatment plan
 - involving patients as active partners in their drug treatment is good practice and is associated with better outcomes
- involvement in strategic development, commissioning, monitoring and evaluation
 - competent patient representatives may contribute at a senior level in organisations
 - there are formal strategies and mechanisms for patient involvement in health services in each of the countries of the UK
- developing and delivering peer mentoring, for example:
 - working with individuals or facilitating groups
 - delivering peer education to reduce the risks of overdose and blood-borne viruses
 - supporting access to a range of generic and drug-specific advocacy services
- supporting, developing and delivering user-led, recovery-focused enterprises.

2.7.12 Support and involve carers

Carers can play a positive role in the process of recovery. However, there is evidence that a caring role can be a significant source of stress which can lead to physical and mental health

difficulties. The organisation's policy on carer support and their duty to carers, including carers' entitlement to assessment and support in their own right, should be understood by all staff. Appropriate carer support workers may be available in some services or areas. Carers, including young carers, may benefit from a formal carer's assessment, but this is usually only available if the person cared for is 18 years or over.

It is recommended that clinicians:

- make themselves accessible to family members and carers with the consent of the patient
- provide verbal and written information and advice on the impact of drug misuse and about treatment and the settings in which it may take place
- provide information about self-help, group and individual support for families and carers
- provide referral for individual support including formal psychosocial interventions
- consider family or couples-based interventions.

Carers should also be offered specific information and advice on:

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

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

Depending upon the relationships between a patient and their carer(s), and bearing in mind the patient's right to confidentiality, in as far as it is possible and practicable, appropriate information should be exchanged both ways between clinicians and carers. Carers should be included, when appropriate to do so, as active partners in drug misuse treatment.

2.7.13 Provide trauma-informed care

Drug services need to consider the principles of trauma-informed care and related staff competencies in addressing related patient needs.

Trauma encompasses an event or events that are experienced by the individual as physically or emotionally harmful, cause significant distress and have enduring effects on their development, functioning and wellbeing (affecting social, emotional, cognitive, behavioural, physical and/or spiritual functioning). Service users may use substances to self-medicate trauma-related symptoms, and some individuals will have severe reactions, leading to symptoms of trauma-related disorders and other mental disorders.

Drug and alcohol treatment services have many patients with a history of trauma and its harmful impacts. Services need to recognise these patients and ensure suitable sensitivity and competencies to address their consequent needs, with a treatment environment that promotes healing and prevents inadvertent re-traumatisation through working practices.

Box 2: Principles for trauma-informed care

Underpinning principles for trauma-informed care

- Recognise the high rates of trauma exposure in substance misusers.
- Promote awareness and understanding of trauma among patients and the workforce.
- Recognise trauma symptoms and behaviours as the individual's best attempts to adapt to and manage their experiences.
 - This promotes a 'strengths and resilience' perspective on the individual's difficulties, with the focus not on 'what is wrong with you?' but rather 'what has happened to you?' and 'what has worked for you?'
 - This occurs in familial, community, societal and cultural contexts, which are unique to each individual, and ensures that trauma-informed care is personalised.
- Provide a treatment environment that promotes physical and emotional safety.
- Avoid inadvertent re-traumatisation.
 - Treatment procedures and interventions have the potential to trigger trauma reactions in individuals with a history of trauma, especially when the procedure or intervention is in some way reminiscent of the original trauma experience (e.g. feeling exposed during observation of a supervised urine sample).
- Prioritise trauma recovery as part of treatment goals.
 - Many patients will not recognise the relationship between their trauma experiences and symptoms such as substance misuse. Services should help patients to develop a holistic, compassionate understanding of their difficulties.
- Support patients to make choices and take control of treatment decisions.
- Adopt a stance that is collaborative, participatory and provides hope and a belief in recovery from trauma.
 - This applies to all therapeutic relationships with keyworkers and other professionals, the design and planning of services and the professional development of the workforce.
- Recognise the potential for secondary traumatic stress (also known as vicarious traumatisation) and develop strategies to manage this and promote self-care in the workforce.
- Undertake routine screening for trauma experience and reactions.
- Explain the principles of trauma-informed care to patients
 - For example, by explaining the purpose of trauma-related questions at assessment; by providing psychoeducation/normalisation of trauma reactions; facilitating access to specialised, trauma-specific interventions (where desired by the individual).

2.8 Intimate partner violence and domestic abuse

High rates of intimate partner violence (IPV) – both perpetration and victimisation – are reported among individuals misusing or dependent on drugs and/or alcohol. IPV includes psychological, physical, sexual, financial and emotional abuse, and controlling behaviours with differing degrees of violence and control by a current or former intimate partner. Men and women can be victims of IPV and all those affected should be provided with suitable assessment and support. Other forms of relationship can lead to experience of domestic abuse but most evidence relates to IPV.

Victims of IPV who use substances have been reported to be more likely to experience mental health disorders (depression and post-traumatic stress disorder (PTSD) particularly) and physical health problems, and to have experienced adverse childhood experiences (such as sexual and physical abuse), to report sex trading, and sexual and drug risk behaviours.

Perpetrators identified in substance use treatment services are rarely referred to perpetrator programmes and many refuges do not accept women who use substances. Evidence-based integrated trauma-informed interventions for women currently experiencing IPV or PTSD and co-occurring substance use have reported better substance use and PTSD outcomes.

It is recommended that service users are asked about victimisation and perpetration of IPV and about any experience of other domestic abuse. This should be part of ongoing assessment and risk management. Recent pregnancy, an increase in the severity of violence, a victim's own fear of harm increasing, and sudden changes in circumstances (such as relapse into substance use, loss of job, loss of housing, and separation from children) are some of the factors that have been associated with escalation of IPV.

NICE guidance highlights the need for multi-agency working to ensure that there are integrated care pathways for identifying, referring and providing interventions to support those who are victims or perpetrators of IPV. Staff employed in substance use treatment services should be aware of protocols for identifying, assessing and working with domestic abuse and with IPV victims and perpetrators, and of local care pathways for domestic abuse victims, including IPV victims and perpetrators.

Research suggests that around 40% of men who perpetrate IPV are also violent towards their children so the local policies and procedures for child safeguarding may become important in responding. Adult safeguarding procedures and those local policies and procedures for responding to high levels of risk can also be relevant.

2.8.1 Resources and further reading

A framework for working safely and effectively with men who perpetrate intimate partner violence in substance use treatment settings (Hughes et al 2015) www.kcl.ac.uk/ioppn/depts/addictions/research/drugs/project-outputs.aspx

NICE guidance on Domestic violence and abuse: multi-agency working www.nice.org.uk/guidance/ph50

Complicated matters: a toolkit and e-learning programme addressing domestic and sexual violence, problematic substance use and mental ill-health (Stella Project 2013)

<http://elearning.avaproject.org.uk/>

Can I ask...? An alcohol and other drug clinician's guide to addressing family and domestic violence (White et al 2013) http://nceta.flinders.edu.au/files/2713/6615/8232/EN488_2013_White.pdf

2.9 Planning and contracting or commissioning services

Commissioning is the process by which services and interventions are identified and delivered.

While the decentralised nature of planning and contracting services generates wide local variation, a commissioning cycle is generally considered to incorporate elements of:

- assessment of the needs and resources of the local population
- strategic planning and the prioritisation of investment
- contracting against service specification and procurement and maintenance of services via competitive tendering or other routes, such as grant aid
- the ongoing monitoring and assessment of performance and service quality.

The planning and contracting or commissioning process incorporates a number of general principles and aspirations:

- decision-making based as much as possible on the best available evidence
- prioritisation of investment in line with an objective analysis of need
- responding not only to current need but also to anticipated future trends and developments
- reducing inequality, promoting diversity and maximising choice
- engaging with service users and carers at each stage of the contracting and planning process and consulting the public on service development
- supporting service providers to deliver an optimal quality of service and value for money
- drawing on clinical leadership, complex case management and specialist expertise
- encouraging peer-led, asset-based recovery groups and recovery champions
- ensuring clear and effective quality governance is in place and adequately resourced
- contracting with third sector service providers in line with arrangements between government and voluntary and community organisations.

Those planning and contracting services, or those commissioning services, aspire to use the best available evidence and advice by drawing on, for example, reports of the National Institute for Health and Care Excellence (NICE) and the Scottish Intercollegiate Guidelines Network (SIGN), as well as reports of the Advisory Council on the Misuse of Drugs and of national public health bodies. However, the planning and contracting or commissioning

process does not itself have a substantial evidence base that identifies the most effective approaches. Research in this area tends to interpret existing arrangements through use of surveys and audits rather than being able to use controlled comparative methods. Moreover, even the measurement of local outcomes does not readily indicate the actual contributory or causative commissioning factors which led to those outcomes because service users almost always experience a range of interventions and differing selection processes, and differing external influences during any measurement period.

The increased focus on the recovery agenda in most of the UK has led to local planners extending their commissioning or contracting scope beyond the most evidence-based pharmacological and psychosocial treatment interventions traditionally provided by 'clinical' and NHS services to a broader range of rehabilitative interventions, typically involving additional interventions that have more limited evidence of effectiveness, and from a wider range of providers. This change aims to support people with drug use problems to progress further in their wider recovery. Planners and commissioners of such systems of care need to maintain the crucial health benefits and reduced harms from the well evidence-based and cost-effective interventions, while providing a suitably balanced and responsive range of options to meet the wider needs for recovery support desired. Specialist clinicians need to assist planners and commissioners in understanding the evidence base and to help them in the difficult task.

One of the challenges during the lifespan of the 2017 Clinical Guidelines will be for planners and commissioners, with assistance from clinicians, to continue to deliver the different forms of appropriate treatment as well as to improve outcomes, when resources may be more limited.

Chapter 3: Psychosocial components of treatment

3.1 Key points

- Treatment for drug misuse should always involve a psychosocial component to help support an individual's recovery.
- Core elements that commonly underpin effective psychosocial interventions include developing therapeutic alliance, use of evidence-based interventions, adequate staff competence and supervision, and monitoring and reviewing of progress against identified needs and wishes.
- Treatment can be conceptualised as a 'journey into recovery' through four phases (with either standard or enhanced packages of care suitable at each phase).
- Better outcomes can be achieved by using suitable interventions, including those that emphasise personal-goal-directed work; use rewarding activities; build self-efficacy and coping skills, and help to develop more positive non-drug-using social networks.
- Discrete formal psychosocial interventions can be targeted at specific needs such as addressing cocaine misuse or co-occurring depression or anxiety.
- Psychosocial interventions can be delivered alongside pharmacological interventions or alone. They are the mainstay of treatment for the misuse of cocaine and other stimulants, and for cannabis and hallucinogens.
- Self-help and mutual aid approaches, including 12-Step and SMART Recovery groups, have been found to be highly effective for some individuals in supporting recovery, and patients seeking post-treatment support should be signposted to them.
- There is a strong evidence base for contingency management and family and couples interventions but a wide range of psychosocial interventions have been found to be effective and can be used to support recovery.

3.2 Introduction

Changing entrenched patterns of drug-using behaviour is difficult, requires concerted effort and a range of internal and external resources. Identifying and developing the resources that will support an individual's recovery is an essential component of treatment, with psychological and social interventions often crucial to this process.

The term 'psychosocial intervention' is used to refer to a broad range of processes aimed at psychological and social change:

- Interventions aimed at psychological change range from less structured forms of support and simple motivational interviewing techniques integrated into keyworking to more highly structured psychological techniques and therapy delivered by specialists.
- Interventions aimed at social change include assistance with basic needs such as food, clothing and accommodation; supporting engagement with healthcare services, pro-social activities and employment; and supporting the development of positive friendship, family and community relationships and networks.

For drug problems (for example, heroin) for which medication is usually a necessary component of treatment, psychosocial interventions need to be offered alongside the medication.

For other drugs, there may be no medication-based treatment and psychosocial interventions are the primary intervention. These drugs include cannabis, cocaine, amphetamines and many of the new psychoactive substances.

Treatment providers should choose which psychosocial interventions to offer to patients based on what is known of their suitability and effectiveness from the evidence base, how appropriate a particular method is to the patient's individual situation, including how acceptable it is to the patient, whether suitably trained staff are available, and taking account of cultural appropriateness.

Treatment for drug misuse and dependence can be conceptualised as a 'journey into recovery' characterised by four phases:

- assessment
- engagement
- behaviour change
- early recovery.

A different balance of psychosocial interventions tends to be needed in each phase and, although a standard level of care is sufficient for most, some people may require an enhanced level of intervention.

Whether a service user feels they have been coerced by external pressures to engage in treatment or has come to treatment independently, a period of assessment and engagement is normally required to develop an agreement on treatment and to prepare for longer-term behaviour changes.

For heroin users stabilising on OST, this intervention alone, usually provided in the context of care planned treatment with a keyworker, provides a powerful support for behaviour changes, particularly resisting heroin use and associated risky behaviours. However, optimal behaviour change is unlikely without a good therapeutic alliance and suitable psychosocial interventions alongside the OST. Later in treatment, the positive changes made can easily be lost if inadequate attention is paid to the need to focus more on maintenance of change

and building resilience. Where medication is not part of treatment, these issues are equally important.

This chapter is organised with a dynamic pathway to recovery in mind. It provides a simple, high-level framework, based on a phased and layered model (like that introduced in Medications in Recovery (RODT 2012)) that describes the key treatment tasks and processes. Within each of the four phases the psychosocial approach that should be offered as standard is described, as are the specialist interventions that constitute the enhanced or higher-intensity layer of care needed for individuals with complex needs, or for where there is a poor response to standard care.

This framework of phases and levels of care, and how it relates to the rest of this chapter, is shown in the diagram overleaf.

The chapter focuses mainly on the range of psychosocial interventions that have been identified can contribute to supporting recovery. However, there are also fundamental elements for delivering these psychosocial interventions that are core to all phases of care. They include:

- the development of a suitable organisational structure for providing care
- an effective therapeutic alliance between service users and the workers providing care
- an understanding of the social networks in which the individual is recovering
- adequate supervision and governance of the interventions delivered
- integration of the use of any medications with psychosocial interventions
- the systematic use of treatment reviews reflecting on progress and outcomes achieved.

Some of the above factors are discussed in [chapter 2](#) and some are elaborated below.

Table 1: A model of phased and layered interventions

LAYERS	PHASES			
	Assessment	Engagement	Behaviour change	Early recovery
Cross-cutting issues	<p>Organisation: treatment review, outcome monitoring, treatment population segmentation, staff supervision</p> <p>Process and delivery: therapeutic alliance, structure and goal directed, reinforcement of change, engage with and develop supportive social networks, develop confidence and resilience, integrate with use of medications</p>			
Standard care	<ul style="list-style-type: none"> Assess substance use treatment needs including strengths and risks. Harm reduction advice. Identify network support. 	<ul style="list-style-type: none"> Actively monitor engagement. Incentivise attendance. Offer support to address social issues. 	<ul style="list-style-type: none"> Interventions to support service user goals, reduce risks, build support for and reinforce change, develop social networks, grow confidence and learn coping skills. 	<ul style="list-style-type: none"> Relapse prevention. Active linkage to mutual aid. Support to engage in community recovery and peer based recovery support.
Enhanced care	<ul style="list-style-type: none"> Identify service users at risk of disengagement including those with mental health problems. 	<ul style="list-style-type: none"> Brief motivational interventions. Contingency management. 	<ul style="list-style-type: none"> Formal psychotherapy to address issues impeding change. Community reinforcement approach. Specialist support to address social issues. Vocational training. 	<ul style="list-style-type: none"> Community day programmes. Residential treatment. Therapeutic communities.

3.3 Core elements underpinning effective delivery

Effective interventions tend to be structured and goal-driven, with a focus on sustaining engagement. They commonly use the principle of positive reinforcement of change, and build self-efficacy and coping skills. Progress needs to be monitored and reviewed systematically and used as a basis to adapt interventions as required.

3.3.1 Reviewing psychosocial interventions within the care planning process

If psychosocial interventions are to remain relevant and appropriately focused for each individual, they must sit within the wider treatment and recovery care planning and review processes (section 2.2.4). These processes provide an important opportunity to measure and evaluate progress towards goals and the impact of psychosocial interventions, and to adapt interventions to enable individuals to move along in their personal recovery journey.

A broad range of indicators of progress may be considered, including patient self-report and reflections of the keyworker and other clinicians, as well as comments from family (and any significant others) where this may be useful and appropriate. In addition, there will be reviews of progress of specific interventions, following for example:

- an agreed programme of relapse prevention sessions
- an assessment for skills or employment support
- review for emergency housing.

The higher-level 'strategic reviews' of the care plan can be a good opportunity to consider the overall recovery path and the current mix of interventions with a suitably experienced clinical supervisor or other colleague(s). This provides an opportunity to consider whether the current balance of pharmacological, psychological and social interventions needs adjustment alongside any progress made.

The focus of a strategic review is likely to be different in different phases of treatment. For all people who use drugs, early treatment review might include levels of engagement and offer of social interventions to address immediate concerns. For heroin users commencing OST this review may include focus on arrangements for substitute prescribing. Once engaged the focus for anyone who uses drugs may be more on psychosocial interventions to enable further behaviour change or sustained cessation of illicit drug use. At a later stage, the focus may be more on assessment and development of vocational and education needs, therapeutic family work or improving social relations. This may involve more varied contributors to the care plan. As treatment and recovery progress, the review may consider the extent to which the service user is managing with reduced clinic contact and is remaining positively engaged in community support activities.

3.3.2 Measuring treatment benefit to support psychosocial interventions

There is good evidence that the routine monitoring and feedback of outcomes to the service user can lead to better engagement and treatment outcomes.

For all drugs, monitoring of use or abstinence is an essential part of ongoing assessment of treatment benefit and can also signal the need for adaptation of, or for additional, psychosocial interventions.

Measures of dimensions of health and wellbeing associated with recovery may also be useful for highlighting areas that may require intervention and support. For example:

- quality of life
- psychological health
- days volunteering.

Tools focusing on changes in psychological dimensions of dependence (such as the desire or compulsion to take drugs, difficulties in controlling drug use, and time devoted to obtaining or taking the drug or to recovering from its effects) can also be useful for some approaches.

Tools may also be useful for measuring response to the specific approach deployed in the psychosocial intervention, for example:

- improvement in the quality of family relationships
- improved confidence in coping with high risk situations
- reduction in feelings of anxiety.

3.3.3 Segmentation and caseload management of psychosocial interventions

The variation between and within individuals over time, their differing social circumstances and the different configuration of services suggest that a 'one-size fits all' model for delivering psychosocial interventions is unlikely to be effective or practical. A flexible response for efficient treatment delivery may involve services segmenting their treatment population into recipients of different care packages. These may range from a low-intensity offer for service users not requiring or not wanting more involvement, to intensive recovery-focused packages of treatment for service users motivated to make changes. It may involve periods of more intensive support provided for service users in crisis or for others at times of increased need (such as around pregnancy and delivery).

Ongoing review of treatment benefit, and if necessary adjustment to support changes within the care plan, is still necessary however treatment is organised.

3.4 Making psychosocial interventions effective

Three things have been identified as important in maximising the effectiveness of a psychosocial intervention:

- using a proven intervention (research evidence which supports efficacy)
- a trained and competent practitioner (able to develop an effective therapeutic alliance and deliver an intervention with skill)
- a process of ensuring the practitioner uses the proper intervention to best effect (clinical supervision).

3.4.1 Common factors in delivering effective psychosocial support

In addition, five broad elements of psychotherapeutic approach or style are consistently linked with positive outcomes in the literature and should be taken into account in delivering specific psychosocial interventions (Moos 2007).

1. Therapeutic alliance

A good therapeutic alliance is crucial to the delivery of any treatment intervention, medical or psychosocial. When a stronger helping relationship is established, service users are more likely to complete treatment, actively explore problems, experience less distress and a more pleasant mood, abstain from alcohol and drugs during treatment, and achieve better long-term substance use outcomes.

The core competencies of the clinician or keyworker in building the therapeutic alliance and that underpin effectively delivering any psychosocial intervention include:

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

Studies of general therapist attitudes or beliefs suggest more flexible orientations and ability to draw on different approaches contribute to better outcomes.

The most effective way for services to assure the building of such positive therapeutic relationships is through provision of regular clinical supervision from appropriately qualified professionals.

2. Focus on structure and goal direction

Patients of therapists who follow an underlying theory of treatment tend to achieve better treatment outcomes. Greater clarity and organisation of treatment sessions, with an emphasis on goal-directed work to support service user's aspirations are associated with more positive reactions to treatment and better outcomes (see [section 3.7.3.1](#)).

3. Opportunities to use rewards and rewarding activities

This can be delivered in simple ways, such as acknowledging the positive progress towards treatment goals and adjusting treatment expectations to encourage self-reliance. Treatment goals can also emphasise the potential rewards for activities outside of the treatment system that have longer-term benefits for recovery. This idea is central to the community reinforcement approach (see [section 3.7.3.1](#)).

4. Engagement with positive social norms and moving away from drug-using networks

There is evidence that people evaluate and change their substance use behaviour with reference to prevailing social norms. The provision of normative feedback is likely to be an important ingredient of treatment, and linking service users to peers in recovery may provide this. The overall goal may be to help the service user change their social network from one populated mainly by people who use illicit drugs to one where more positive support for change is provided. For some patients on OST, this will be facilitated by moving from a multidisciplinary clinic focused on safe stabilisation, to individual appointments solely with a keyworker in a non-drug-treatment setting such as a community venue or GP surgery. This can help to create a more normalised therapeutic context within which any specific psychosocial interventions are supported or may even be provided.

5. Focus on building self-efficacy and coping skills

A keyworker may usefully focus on building a service user's confidence and skills to manage high-risk situations and life stressors, to resist the urge to return to substance use when experiencing distress and to engage in activities that can provide positive alternatives to substance use (see [section 3.7.4.1](#)).

3.4.2 Choosing and delivering specific psychosocial interventions

On the basis of the available high-quality research base, contingency management (CM) and behavioural couples therapy (BCT) have particularly strong evidence for effectiveness when indicated for use in the treatment of drug dependence. There is, however, a wider range of interventions that have been shown to have some effectiveness but not with the level of evidence to be able to recommend one over another for a specific individual or service setting.

The selection of a specific psychosocial intervention will therefore be determined by considerations that include:

- the goals of specific treatment packages
- service user need
- the availability of staff trained in a relevant psychosocial intervention to meet this need
- skilled supervisors able to assure consistency of and fidelity to the intervention.

The use of psychosocial interventions is described in the following sections in the context of four conceptual phases of treatment progression: assessment, engagement, behaviour change and early recovery. This reflects a pragmatic approach to organising the delivery of the range of interventions, which also takes account of whether the intervention in each phase is more likely to be provided as part of standard care or as part of a more enhanced package if clinically indicated.

While some detail on delivery of the main interventions is provided below in the phases of intervention, this chapter is not intended as a detailed implementation support tool for any intervention.

It is vital to understand the importance, when choosing an intervention, of the underlying and common elements that contribute to effectiveness described above, and of the context of the organisational ethos and overall staff and service orientation supporting effective engagement and care delivery. As noted above this includes elements of good therapeutic alliance, developing service user-led goals, collaborative care planning (including between providers when different ones are providing pharmacological and psychosocial interventions), and regular monitoring of progress and feedback of results. The framework of delivery and the underlying therapeutic approach underpins the choice of more specific psychosocial interventions targeted at achieving specific goals.

Some individuals will only require simple, standard psychosocial interventions, including motivational support, to address their care plan goals (often delivered by their keyworker or by group attendances). However, the balance of the interventions used will be likely to change as they move through the phases of a typical treatment and recovery path.

More intensive and structured interventions tend to be provided where there is a need for enhanced care at the different phases of treatment. To be effective, more highly structured interventions should be provided by those with specialist training, using approved manuals and techniques. However, even if a fully manualised, structured psychosocial intervention cannot be delivered, such interventions have important elements that services can consider integrating into standard care. For example, where a need has been identified for more supportive social networks, formal implementation of social behaviour network therapy (SBNT) might be helpful. However, if this is not feasible locally, progress in meeting this need may be addressed by a lower-intensity psychosocial intervention using relevant techniques (such as a social network diagram). Adapting such evidence-based interventions to the platform of keyworking requires suitable clinical leadership and a robust clinical supervision structure. This is required to ensure the critical ingredients of the full intervention are not so diluted they become meaningless and remain within the boundaries of safe and ethical practice.

3.4.3 Clinical supervision

A key role of senior clinicians is to oversee the balanced implementation of a range of psychosocial interventions within overall programme design and the needs of people in treatment. Clinical supervision is the predominant method by which the quality of psychosocial interventions is assured. The supervision a practitioner receives should monitor how they put the skills and competencies gained in training into practice, including core skills in development of therapeutic alliance, motivational work and any more specific techniques or interventions used. Effective supervision requires the supervisor to have competencies in both the intervention being supervised and the process of supervision itself. Services providing psychosocial interventions therefore need staff of sufficient seniority and competence to provide effective supervision and to monitor the overall quality of treatment delivered. All clinical services should build in adequate time to both deliver and receive supervision in the routine work plan of all staff.

3.5 Interventions focused on social network and family, friends and carers

Problematic use of drugs occurs in a social context that may be geographical or based around cultural identity. Building more positive relationships with family, friends and community is a common goal of recovery, and should be supported in all phases of care. It is important to consider the individual user's social network in supporting treatment for two key reasons:

- The nature and extent of an individual's social network will be a significant influence on their prospect of recovery.
- Members of the individual's social network (such as family and friends and concerned significant others) may have support needs of their own but may also be able to contribute to the treatment process. Supporting the needs of carers is now recognised as an essential component of delivering effective public health and social care services. This is discussed in the section on organisational issues for effective care (see [section 2.7](#)).

Because of the potential importance of the social context of use, all clinicians should be able to make a basic assessment of dimensions of an individual's social network, when this is appropriate, in terms of being able to identify:

- the people in regular contact with the service user and who the service user judges to be important to them
- the kinds of support provided by other people, gaps in that support, and any support being provided to others by the service user
- the different roles that the service user has, for example, as a valued friend, parent, or sibling (discussion may provide a basis to boost self-esteem or identify risks)
- members of the patient's social network who could be engaged in supporting the treatment process (for example, to provide access to rewarding activities or opportunities for an alternative to drug use)
- whether the patient has regular contact with individuals in recovery or is engaged in any supportive or recovery community (including mutual aid)
- family members or carers who may require support in their own right.

For some service users, a social network diagram (SND) can be used to develop a visual map of their social network (including family, friends, colleagues and the local community). It is useful for understanding the context of drug use and usually focuses on adult members of the social network, especially those who might be able to provide positive support for change. Gaps in available support, such as a lack of contact with people in recovery, can be useful to highlight in a visual map. Such an exercise can prompt the clinician to encourage the service user to use their existing natural social support more effectively or create other opportunities including mutual self-help or other recovery support groups. Even incorporating one positive member into the network is associated with beneficial outcomes.

Mapping and exploring social network issues can either be part of initial assessment or may be developed later as the service user's engagement progresses. It can also be reviewed at

different stages of progress in treatment. And it can be explicitly integrated into an intervention focusing on developing an individual's social network.

Formal, structured interventions such as behavioural couples therapy are evidence-based treatments for both alcohol and drug problems. These interventions are based on the principle that substance use occurs in a social context, which can both enhance and undermine behaviour change. Changes in the family system are targeted, and core elements include improving communication skills, problem solving, reinforcing prosocial behaviour and reducing unhelpful behaviours (e.g. collusion, enabling) to improve the quality of relationships and reduce stress. Other interventions work with the broader social system surrounding the patient to promote behaviour change. Social and behaviour network therapy explores and builds social network support for changing drug use and other behaviour.

3.6 Medication and psychosocial interventions

The role of medications in treatment and recovery will vary according to type of substance and individual patient need.

There are no recommended medications to treat stimulant or cannabis dependence, and not all opiate dependent individuals will want opioid substitution treatments. Psychosocial interventions will therefore form the mainstay of treatment for these issues.

Substitute medications prescribed for opioid users can be effective in supporting engagement in treatment, thereby providing a platform for the delivery of psychosocial interventions to facilitate change. However, access to medication should not be contingent on compliance with a psychosocial programme. Rather, services should offer a programme that service users will wish to engage with voluntarily.

An integrated approach using psychosocial skills and interventions along with prescribing allows care to be managed in a way that incentivises recovery, harnesses motivation, and supports harm reduction and relapse prevention.

3.6.1 Psychosocial interventions in management of OST prescribing

A range of psychosocial interventions can be used alongside OST. Initially, core elements that support safe prescribing identify service user objectives, encourage engagement, develop the therapeutic alliance and provide motivational support.

The evidence base on rewards and contingency management (CM) supports linking stabilisation on medication to positive feedback, and using encouragement and acknowledgement of incremental progress to reinforce improvements. Rewards, rather than punitive responses, are appropriate, although it is important to explain the constraints of safe prescribing and what evidence of progress will be needed to enable changes to be made to prescribing arrangements. As individuals demonstrate progress, arrangements for supervision of consumption, prescribing regimens and the availability of take-home doses can all be adjusted to incentivise and support recovery. A clear and consistent approach should be used for this to be effective so that the individual is clear about how their behaviour will affect their progress in treatment.

Motivational interviewing techniques may enhance discussions about changes to prescribing and the results of drug tests. Progress towards service user goals should be noted and provides an opportunity to affirm personal strengths and resources. The clinician should avoid unhelpful negative responses to non-achievement of outcomes, but instead use this information to build a positive therapeutic alliance through empathetic listening. This is also an opportunity to continue to reflect on goals and barriers to change. Lack of success may be an opportunity to understand the need for additional support in other areas, or to reinforce a focus on optimising harm reduction behaviours. It is important to continue to acknowledge the value of remaining engaged in treatment, not least to reduce harms.

Formal CM programmes, as an adjunct to OST, may be considered. Examples of goals of CM are regular attendance at the pharmacy to collect medication, or achieving or maintaining abstinence from heroin. Abstinence from other substances of dependence, such as crack cocaine, or cessation of injecting can also be incorporated into CM programmes as goals for those on OST (acknowledging that OST is not a treatment itself for crack cocaine dependence or for cessation of injecting of other drugs). Programmes should be voluntary for service users. They should be subject to governance processes that include a clear protocol for delivery and intervention-specific supervision for the staff delivering the programme. Rewards for achieving the goals set would typically be cash or shopping vouchers. See [section 3.7.2.2](#) for further information.

Individuals who have become stable on maintenance OST may have other recovery-related goals, and should be considered for individual and group psychosocial interventions that might support their progress with these goals. The interventions can then be provided alongside continued maintenance prescribing or any planned detoxification.

3.6.2 Relapse prevention medication and psychosocial interventions

Relapse prevention medications such as naltrexone can be integrated into an adjunctive psychosocial relapse prevention programme. Additional support from a keyworker or group in which service users can discuss any issues related to sustaining abstinence as well as test out new skills and behaviours may enhance the impact of the medication.

3.7 Delivering psychosocial interventions

3.7.1 Assessment phase

3.7.1.1 Assessment phase: standard care

First impressions are important and the service will want to make it quick and easy for people to be assessed, start to receive treatment and address their presenting concerns, such as a specific health concern, or an issue with benefits, housing or a forthcoming court appearance.

Good assessment is essential to the start and continuing care of the patient. Not only can it facilitate engagement in treatment but it can begin a process of change. Clinicians need to be competent to assess all areas of patient need. Assessment also provides an opportunity to provide information about treatment options and the expectations of treatment.

Assessment is also the start of building a good therapeutic alliance with service users. It is important that staff have a consistent therapeutic approach to avoid repeat questioning of the same issues and build the service user's confidence (see also [trauma-informed care section 2.7.13](#)).

Assessment for the use of psychosocial interventions often focuses on the two broad areas of strengths and risks. These are interrelated and their relationship is dynamic. For example, in the case of the person who starts employment while still occasionally using illicit drugs, their strength in and by returning to work may impact on, and can be impacted by, the risks of or from continued use. But the treatment journey can be broadly conceptualised as a general transition from managing risks to building strengths and recovery capital. In cases where there are lots of risks (for example, the individual has thoughts of self-harm or suicide, or is caring for dependent children), the early stages of the journey may have a greater involvement of professionals and the overall plan of care may have a relatively greater focus on those issues and more professional oversight of the risks.

As the treatment journey progresses beyond the assessment phase, and with progression through further phases, there is likely to be a greater focus on developing the service user's own strengths, including those of their social environment to help support the progress. The professional should encourage the service user to take control of their own recovery plan and to become independent of professionals. For those on substitute medication, this progression will normally also be reflected in the degree of supervision and flexibility of prescribing and dispensing arrangements (see [section 4.5.2](#)).

Assessment for psychosocial interventions may need to be conducted over several meetings with the service user. The assessor should balance obtaining comprehensive information with engaging the individual. One way of achieving this is to quickly identify treatment goals that reflect the individual's short and long-term aspirations. Some patients may be keen to focus on issues such as medication management while others may be focused on early treatment exit. The clinician needs to manage this early stage carefully to ensure they are providing the service user with important information about all their main options without appearing to ignore the current priorities for the patient. Clinicians should work collaboratively with patients to identify preferred options from a positive and flexible menu, with opportunities to review decisions as part of the ongoing process. This can help the patient define their own recovery journey carefully in an informed way.

For some drug users with more complex needs, several professionals may need to be involved in achieving adequate assessment, whether involving additional clinicians for specific elements of their drug and alcohol use, for assessing other health needs (physical and psychological) or social needs (such as housing, employment, or addressing criminal involvement).

Keyworkers assessing patients should be able to:

- assess aspirations, goals and strengths (even if they are nothing to do with drugs)
- identify problems (physical, psychological or social) that may pose risks to engagement in treatment
- deliver core harm reduction responses

- assess 'readiness to change' or motivation and act in a way that aims to increase these
- consider the function(s) drug and alcohol use may be serving (e.g. heroin to numb emotional pain or stimulants to enable engagement in sex parties).

Assessment of strengths

Assessment for psychosocial interventions will normally aim to identify resources that support an individual's recovery. The resources required will differ for each person. In addition, an individual may need different resources when beginning their treatment to those required to maintain or build change.

It can be helpful during assessment to explore the individual's 'recovery capital', which could impact positively or negatively on progress. Recover capital includes:

- their own personal resources (e.g. skills, levels of personal responsibility, mental and physical health, job status and meaningful occupations)
- their social network resources (e.g. support from and obligations to family, partners, children, friends, peers, local community)
- key factors in their social environment (e.g. finances, safe and stable accommodation, stability of employment)
- their cultural resources (which is an extension of their individual resources, such as values, beliefs and attitudes).

It is also important to assess strengths and opportunities in the family and social network by:

- identifying members of the patient's social network that could be engaged in the treatment process
- assessing whether the patient has regular contact with individuals in recovery
- identifying family members that may require support in their own right.

Dedicated tools are available to help map family and social networks (see [section 3.5](#)).

Assessment of risks

Assessing risks is an important part of assessment that can help to determine the timing and focus of psychosocial interventions.

Specific risks related to drug use include overdose, polydrug and alcohol misuse, unsafe injecting practices and unsafe sex. Wider risks may include self-harm or harm to others.

Risks to dependent children should be assessed as soon as possible after contact with services.

The aim of identifying risks is to develop a plan of action that prioritises, reduces or eliminates them. There may be risks that pose a serious challenge to the person's recovery. The focus of psychosocial interventions may then need to be on addressing some of these risks as a priority, agreed with the service user. However, the clinician may also have to take account of some reluctance to engage fully in treatment in certain cases (e.g. where there are concerns about dependent children or where stopping unsafe injecting is not an agreed goal).

The management of this by the clinician requires some skill and sensitivity which can be supported by clinical supervision.

The assessment process can provide an excellent opportunity for clinicians to provide brief interventions to reduce immediate harm from drug misuse including, if needed, access to sterile injecting equipment, testing for hepatitis and HIV, immunisation against hepatitis B, providing overdose prevention training and take-home naloxone. All of these can enhance the patient's experience of being respected, enhance the therapeutic alliance and improve engagement.

It is important to assess the most appropriate level of expertise required to support the service user, and liaise with or refer appropriately, for example, to clinicians who have relevant competencies in treating specific elements of drug misuse or in delivering specific psychosocial interventions.

Tools used in the process of assessment

The assessment process should result in a clear understanding of clinical issues and the service user's aspirations for treatment, and their strengths and their risks. This can then be referred to and used as a basis for formulating with them their treatment and care planning goals and the package of psychosocial interventions offered or chosen, and can be used to inform any risk management plans.

Routine screening tools such as the Alcohol Use Disorders Identification Test (AUDIT) or outcome measures such as the Treatment Outcomes Profile (TOP) may provide prompts for further discussion of psychosocial issues.

While a range of other tools can be useful at the assessment phase in determining priorities for intervention, these are generally used selectively on a case-by-case basis. For example, various mental health screening tools may be used by the assessor, particularly where it may be important to treatment planning. This is discussed in more detail as part of enhanced assessment below.

Conventional checklist methods of assessment are often not the best way of capturing strengths and risks or engaging service users in the care planning process. Asking open-ended questions and adopting a motivational, guiding style is more likely to be effective in engaging patients and should be used as during assessment. Substance use diaries can enable service users to take an active role in the process.

Mapping (including node link mapping) can also support a reflective and collaborative approach. Terms such as 'node link mapping' and 'mapping' are often used interchangeably to describe clinical tools and interventions used to enhance keyworking sessions. The generic term 'mapping' is used here to encompass these. Mapping is a simple technique for presenting verbal information in the form of a diagram or map. It has been shown to have positive benefits for counselling interactions with service users, irrespective of the style of counselling used. It can be used to encourage a sense of collaboration by taking the direct focus off the service user and putting it on a visual map summarising the therapeutic issues. Drawing out the issues under discussion in a diagrammatic form has been shown to enhance therapeutic engagement and alliance.

Using maps can:

- provide a workspace for exploring problems and solutions
- improve therapeutic alliance
- enable clearer and more systematic thinking
- create memory aids for service user and counsellor
- provide a method for getting unstuck by providing new ideas
- focus attention on a certain topic
- provide easy reference to earlier discussions.

Typically, a map is in one of three forms:

- ‘knowledge maps’ that are pre-prepared and structured, and typically used to convey information, and that facilitate discussion and service user understanding (for example, ‘a managing overdose’ map)
- ‘free maps’ that are initially an empty page but are developed with the service user to represent and explore personal issues, and can be used to respond to a service user’s emerging concerns (for example, considering how a lapse occurred)
- ‘guide maps’ that provide a framework of questions or themes which the service user is usually taken through by the keyworker on common or important topics, and enables service users’ reflections within a defined structure (for example, a map used to look at personal strengths).

The choice of which type of map to use will be determined by the goals of the keyworking session, the worker’s ability to negotiate a shared agenda with the service user and to agree how those agenda items may be best fulfilled.

It is important to note that a map only has value in so far as it enhances communication and understanding between keyworkers and service users, so a ‘good’ map does not exist outside of a specific communication and relational context. Mapping is best thought of as done with service users not to service users.

The technique of mapping has been tested and adapted in UK treatment services, and maps for supporting treatment sessions have been published in the ‘Routes to Recovery’ series (NTA 2010 and PHE 2013).

3.7.1.2 Assessment phase: enhanced care

Service users with specific cultural and complex social needs, and those with mental health problems including any cognitive impairment, should be identified as part of the assessment process given the individuals may be at particular risk of early disengagement from treatment if such needs are not identified and addressed. Service users who have repeatedly dropped out of treatment will already be known to services, providing an opportunity to offer targeted interventions (see [engagement phase section 3.7.2](#)).

Screening and assessment of mental health problems

There are high rates of mental health problems within the substance misuse treatment population. These include developmental disorders, common mental health problems, personality disorders and severe and enduring mental health problems. Substance use can be both a cause and consequence of mental health disorders and some mental health symptoms improve with abstinence from substances. There is commonly an ongoing interaction between substance use and mental health symptoms, where each can affect vulnerability to developing the other or influence its clinical course and outcome.

When discussing mental health issues with patients, it is important to consider the role of substances in relation to the problem. Patients may consider substances to be a way of managing emotional distress and therefore have concerns about dropping this perceived way of coping. There is evidence that stabilising substance misuse can be beneficial for mental health. Commonly, therefore, the first line of intervention will generally be standard drug treatment while also assessing the impact of this on mental health. However, in particularly severe or acutely risky cases it may be essential to prioritise specialist mental health assessment, which may only be available from a specialist mental health team. Substance misuse services should endeavour to make effective partnerships with these teams and to support mental health services to accept referrals for assessment. This requires collaboration and partnership and may be assisted by having staff with mental health experience working in substance misuse services to identify which service users are appropriate to refer, and to forge relationships with colleagues in mental health (PHE and NHSE 2017 in press).

Detecting mental health needs at assessment can enhance engagement by anticipating possible barriers, and it enables provision of brief advice and information. For example, implementing simple strategies for managing depression or anxiety can give the service user a sense of their ability to make progress. Appointments can be sensitively scheduled to take account of mood and anxiety problems and increase the likelihood of attendance.

Mental health needs may be identified through use of screening tools, the historical information available, through prior knowledge of the service user or through a sensitive appraisal at assessment.

Tools to assist identification of mental health problems

Some services may rely on assessment by more specialist mental health trained staff to assess suspected mental health problems, but it can also be helpful to use dedicated tools where there are concerns. In addition, routine screening for depression and anxiety may form part of the agreed assessment process locally. Such tools should only be introduced with adequate clinical governance to ensure their proper use (and understanding of their limitations and benefits).

Potentially useful tools include:

- Patient Health Questionnaire (PHQ-9) which can be used for screening for depression
- Generalised Anxiety Disorder Scale (GAD-7) which can be used for anxiety disorders
- Eating Disorder Examination – Questionnaire (EDE-Q) which can be used to screen for eating psychopathology

- Primary Care PTSD Screen (PC-PTSD) which can be used to screen for PTSD
- PTSD Checklist Civilian Version (PCL-C) or Impact of Events Scale (IES-r), which can be used by an appropriately trained clinician to screen for PTSD.

When possible mental health problems are identified, this should lead to a discussion with the service user about the value of referral for assessment from a clinician with skills in assessing and treating mental health problems. The timing of any referral to specialist mental health services is important and needs to be sensitive to service user need and concerns.

Cognitive impairment

Cognitive impairment, including learning disability, can be present in those with substance use disorders. It is associated with negative outcomes including poor retention in treatment, reduced likelihood of achieving abstinence and greater risk of relapse. When cognitive impairment is suspected or self-reported further assessment may be indicated.

Screening tools include the Montreal Cognitive Assessment (MoCA), the Addenbrookes Cognitive Examination (ACE-III), the Mini-Mental State Examination (MMSE) and the General Practitioner Assessment of Cognition (GPCOG). The MoCA has been shown to identify impairment in substance using populations and the ACE-III is more specific than the MMSE in assessing the key cognitive domains affected by substance use. Interpretation requires a suitably competent clinician.

Where screening highlights deficits in one or more cognitive domains, advice on adaptation of psychosocial interventions may be needed, such as:

- shortening the length of sessions
- increasing the frequency of sessions
- involving family members or concerned others to provide reminders or to assist with agreed goals and using memory aids (e.g. cue cards, visual prompts)
- using mapping techniques.

In the most complex cases, a referral for comprehensive neuropsychological assessment or an occupational therapy functional assessment may be needed.

3.7.2 Engagement phase

Engaging a service user in treatment and building a therapeutic alliance are key steps towards facilitating recovery in treatment settings. The frequency with which service users attend their appointments and the level of active participation in the process of treatment are both important markers of engagement. They are both helped by having a clear and consistent focus on the service user's aspirations for change.

Patients who are highly motivated at intake are twice as likely to participate in treatment in the first few months. Furthermore, patients achieving higher participation are then twice as likely to develop a favourable therapeutic relationship with their counsellor. The engagement phase may therefore vary enormously in length, and may be very short for those with high levels of recovery capital.

For those with opioid dependence and complex associated problems, access to medication is one of the key drivers of early engagement. However, the process of developing a strong therapeutic alliance may be more important in promoting recovery in the longer term. Clinicians should therefore attend to markers of whether someone is engaged with the treatment process, and act if they are not.

3.7.2.1 Engagement phase: standard care

Many factors determine the nature and degree of engagement, including:

- service user factors – nature and degree of drug use problems, level of motivation for change
- therapist factors – motivational style of communication, and empathy
- service and organisational factors – ease of access, availability (opening hours), and the provision of services that service users find useful such as legal and welfare benefits advice, and housing support.

Two simple measures act as markers of service engagement:

1. **Attendance at appointments** is an obvious marker of effective engagement, and reasons for non-attendance may be:

- service-related (inaccessible service, restricted opening times)
- personal (forgetting, oversleeping, lack of money, other priorities).

A tailored plan using simple strategies to encourage attendance (e.g. texting in advance or scheduling to coincide with another appointment) should be used.

2. **Level of therapeutic alliance** is usually determined by clinical judgement (although can be measured using brief measures such as the Session Rating Scale). Practitioners, and their supervisors, should actively consider therapeutic alliance and plan actions to improve it if required. Techniques such as motivational interviewing and mapping have been shown to improve therapeutic alliance.

Strategies for improving levels of engagement include:

- the use of special 'induction' efforts (such as structured programmes to orientate service users to treatment)
- using motivational interviewing techniques
- incentivising attendance with contingency management, for example, voucher-based incentives for regular attendance.

Consideration should be given to low threshold (e.g. flexible drop-in times for attendance) as well as assertive techniques (e.g. in-reach to hostels) to keep service users with complex needs engaged. Services should make every attempt to re-engage service users that drop out of treatment quickly and proactively.

3.7.2.2 Engagement phase: enhanced care

If standard care does not result in successful engagement, the intensity can be increased. More formal motivational interviewing techniques, contingency management and assertive outreach may all be useful. Inpatient assessment and stabilisation could also be considered, based on clinical need.

Brief motivational interventions for service users not engaged in structured treatment

NICE recommends the provision of brief opportunistic interventions focused on motivation. They normally consist of one or two brief sessions between 10 to 60 minutes, focused on exploring ambivalence about changing behaviour and are offered in a non-judgemental way. They should be offered to people with no or limited contact with services if they have identified concerns about their drug misuse (for example, attendees at a needle and syringe programme or in primary care). They may be useful to enable people to engage in treatment. However, they would not routinely be offered as the main intervention by a keyworker once a care plan for structured treatment is in place.

Motivational interviewing and other motivational enhancement techniques

These incorporate a set of therapeutic principles, an interactional style and specific techniques in which the therapist takes the position of a collaborative partner in discussions with the patient about their drug use. Motivational enhancement would include the use of feedback on structured assessments or test results as part of the process. Therapists use specific skills, such as asking open questions, listening, and summarising the ideas the patient has expressed, reflecting these back and providing affirmations that support the change process. Underlying this approach is the principle that patients persuade themselves that change is desirable, achievable and will bring benefit.

They may be considered a core skill for keyworkers but may also be deployed in a more systematic and structured way as part of enhanced care for those for whom it has been difficult to engage.

Contingency management

Contingency management (CM) is the process of providing incentives typically in the form of vouchers, clinic privileges, prizes or modest financial incentives to modify a person's drug misuse or to increase health promoting behaviours. A growing number of research studies have found CM to be very effective for people engaged in OST who are continuing to use illicit drugs, and it is effective in promoting abstinence in stimulant misusers and cannabis misusers. It is one of only two psychosocial interventions for the management of drug dependence formally recommended by NICE because of the strength of evidence for its effectiveness. In the engagement phase, CM may be used to enhance engagement (e.g. by incentivising attendance at appointments), encourage health-promoting behaviours to reduce harm (e.g. attending for hepatitis B vaccination programmes or testing for blood-borne viruses) or encourage medication compliance.

Contingency management programmes should always be voluntary and require:

- a clearly specified target behaviour (e.g. attending within a specific time-frame)

- a clear method of verification (e.g. vaccination delivered by nurse)
- a finite time period for achievement (e.g. collecting medication from the pharmacy every day for the next week)
- a clear service response (e.g. provision of a £5 shopping voucher for every hepatitis B vaccine received)
- a process for review that is agreed with the service user.

3.7.3 Behaviour change phase

The focus in this phase is on interventions that seek to initiate and maintain change in drug using behaviour and other areas of the individual's life (for example, improvements in mental health, steps towards employment).

For everyone who uses drugs, this phase will include interventions to support maintenance of change and build resilience as well as steps to achieve abstinence with or without the support of medications. However, the clinician should always be ready to provide harm reduction information when needed, and to support engagement and motivation through cycles of abstinence and relapse.

Many patients dependent on opiates, once engaged in treatment, will have stabilised on OST and will opt for a period of OST maintenance. The immediate and obvious benefits that OST brings (including a reduced need to buy and use opioids every day, enhanced tolerance and less risk of accidental overdose, cessation of injecting) mean that some of the initial pushes or pulls that led to treatment entry may diminish. A similar process may also occur with people who use other substances when the 'crisis' that precipitated service contact has passed. Consequently, it is important to identify other changes that the service user wishes to achieve and any ongoing risks to address. Examples might include:

- continued intermittent injecting
- continued intermittent 'on top' use of heroin
- continued involvement in drug supply networks
- continued impact of drug use on the health and wellbeing of the individual and on their family and social networks.

Such behaviours are a suitable focus for psychological and social interventions to support positive, individualised, behaviour change goals.

For all drug users and for opiate users who have adequately stabilised on OST, the focus of recovery support is likely to move to wider recovery goals and general wellbeing. Regular collaborative care plan reviews can be used to set goals and reward achievement, while enhanced visibility of, and facilitated access to, mutual aid should ensure all recovery options are available. The choice of pathway should belong to the service user, and no pathway to recovery should be rejected.

Resources should be used efficiently, avoiding the provision of interventions unlikely to be successful or that could be harmful for those not yet ready to benefit. By developing the care

plan with the service user, it is possible to ensure that the same approach is not applied rigidly across the entire caseload (see [section 3.3.3 on segmentation](#)).

3.7.3.1 Behaviour change phase: standard care

There are two broad goals in promoting and supporting behaviour change in this phase of treatment:

- improvement in drug use behaviours: while abstinence from illicit drug use may be the most effective long-term strategy, any improvement in use (for example, in the amount, type or safety of use) should be seen as a positive move forward
- improvements in other negative behaviours and social issues: this may include better physical health, improved mood, lower anxiety levels, better vocational skills or increased number of days in employment, improved relationships, and a better overall quality of life.

Although there is evidence to support many packages of psychosocial interventions used for abstinence-oriented drug misuse treatment, the evidence for their use in people continuing on OST is more limited. However, in practice it is widely accepted that psychosocial support is important to help OST service users achieve recovery goals.

The speed of recovery and the sequence of steps required to achieve it are highly individualised, and different service users respond to different packages of care. It is helpful to consider a menu of treatment interventions for people at different times in their personal recovery journeys. Four broad strategies have been identified as being common to most effective behaviour change interventions.

1. Engagement, structure and goal direction

The importance of the therapeutic alliance was highlighted in the engagement section above, and it has been consistently associated with treatment outcome.

Patients of therapists who closely follow an underlying theory of treatment tend to experience better treatment outcomes.

Greater clarity and organisation of treatment sessions, and an emphasis on goal-directed work aiming to achieve a service user's personal milestones and objectives, are associated with more positive reactions to treatment and better outcomes.

An effective goal setting exercise has two components:

- considering all possible areas of a person's life where changes could be made, and helping them to prioritise which to work on first
- setting SMART goals (specific, measurable, agreed-upon, realistic, time-limited) and breaking down the initial goal to the smallest possible part helps ensure that the service user can achieve it.

Assessment of strengths (and deficits) naturally leads into goal setting. Done well, setting goals is a 'win-win' exercise. If the service user achieves the goal, the keyworker can praise and encourage them (reward), which increases self-confidence and self-efficacy and makes attempts to achieve further goals more likely. However, failure to achieve the goal also provides valuable information and can highlight specific skill deficits that can be addressed

(for example, assertiveness, communication skills, time keeping, or problem solving), with a subsequent review of progress.

It may also prove helpful to use literature, self-help manuals, websites and apps that aim to highlight recovery stories, provide personal feedback, and support goal setting and skill acquisition (such as learning relaxation and mindfulness).

2. Set up opportunities to use rewards and rewarding activities

Services should consider how the organisation and delivery of treatment can provide opportunities to acknowledge the positive changes that service users make. Shaping behaviour, through rewarding positive change, works better than punishing negative behaviours. The community reinforcement approach focuses directly on support to enable service users to change their lives in a way that intrinsically provides rewards for remaining substance-free and increase the likelihood of pleasurable activities. Formal contingency management programmes may also be deployed to incentivise abstinence or engagement in recovery related activities (see [section 3.7.2.2](#)).

3. Building social network support for change

There is strong evidence that people evaluate and change their substance use behaviour with reference to prevailing social norms, and the provision of normative feedback is likely to be an important ingredient of treatment. There is also growing awareness that involving family and social network members in the treatment process can be beneficial to both the individual and their concerned significant others (see [section 3.5](#)).

Service users can be encouraged to systematically review their current social network through a social network diagram (see [section 3.5](#)).

4. Focus on building self-efficacy and coping skills

Overall, there is evidence that patients' coping skills and self-efficacy improve during treatment and are associated with positive treatment outcomes. It is helpful to focus on building a service user's confidence and ability to manage high-risk drug using situations and life stressors and to resist the urge to return to substance use when experiencing distress.

A motivational interviewing style can be useful because it can help to evoke personal qualities and promote autonomy over decision making (see [section 3.7.2.2](#)).

Simple, structured techniques for focusing on the service user's strengths and on the opportunities they have available to them are a good place to start. Mapping techniques are an easy and effective way to do this collaboratively, supporting the service user to direct the focus and content of the session (see [section 3.7.1.1](#)).

Depending on the outcome of the review of strengths and problem areas, simple skill development activities may provide a focus for ongoing treatment sessions. This could include:

- improving time management
- problem solving
- increasing meaningful activity (e.g. jobs, volunteering, peer mentoring)

- increasing pleasant activities
- identifying high risk drug using situations (e.g. receiving social security payments) and planning how to manage them.

Adapting behaviour change psychosocial interventions for specific substance use problems

OST medications are a powerful means to engage opiate-using service users in treatment and a platform on which to deliver psychosocial interventions (see [chapter 4](#)). However, there are no effective medications for those dependent on stimulants, cannabis, ketamine and many other psychoactive substances (including new psychoactive substances). The mainstay of initial and ongoing treatment for problems with these substances is abstinence-oriented psychosocial interventions.

The broad approach to delivering effective behaviour change interventions described above is relevant for these substance use problems. But exactly how they are packaged and delivered may need to be different to engage people in treatment, since reducing or stopping all use usually requires greater motivation and behaviour change compared to the point of treatment entry.

Clinicians should be sufficiently knowledgeable about the effects of drugs and their associated problems to be able to carry out an adequate assessment, and to provide substance specific health prevention and risk management advice. Structured, care planned treatment is likely to be needed for anyone with a high level of drug dependence, or with complex comorbid problems that impede their ability to resolve their own problems. Many will recover without treatment and others with less structured interventions (such as mutual aid groups), but some will need access to a range of psychosocial interventions. The therapeutic approach and menu of psychosocial interventions is essentially the same for any abstinence-oriented treatment. However, consideration may be given to providing substance specific treatment pathways with which particular service users may be able to identify (for example, access to cannabis-specific groups or to a 'chemsex' programme).

Cocaine and other stimulants

Problem cocaine users may include users of powder cocaine or crack cocaine. Powder cocaine users commonly also use alcohol problematically. Many heroin users may also use crack cocaine as an integral part of their drug using repertoire. Amphetamine and methamphetamine users may also seek treatment (with methamphetamine being increasingly seen among men who have sex with men and are involved in 'chemsex').

Treatment should target the stimulant drug use as well as any co-occurring substance use, calibrated to the severity of dependence and problem complexity. For example:

- A primary cocaine user with a short history of use may benefit from a brief motivational intervention.
- An individual with more severe crack cocaine dependence may respond to attendance at mutual aid groups such as Cocaine Anonymous, while others will not succeed without more structured treatment.

- Those who are using crack cocaine in combination with heroin and wish to address this are more likely to benefit from care planned structured treatment with a keyworker. They may respond to a combination of OST to stabilise heroin use and contingency management to encourage achievement of abstinence from crack and heroin use. However, it is also important to work with any remaining ambivalence about giving up crack use.
- A range of accompanying physical and psychological problems such as weight loss or stimulant-related psychiatric problems may require acute or more prolonged medical or psychiatric interventions.

Cannabis and cannabinoids

Clinicians may meet people seeking help to reduce or stop their cannabis use or to manage side effects. They may be using traditional resin or herbal cannabis, or high-THC herbal cannabis (often known as ‘skunk’).

Repeated and heavy consumption of cannabis may cause physical and mental health problems as well as substantial levels of dependence. The latter can require psychosocial treatments to help avoid relapse following cessation of use.

Heavy cannabis users may experience symptoms such as depression, lethargy, paranoia and memory loss. Cannabis can also trigger symptoms of psychosis and contribute to the development and maintenance of enduring mental health problems. These may need to be a focus of psychosocial interventions, but helping the service user to achieve a period of abstinence may be the key to disentangling difficult diagnostic questions.

Cannabis may only be one of a range of drugs used by the patient, and its use may increase in patients trying to reduce or stop using other drugs. As with tobacco use, the use of cannabis can sometimes be overlooked despite its potential contribution to harm.

There are currently no medications licensed for treating cannabis dependence.

Brief motivational interventions may be effective with less dependent service users, while more heavily dependent service users (and those with comorbid mental health problems) may require structured care-planned treatment for more than four sessions, using motivational enhancement, cognitive behavioural therapy and incentives for abstinence.

In cases of comorbidity with depression and anxiety, treatment should include cognitive behavioural therapies targeting these issues delivered by a competent clinician.

3.7.3.2 Behaviour change phase: enhanced care

There are numerous change-orientated interventions targeting specific psychological or social issues that may be maintaining dependence. A number of formal psychosocial treatments are highlighted in the following section because the evidence suggests that they may have significant clinical benefit.

Where treatments have a more limited evidence base (for example, psychodynamic approaches), it is particularly important to monitor their outcomes regularly. As with other enhanced care interventions, appropriate qualifications, training and supervision in the intervention in question are a requirement.

The main interventions can be broadly described in the following terms:

1. **Cognitive and cognitive-behavioural therapy (CBT) approaches** primarily aim to modify addictive behaviours by changing unhelpful cognitions that serve to maintain behaviour, or by promoting positive cognitions or motivation to change behaviour. Commonly used variants are CBT-based relapse prevention, motivational enhancement therapy, and CBT focusing on treating depression and anxiety. More recent developments of CBT are collectively known as ‘third-wave’ or ‘contextual’ CBT and include acceptance and commitment therapy (ACT) and mindfulness based relapse prevention. Here the emphasis is on mindfulness and acceptance strategies to reduce the impact of internal triggers and encourage psychological flexibility. There is some evidence that mindfulness can reduce cravings and promote abstinence and that the ACT approach has promise as a treatment for substance dependence.
2. **Behavioural approaches** are based on the principles of learning theory and aim to modify learnt drug using behaviours. They include interventions that aim to extinguish classically conditioned cues to using drugs (e.g. cue exposure and response prevention), or that are based on instrumental conditioning (e.g. community reinforcement or contingency management), where positive non-drug taking behaviours are rewarded. The community reinforcement approach is based on the principle that individuals have their own reinforcers which maintain their behaviour (both drug-using and non-drug-using behaviours). By altering these reinforcement contingencies (and involving the patient’s social network in this process), the individual will make changes in their lifestyle that will support the goal of reducing or stopping substance use (see [section 3.5](#)). Contingency management rewards specific behaviours using a structured, transparent approach that increases learning of desired behaviours. Programmes focus on reinforcement for the desired behaviour. This approach has been identified as having the strongest evidence base for the most effective outcomes for the psychological management of drug dependence. Contingency management, as well as encouraging abstinence, may be used to encourage prosocial behaviours (e.g. participation in training schemes or voluntary work) or reduction of illicit drug use (see [section 3.7.2.2](#)).
3. **Family, couple or social network interventions** are based on the principle that substance use occurs in a social context, which can both enhance and undermine behaviour change. Changes in the family system are targeted, and core elements are improving communication skills, problem-solving, reinforcing prosocial behaviour and reducing unhelpful behaviours (e.g. collusion, enabling) to improve the quality of relationships and reduce stress. Behavioural couples therapy and family therapy are examples of this approach. Other interventions work with the broader social system surrounding with patient to promote behaviour change. Social behaviour network therapy (SBNT) explores and builds social network support for changing drug-using and other behaviour. It aims to develop positive social support for change in drug misuse and diminish support for continuing use.
4. **Social skills training** refers to methods that use the principles of learning theory to promote the acquisition, generalisation and durability of skills needed in social and interpersonal situations. Training should take place in the context of real everyday life experiences.

5. **Vocational training** includes a range of programmes designed to help patients find and retain employment. Vocational training can include skills training, sheltered work environments and monitoring of drug use during employment.
6. **Leisure activities** – the ability of patients to participate in and enjoy leisure activities of their choice is an important aspect of psychosocial support. Programmes can provide access to a range of healthy leisure activities.
7. **Housing services** can vary from group accommodation for people experiencing homelessness to more stable, affordable, long-term accommodation. The importance of housing is such that assistance with housing may be necessary before cessation of drug use can be achieved. While there may be risks in accommodating people who use drugs together in institutional settings, stable accommodation in a drug-free environment is desirable. The strategies adopted will depend on local resources.

Psychosocial interventions delivered in groups

Many interventions that can be delivered to individuals can be adapted to be delivered in groups. Groups should be offered to patients based on their preferences and in a way that allows them to make an informed decision to participate. They would generally be an adjunct to one-to-one support. Group interventions may be a way of delivering effective care to a larger number of patients and can encourage peer identification, mutual support and exposure to therapeutic opportunities not available in one-to-one work. However, there are significant risks of service user attrition from groups provided in community treatment settings and significant resources, including staff training and supervision, need to be deployed to make groups safe and viable.

Groups may be developed to support specific treatment functions (for example, induction or preparation for detoxification), or to encourage peer support (e.g. SMART Recovery). They may be underpinned by a specific theoretical model and be highly structured (for example, a mindfulness based relapse prevention group) or more exploratory. Depending on the focus and function of the group, it may be open, with a low threshold of access, or closed: restricted to a particular cohort of service users. Closed groups are better suited to content that might be emotionally challenging. Attention to group composition is advised for these groups, with pre-screening for suitability and ability to mix with other service users.

Coexisting substance use and mental health problems

Co-occurring mental health problems are common in drug treatment populations. Evidence-based guidelines exist for the treatment of many of these mental health problems and, in general, the coexistence of a drug problem should not be a reason for denying a service user access to the recommended treatment usually provided by mental health services.

For some service users it will be necessary to include a dual focus on these issues in an enhanced treatment package. This can be the adaptation of a single treatment approach (for example, cognitive-behavioural therapy) to address both disorders simultaneously as well as the blending of two evidenced-based treatments (such as cognitive-behavioural therapy and motivational interviewing). While there is growing research in this area, to date effectiveness of

specific dual-focused treatment combinations has mainly been found for depressive disorder, bipolar disorder and post-traumatic stress disorder. The availability and implementation of specific dual-focused treatments will be affected by the competencies of staff, available supervision and the treatment orientation and provision of services.

Management of coexisting mental health problems or disorders will also need to be provided from mental health services, using an integrated or parallel model depending on local service configurations and pathways of care. See [section 7.9](#) for the broader discussion of the framework of provision and pathways of care for those with coexisting mental health and substance use problems.

Depression

Patients may present with depressed mood following recent substance use, intoxication or withdrawal. However, primary mild or moderate depressive disorder is also very common.

For a mild or moderate depressive disorder, cognitive behavioural guided self-help can be helpful (one or two sessions) and should be provided as part of routine clinical care (e.g. within keyworking).

Dual-focus treatments that combine cognitive (e.g. cognitive restructuring), behavioural (e.g. behavioural activation) and motivational (e.g. motivational interviewing) components have been shown to be superior to no treatment, with better outcomes at follow-up than parallel treatments. If treatment is offered as an adjunct to standard care, psychological therapy for depression should ideally be co-located with substance misuse treatment services as this may improve retention.

Bipolar disorder

Dual focused treatments focused on bipolar disorder, substance use disorder and their interactions, that are based on cognitive behavioural principles, should be offered to individuals with these co-occurring disorders. This would generally be by mental health services. Randomised control trials indicate better impact on depressive, manic and substance use symptoms relative to comparison treatments.

Post-traumatic stress disorder (PTSD)

Very high rates of PTSD have been reported in those attending substance misuse treatment services. It is essential that all services assessing for drug misuse treatment can identify possible PTSD and can confirm diagnosis or can refer to a specialist team for confirmation of the diagnosis.

There is a need for collaborative working between services treating PTSD and drug misuse treatment services where this is not available in-house.

Trauma-focused treatments with an exposure component (in combination with intervention for substance misuse) have been shown to reduce PTSD severity in individuals with co-occurring disorders. However, some individuals may require stabilisation treatments (for example, to reduce risky behaviours and increase emotional regulation skills) to help prepare them for trauma-focused treatment and minimise drop-out.

Treatment for complex PTSD requires a phase-based approach initially oriented to safety and symptom stabilisation (present-focused), followed by processing of traumatic memories (past-focused), and re-integration (future-focused). Stabilisation of drug misuse can support this phased approach but the specific role for substance misuse services in relation to trauma treatment would be determined locally.

Anxiety disorders

Diagnosis of a comorbid anxiety disorder is common in those with substance misuse problems.

Sometimes, confirmation of diagnosis and treatment planning needs to await stabilisation of substance use although advice on anxiety management can often be given at assessment.

The use of the standard interventions for treatment and management of anxiety disorders, in line with current NICE guidelines, should be recommended to patients, when appropriate. These may be provided by specialist mental health services, or integrated in-house if feasible.

Eating disorders

Eating disorders are commonly seen alongside substance use disorders but there is little research on the co-occurring conditions.

The use of the standard interventions for treatment and management of eating disorders, in line with current authoritative guidelines, should be recommended to patients, when appropriate.

Common components of the management of both disorders can include psychoeducation, cognitive restructuring and teaching coping skills (and this would be likely to include asking the patient to reflect on the impact of the one disorder and its associated behaviours on the other). Targeting psychological processes that characterise both disorders (e.g. emotion dysregulation) may be helpful for each condition.

Personality disorder

Identifying personality disorder can help to point to potentially appropriate treatments and can help in planning for management of complex needs.

Patients with personality disorder should be offered relevant drug treatment regardless of whether they are involved in treatment services for their personality difficulties. Patients with borderline personality disorder, for example, can remain under the care of mental health services for treatment of their personality difficulties, and be referred to drug treatment services for assessment and management of their drug dependence. However, some patients with personality disorders will have difficulties engaging with mental health and may remain exclusively under the care of drug treatment services for periods of time.

The use of standard interventions for the treatment and management of personality disorders in line with current authoritative guidelines should be recommended to patients where appropriate. This treatment (whether offered in-house or in a specialist mental health team) should form part of a broader case management approach to aid the management of complex dynamics (e.g. splitting) that often accompany the treatment of patients with personality disorders.

Patients with comorbid personality disorder and substance use who are experiencing a psychiatric crisis will require assessment and management of the crisis through the established systems and pathways of emergency psychiatric care.

Psychosis

Typically, mental health services or the GP will take the lead in caring for individuals with this comorbidity.

At present, there is not sufficient evidence to recommend dual-focused treatment for management of psychosis and substance use disorder.

Patients should therefore be offered specific interventions for each disorder (e.g. substance misuse and psychosis) as outlined in existing guidance.

3.7.4 Early recovery phase

For those who have achieved sustained abstinence from problem substance use, completing formal treatment may require a focus on building resilience to manage without professional support, to help ensure positive gains made during treatment are sustained.

For those stable on opioid substitution medication who are no longer using illicit drugs in addition to their prescription, the goal of this phase of treatment is to maintain this stability while achieving recovery goals and increasing integration into positive social networks. The level of keyworker engagement and frequency of review of care plan goals may be substantially less than earlier phases of treatment, but the clinician needs to be aware of possible risks while helping the service user prepare for abstinence from prescribed medication if they wish to pursue this goal.

Building resilience is a key task centred on a reconnection with, or development of, activities that provide valued meaning and purpose. Work, involvement with peer support and involvement with mutual aid are all good examples of such support structures.

It is important that the decision to end an episode of treatment is service user-led. There is no evidence that service-directed time limits for treatment achieve positive outcomes for service users. The risks of accidental overdose and death are increased in the period immediately after opioid substitution prescribing ends, and lapse back to substance use is extremely common in the first year after completing a treatment episode for dependence. There is therefore an important balance to be struck in remaining encouraging and optimistic about the decision to leave structured treatment, while communicating the risks, and while discussing the options for re-engaging with treatment if needed.

It is important that individuals can gain rapid access to support if they require it after discharge. Early re-engagement in structured treatment may prevent a more serious relapse and reduce the eventual length and intensity of treatment required.

Patients may also benefit from a package of planned ongoing aftercare, which may include psychosocial supports such as group attendance or engagement with mutual aid, alongside some feedback mechanism on progress, whether by telephone or face-to-face review. Reminders can be used effectively to encourage former patients to use aftercare services. 'How are you doing?' contacts can themselves help sustain the impact of the initial

treatment, and a 'recovery check-up' is an opportunity to contact ex-service users to offer encouragement and support as well as identify where extra support may be required.

Ongoing support and help to maintain health and wellbeing from a GP is also important, together with support from social care providers (such as housing, education or employment access schemes). Support may also be provided through organisations such as Narcotics Anonymous, Cocaine Anonymous and SMART Recovery.

3.7.4.1 Early recovery phase: standard care

Keyworking during this phase is focused upon strengthening recovery resources, further developing a system of support and enhancing confidence with a view to ending formal treatment for those sustaining abstinence. It is a phase of both consolidation of learned skills and the ongoing development of new ones. A range of issues are likely to be the focus of keyworking sessions including peer support, family support, parenting support, housing, employment, education and training, general health, mental health, and relapse prevention skills.

Psychosocial interventions

Once complete abstinence is achieved, or abstinence from all illicit drugs, relapse prevention strategies are essential. Cognitive-behavioural relapse prevention can be delivered on an individual or group basis. Typical components of a relapse prevention programme include:

- identifying high-risk situations and triggers for craving
- developing strategies to limit exposure to high-risk situations
- developing skills to manage cravings and other painful emotions without using drugs
- learning to cope with lapses
- learning how to recognise, challenge and manage unhelpful or dysfunctional thoughts about drug misuse
- developing an emergency plan for coping with high-risk situations when other skills are not working
- generating pleasurable sober activities and relationships, improving quality of life and attaining a lifestyle balance.

Relapse prevention is enhanced if others support this work outside the treatment setting. By combining an individual or group based intervention with an assessment of the service user's social network support and links to mutual aid or other communities of recovery, the keyworker can help the service user to develop a social network relapse prevention plan (see [section 3.5](#)).

Vocational and skills training are also very useful in this phase, as is assertive linkage to community recovery resources such as mutual aid groups and recovery cafes.

Mutual aid, peer support and community recovery resources

Mutual aid, peer support and recovery communities can help support and sustain recovery journeys for individuals affected by drug use who engage in treatment: before, during and

after such treatment. They can also provide support if someone lapses or relapses following a period of sustained recovery (either still on medication or after leaving formal treatment).

Professional treatment is only part of a service user's recovery journey. For many, their early steps to recovery may be instigated and supported while receiving professional treatment but an important feature of their personal sense of recovery is the ability subsequently to live a healthy and fulfilling life in the community without any formal treatment. For others, including some of those stabilised on long-term OST, their personal sense of recovery involves remaining abstinent from all illicit drugs while living a healthy and fulfilling life in the community in continuing receipt of maintenance medication. In either case, some will opt to remain engaged with mutual aid, peer support or within a wider recovery community and will contribute to the recovery of others through this process.

Mutual aid groups

These come in different types, with the most widely available groups based on 12-Step principles (e.g. Narcotics Anonymous, Alcoholics Anonymous and Cocaine Anonymous). SMART Recovery groups (informed by rational emotive behaviour therapy) offer an alternative or additional resource.

The combination of mutual aid with treatment is associated with enhanced outcomes. Participation in mutual-aid groups is associated with improved long-term recovery rates, improved functioning across a range of domains, and a reduction in post-recovery costs to society. The risk of relapse following recovery initiation rises in relation to the density of drug users in the post-treatment social network and declines in tandem with social network support for abstinence.

Social support is one of the primary mechanisms of change within recovery mutual aid societies. There is evidence that mutual aid is effective through enhancing motivation for recovery, helping members to reconstruct a positive identity, improving coping skills and through the positive effects of altruism. There is some evidence that post-treatment engagement in mutual aid has benefits to the children of substance-using parents. More active engagement with mutual aid groups (for example, attending at least weekly, committing to a group, helping others or becoming a sponsor) is associated with better outcomes.

Active linkage to mutual aid

The likelihood of a service user's engagement with mutual aid is influenced by professional attitudes towards it, and is increased if attempts at linkage are active (e.g. through taking someone along) rather than passive (e.g. through leaflets). Timing is important, as it is better to link during treatment than after treatment. Weak linkage procedures are likely to result in less positive effects.

Professionals should be aware of the range of mutual aid meetings locally and emphasise the importance of mutual aid participation, particularly for those with extensive substance-using social networks. Ideally professionals should visit an open meeting and be able to accurately educate service users on what to expect. Mutual aid group representatives are often willing to give presentations to treatment and support professionals.

Suggested active linkage strategies:

- Ask the service user to ring the mutual aid group local or national helpline while in the presence of the keyworker.
- Introduce the service user to an existing group member and set up an appointment to attend a meeting.
- Arrange to take the service user to the first meeting.
- Set up a review appointment to address concerns and encourage further engagement.
- If available, service users should be encouraged to sample a variety of meetings until they find one they are comfortable to be in.

Community recovery resources

Community recovery centres – such as recovery cafes, social and sports groups – have developed in many towns and cities. The activities they run, such as peer mentoring, leadership training, support groups, telephone check-ins and social events, are associated with improved outcomes. Treatment providers should be knowledgeable about such local resources and connect service users to them as a way of building their recovery capital.

Recovery residences – such as sober living houses, recovery homes, and Oxford Houses* – promote recovery from substance use and associated problems. There is an emerging evidence base on their effectiveness.

(*Oxford Houses are a specific model of recovery residence embracing a community-based approach to drug treatment, providing a democratically run, safe, drug-free and supportive living environment)

Peer recovery support services

Peer recovery support services are delivered by people in recovery to peers with substance use disorders. Such interventions are associated with reduced relapse rates, increased retention in treatment, better relationships with treatment providers and social supports, and increased satisfaction with the overall treatment experience.

Treatment providers should use trained and supervised peer supporters or recovery coaches in clinical settings. Such peer supporters may be volunteers or can be in paid roles. Peer supporters can act as efficient conduits to bridge service users to mutual aid and other recovery resources, and may be able to assist with recovery check-ups.

3.7.4.2 Early recovery phase: enhanced care

Services may wish to consider extended recovery support programmes beyond treatment for some individuals. Those who have had multiple previous failures at sustaining abstinence may fall into this category. A combination of psychosocial interventions (e.g. cognitive behaviour therapy and medications for relapse prevention supported by contingency management for abstinence) can be helpful at this stage.

Some individuals will opt for, and engage very successfully in, time-limited programmes of intensive recovery support either in a residential setting or in a community day programme,

to prepare themselves for sustaining their recovery long-term (the programmes typically supporting abstinent recovery only). Pathways to, and entry criteria for, accessing such programmes should be as clear as possible to staff and drug service users.

Residential treatment and structured day programmes

Residential rehabilitation programmes are one of the longest established forms of treatment for drug dependence. The evidence base is mixed, with methodological problems inherent in studying or comparing this intervention. While those who complete residential treatment programmes have better outcomes than those who do not complete, cost-effectiveness still needs to be formally assessed in research. Despite this, residential rehabilitation may be an important option for some people requiring treatment for drug dependence.

Many of those who choose to pursue residential or intensive day treatment will have previously engaged in community interventions and come to a point where they feel such options are now appropriate for them and they are ready to engage. The best outcomes are seen for those who complete full programmes. Where abstinence from opiates is the goal, service users need to be made aware of the danger of relapse and overdose. Strategies should be in place to warn clearly of the risks and to mitigate these. This includes take-home naloxone training. Pathways to early reengagement with community treatment services need to be in place for those who do not complete treatment or who relapse after completion. The decision to pursue an abstinence based approach should be voluntary and the benefits and risks of this approach, as for any other treatment option, should be discussed openly and supportively to help patients make informed choices.

The range of therapeutic approaches employed in residential treatment makes some programmes especially suitable for those with the most complex needs and for those who “have not benefited from previous community-based psychosocial treatment” (NICE 2007). However, there will be some people who desire to go directly into residential treatment and some may benefit from doing so. Such decisions will need to rely on a best clinical judgement.

Although most residential settings are focused on abstinence from illicit and prescribed medication, there is emerging evidence from outside the UK of benefit for service users receiving OST and residential treatment simultaneously. However, at present there is insufficient evidence to make a recommendation for this approach.

Structured day programmes normally require service users to attend four or five days a week during the day. Programmes are typically of finite length and are structured with a compulsory rolling schedule of activities, which often includes group work. The aim is to improve social functioning and to help service users achieve their goals focusing on community rehabilitation.

These programmes may suit those with greater recovery capital or social support and can be comparable to residential programmes in terms of effectiveness although they have significantly higher drop-out rates, particularly for those dependent on opiates.

3.8 Resources and further reading

Routes to Recovery via the community: mapping user manual (PHE 2013) www.nta.nhs.uk/uploads/ntamappingmanual.pdf

Routes to Recovery via criminal justice: mapping user manual (NTA 2010) www.nta.nhs.uk/uploads/mappingusermanual.pdf and www.nta.nhs.uk/routes-to-recovery.aspx

Medications in recovery: best practice in reviewing treatment – supplementary advice from the Recovery Orientated Drug Treatment Expert Group (PHE 2013) www.nta.nhs.uk/medications-in-recovery-reviewing-treatment.aspx

3.9 References

Moos R (2007) Theory-based processes that promote the remission of substance use disorders. *Clin Psychol Rev* 27(5): 537-551

NICE (2007) Drug misuse: psychosocial interventions. NICE clinical guideline 51. London: National Institute for Health and Care Excellence

NTA (2010) Routes to Recovery via criminal justice: mapping user manual. London: National Treatment Agency for Substance Misuse

PHE (2013) Routes to Recovery via the community: mapping user manual. London: Public Health England

PHE & NHS England (2017) Better care for people with co-occurring mental health and alcohol/drug use conditions: a guide for commissioners and service providers. London: Public Health England

Recovery Orientated Drug Treatment Expert Group (2012) Medications in Recovery: Re-Orientating Drug Dependence Treatment. London: National Treatment Agency for Substance Misuse

Chapter 4: Pharmacological interventions

4.1 Key points

- Methadone and buprenorphine are both effective medicines for maintenance treatment for heroin dependence, particularly when taken within the optimal dose range.
- Death during induction on opioid substitution treatment (OST) remains a rare event but close monitoring and prompt corrective action are needed, particularly in the first month.
- Dose induction should aim carefully, as soon as possible, for a stable dose of opioid that avoids both intoxication and withdrawal. Dose induction with buprenorphine may be carried out more rapidly with less risk of overdose.
- Supervised consumption should be available to all patients to support induction on to opioids, and provided for a length of time appropriate to their individual needs and risks.
- Patients must be made aware of the risks of their medication and of the importance of protecting children and others from accidental ingestion. Prescribing and dispensing arrangements should also aim to minimise risks to children.
- For treatment of addiction to opioids other than heroin, methadone or buprenorphine substitution is commonly used but alternative opioids may sometimes be chosen after careful consideration.
- It can be extremely important to patients to know that pharmacy staff will give professional care and will protect their privacy and dignity, in confidential and in open pharmacy areas.
- Overdose awareness training and access to take-home naloxone can be important for those with heroin dependence but this should not delay initiation of induction on to OST.
- A key goal of OST is to provide the dose that leads to complete cessation of heroin (and other illicit opioid) use, which may be higher than the dose at which the patient feels 'stable'.
- Clinicians should aim to optimise treatment interventions for patients who are not benefiting from them, by intensifying support (pharmacological and psychosocial) rather than reducing it.
- Opioid detoxification should be offered for suitable patients, with preparation and provision of post-detoxification support to prevent relapse, and support in place for rapid re-engagement.
- Methadone, buprenorphine and lofexidine are all effective in detoxification. The medicine on which a patient has been maintained should normally be used to start the detoxification.

- In highly motivated patients, naltrexone, provided with adequate supervision and as part of a programme of supportive care, can be helpful to maintain abstinence following detoxification.
- There is compelling evidence for providing supervised programmes of injectable opioid treatment (primarily heroin) for a minority who do not respond to optimised oral OST.
- Prescribing benzodiazepines for dependence is more likely to be appropriate in secondary care and will normally be provided as a time-limited detoxification programme.
- There are no specific pharmacological treatments to eliminate the symptoms of withdrawal from stimulants although the symptomatic treatment of acute psychiatric syndromes may be needed. Psychosocial interventions are the mainstay of treatment.

NB: The principles described in this chapter apply to all patients but there are specific issues in relation to prescribing for young people described in [section 7.10.8](#).

4.2 Prescribing

4.2.1 The responsibility of the prescriber

Prescribing is the responsibility of the person signing the prescription. This includes a non-medical prescriber, whether working as a supplementary or independent prescriber.

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

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

The British National Formulary (BNF) is updated twice a year and is a key reference for prescribing. The dosages stated in these guidelines and in the BNF are intended for general guidance and represent (unless otherwise stated) the range of dosages that are generally regarded as being suitable for prescribing to treat adults who have become dependent.

A clinician who is more experienced in the treatment of drug misuse, and in the use of medications for its treatment, and who has adequate access to support and monitoring of the patient may feel it is appropriate, in certain circumstances, to depart from these guidelines. A less experienced clinician, particularly if their ability to monitor progress is limited, may feel less able to do so, and may need to take further advice or change the support arrangements before being able to do so. Clinicians, however, should always work within a clinical governance framework drawing on established standards and the evidence base. Clinicians must be prepared to justify their clinical decisions, and keep comprehensive contemporaneous notes to support their decisions. Obtaining informed consent requires that relevant issues, including the evidential basis of treatments, are discussed with the patient

agreeing to them. In addition, there may be local policies on use of off-label or unlicensed medications that need to be followed.

4.2.2 Deciding whether to prescribe

As part of obtaining suitably informed consent of the patient, the clinician should be clear as to the desired outcomes before initiating any medication. These could be to:

- help achieve the patient's expressed goals
- reduce or prevent withdrawal symptoms (usually this will be a first step in initial stabilisation but in some cases the patient will want this to be an immediate start of a planned detoxification)
- break completely with all illicit opioid drug use and associated unhealthy risky behaviours and stabilise other drug intake and lifestyle
- reduce illicit opioid use with positive change in drug taking and risk behaviour
- encourage cessation of injecting
- help to maintain contact with clinicians and offer an opportunity to work with the patient further.

Opioid substitution treatment has a well-established evidence base for the management of heroin dependence. For dependence on opioids other than heroin, while the evidential basis for choice of substitution medication is very limited, the same substitute opioids are also commonly used by clinicians – although alternative opioids are sometimes prescribed in such cases after taking careful account of a patient's circumstances and preferences. A prescription for opioid substitute medication should normally only be considered if:

- opiates are being taken on a regular basis – usually daily
- there is convincing evidence of current dependence
- the assessment – including history, examination and toxicology – clearly substantiates the diagnosis and the need for treatment (when objective signs can be particularly useful or sometimes essential e.g. evidence of injecting sites or evidence of opioid withdrawals – see [table 2](#) for the latter)
- the clinician is satisfied that the patient may be able to comply with the prescribing regimen
- the patient is not receiving an opioid prescription for management of dependence from another clinician.

Before prescribing substitute drugs the clinician should conduct a suitably comprehensive assessment for this purpose and should agree an initial care or treatment plan with the patient (see [section 2.2](#)).

For suitably safe prescribing, as a minimum, agreement is needed from the patient to ongoing attendance for prescribing reviews and therapeutic monitoring by a clinician. This will normally involve the need to agree to engage at least in a minimum level of keyworking and care planned treatment.

Patients on medication need to be advised that engagement with skilled keyworker support for care-planned treatment and with relevant psychosocial interventions can enhance the treatment and recovery experience and can enhance the outcomes achieved on medication.

Table 2: Signs of opiate withdrawal

Objective signs of opiate withdrawal	Subjective signs of opiate withdrawal
<ul style="list-style-type: none"> • yawning • coughing • sneezing • runny nose • lachrymation • raised blood pressure • increased pulse • dilated pupils • cool, clammy skin • diarrhoea • nausea • fine muscle tremor. 	<ul style="list-style-type: none"> • restlessness • irritability • anxiety <p>(The signs listed above may also be useful objective signs)</p> <ul style="list-style-type: none"> • sleep disorders • depression • drug craving • abdominal cramps.

4.2.3 Prescriptions for and management of controlled drugs

There are strict rules governing the writing of prescriptions for medicines controlled under the Misuse of Drugs legislation. Detailed requirements are described in the British National Formulary and in [annexe A4](#) (Writing prescriptions).

Some NHS and independent organisations providing services that involve the management or use of controlled drugs are required, by law, in England, Wales, Scotland and Northern Ireland, to appoint an accountable officer.

Accountable officers are responsible for ensuring compliance with misuse of drugs legislation and the safe, effective management of controlled drugs within their organisations and within services they contract. They play a key role in implementing new arrangements, monitoring systems, auditing controlled drug management, inspecting, and investigating and taking appropriate action where concerns are raised.

If prescribers have concerns about pharmacists dispensing controlled drug prescriptions or if pharmacists have concerns about the prescribing of controlled drugs, they should report their concerns to the relevant accountable officer.

Regular pharmaceutical advice can help ensure that policies and procedures concerning controlled drugs comply with current legislation.

4.2.4 Communication between prescriber and dispensing pharmacist

The relationship between the prescriber and the pharmacist who is dispensing (and often supervising the consumption of) prescribed medicines is important. The name and address of the dispensing pharmacy should be kept up to date and recorded in the patient records.

Prescribers should liaise with the pharmacist when first prescribing controlled drugs for a patient and when the patient starts with a new pharmacy (as the first contact for ongoing two-way communications whenever appropriate):

- to ensure the pharmacy has sufficient capacity to take on a new patient and will agree to dispense to the patient (some patients will approach their local pharmacist in advance to help establish positive engagement at the outset)
- if the prescription is for supervised consumption, to ensure the pharmacist is willing to do so (usually as part of a suitable local scheme) and can provide this
- to introduce a new patient to the pharmacist – for example, by offering a brief description or relevant history by telephone, by letter of introduction, or by shared care agreement
- to check for any special instructions for the patient (such as bringing photo ID where possible)
- to confirm that the medication in the form prescribed will be available for dispensing to the patient when needed.

It is good practice that pharmacists share relevant information with prescribers and other healthcare professionals and agencies in line with their professional duties of care and confidentiality. This is part of the two-way process of communications that also includes prescribers providing relevant information or raising concerns with the pharmacist whenever appropriate, for example, when:

- the pharmacist is aware that patients are failing to comply with their treatment, for example, when patients are missing scheduled pick-ups, and particularly with any significant change of behaviour pattern
- there are concerns about a patient's health or wellbeing
- the patient is repeatedly attending the pharmacy in a state of intoxication, or has unusually presented intoxicated for the first time
- the prescriber is considering changing frequency of supervision or dispensing, at which time clinical feedback from the pharmacist may be helpful to inform the prescribing decision.

It should be noted that pharmacists who are also operating a needle and syringe programme scheme will not usually share information with the prescriber that a patient receiving prescribed medication is also obtaining supplies of injecting equipment from the pharmacy, except where the pharmacist has the permission of the patient to do so. In such circumstances, accessing injecting equipment might reflect destabilisation or a failure to optimise outcomes – perhaps through under-dosing. It is good practice for the pharmacist to engage the patient in a discussion regarding risk management to ensure all harm reduction options have been addressed (such as overdose awareness and provision of naloxone where available) but also to encourage the patient to agree to the pharmacist communicating with the prescriber about current difficulties identified, to facilitate maximum support for the patient.

4.3 Choosing an appropriate opioid substitute

4.3.1 Choosing an appropriate opioid substitute for heroin dependence

Methadone and buprenorphine are both effective at achieving positive outcomes in heroin dependent individuals. Both are cost-effective and recommended, for example, by NICE, for the treatment and prevention of withdrawals from heroin and for maintenance programmes. In England and Wales, it is a requirement that local areas should fund such treatment in line with the relevant NICE technology appraisal (NICE 2007a), if recommended clinically.

While there is accumulating evidence that buprenorphine is associated with reduced risk of fatal overdose in the first weeks of treatment initiation, there is also evidence that methadone is more effective in retaining patients in treatment and so may indirectly reduce risks longer term for those patients. Currently, there remains insufficient evidence to justify recommending one drug over the other. Also, some patients hold strong views against starting buprenorphine and others against starting methadone. Because of the lack of decisive discriminating evidence of greater effectiveness or of better patient safety, and because other factors also affect preference, there is no simple formula that can be recommended to determine the suitable clinical choice of methadone or buprenorphine. However, for both of these medications, there is a very substantial evidence base for effectiveness and it is appropriate for clinicians to discuss these complex issues with patients in obtaining informed consent for their treatment. It is essential that clinicians do not exaggerate what is currently known to support one drug over another, so that patients are empowered to make their own decision, taking account of the reasonable informed advice of the prescriber, which also helps the patient to take account of their own personal circumstances.

A number of clinical factors can be taken into account to help a patient, with the clinician who is treating them, decide which medication to opt for. These include:

- a patient's pre-existing preference for either drug
- the potential value of rapid induction onto effective maintenance over an induction phase that has been assessed as particularly high risk (considered specifically achievable with buprenorphine)
- previous substantial benefit from maintenance on either medicine
- specific safety concerns (e.g. with methadone, potential diversion or previous overdose on it; and, with buprenorphine, previous early disengagement from treatment)
- likely need for strong opioids other than buprenorphine for acute pain management (for example, with pending surgery) or for chronic pain management (e.g. if on the advice of a pain clinic)
- any relevant drug-drug interactions that should be taken into account when prescribing for patients taking other drugs or medication
- local pragmatic factors, such as lack of geographical availability of supervised consumption (which may favour buprenorphine in some cases).

4.3.2 Choosing an appropriate opioid substitute for dependence on other opioids

Unlike for heroin, there is insufficient evidence to give clear definitive advice on the specific substitute opioids to prescribe for cases of dependence following excessive or illicit use of other opioids. For such dependence on opioids other than heroin, while the evidential basis for choice of substitution medication is very limited, buprenorphine and methadone are commonly used by clinicians because of their recognised pharmacological advantages in stabilising dependence. However, alternative opioids other than buprenorphine or methadone are sometimes prescribed in such cases after taking careful account of a patient's circumstances and preferences. Individual clinicians will take account of the potency of the problem opioids and context of use (such as over-the-counter codeine or prescribed dihydrocodeine), evidence of severity of dependence, risks involved such as injecting, other comorbid conditions (including pain management), patient acceptability, treatment goal and other factors. The limits of the evidence base should be discussed and a clinical judgement made with the patient. When any such opioid is prescribed 'off label', local policies on the use of unlicensed and off label medicines will need to be followed.

4.3.3 Choosing buprenorphine-naloxone

A form of buprenorphine is available which includes the opioid antagonist naloxone (buprenorphine:naloxone 4:1) in a combined sublingual tablet. This form is for use at the same buprenorphine dose (the current 8mg sublingual buprenorphine being considered approximately as the same therapeutic dose as the combination of 8mg buprenorphine plus 2mg naloxone). The rationale is that, when taken sublingually as intended, the naloxone has very low bioavailability and has minimal effect and does not diminish the therapeutic effect of the buprenorphine. However, if injected, the naloxone has high bioavailability and is liable to precipitate withdrawal in an opiate-dependent patient, therefore discouraging further misuse by injection. Consequently, the combination tablet is expected to provide the same therapeutic benefit while reducing the liability for misuse. Clinical experience since its introduction suggests this formulation may add value when supervised dispensing is difficult to deliver or where there is concern about a patient's risk of reverting to injecting.

4.3.4 Faster-acting forms of buprenorphine

Several different physical forms of buprenorphine are in development and clinical testing. Rapid-dispersal forms of buprenorphine exist as quick-dissolving film or as rapid-dispersal tablets (as either mono-product or in combination with naloxone). They may be of clinical benefit by enabling simpler supervised consumption. One product (Espranor) was reaching the market at the time of publication but it was too early to comment on its impact.

Ultra-long-acting forms of buprenorphine have also been developed in both implant and depot forms. At least one of these has product approval in the US but, at the time of publication, there are no approved depot or implant forms of buprenorphine in the UK or elsewhere in Europe.

4.3.5 Single isomer levo-methadone

Internationally, the commonest form of methadone available is a racemic mix of two stereo-isomers: levo-methadone and dextro-methadone. The most pharmacologically active stereoisomer is levo-methadone but chemically separating the two isomers is a complicated and expensive process which has limited availability. Some investigators suggest that there may be a better balance of benefits to harms with prescription of an adjusted dose of levo-methadone as a single isomer, and this continues to be explored. Levo-methadone is not available in the UK as a licensed medicine at present.

4.4 Induction onto methadone and buprenorphine substitution treatment

Induction onto methadone and buprenorphine treatment is the process of starting a patient on a suitable dose of a substitute opioid and optimising the dose.

Induction should be monitored by the prescriber, or a suitably trained nurse or pharmacist, often alongside a keyworker or other clinician supporting the care plan.

It may take two to four weeks (or more) to achieve an optimal dose with methadone. It usually takes less time with buprenorphine.

Clinicians should be aware that there is considerable research evidence that in the first weeks of methadone treatment there is an increased risk of death due to overdose. After around a month in treatment, on average, the risk of death due to opioid overdose during maintenance treatment falls to very low levels compared to the risk prior to entry, with a clear protective effect of treatment.

Clinicians therefore need to balance three competing pressures in prescribing as safely as possible for people dependent on opioids over the induction period:

- to exercise suitable care to minimise the risks of overdosing, or precipitating withdrawal, during induction onto opioid substitute medication
- to respond rapidly to the patient's perceived needs for treatment, managing any symptoms of withdrawal, to minimise distress, engage them in treatment and prevent any further harms from illicit drug misuse
- to avoid any unnecessary delays in achieving an effective substitution dose that can be expected to stabilise the patient.

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

Overdose awareness training and take-home naloxone may be usefully offered to those with heroin (or other potent opioid) dependence, as soon as possible following treatment entry. Lack of availability of training should not delay the initiation of induction on to opioid substitution treatment.

4.4.1 Minimising the risks of toxicity

For both methadone and buprenorphine, in cases where there is a clear history of risk taking in drug use patterns (including use of multiple depressant drugs, history of overdose or complications of injecting) and of mental health comorbidity, social isolation or homelessness, it is important that these risks are addressed during assessment and steps taken to manage them during the induction phase. Close observation of the first dose during induction, frequent reviews and access to ongoing supervision of dispensing are practical approaches which can be used. Such high-risk cases require greater supervision and monitoring to avoid overdose.

For methadone, patients with relevant other high risk factors for QTc prolongation need to be assessed including consideration of potential aggravation of QTc prolongation (see [4.4.2.2](#)).

4.4.2 Risk factors for methadone

4.4.2.1 Risks of methadone overdose

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

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

There are many factors affecting methadone metabolism and action, and most are not currently predictable on history and examination. This means that patients can have markedly different responses to the same dose of methadone and to its accumulation.

Drug interactions can slow down or speed up methadone metabolism, or can potentiate toxicity. See [annexe A5](#) for more information.

The critical factor in how someone responds to methadone is their degree of tolerance to opioids. For individuals with low tolerance, a starting dose that would be safe in most patients could become a toxic dose.

4.4.2.2 Risks of QTc prolongation with methadone

Opioids including methadone can affect cardiac conductivity which could, in some cases, result in a prolonged QTc interval. Prolonged QTc interval has been shown to increase the risk

of torsade de pointes and sudden cardiac death. This is thought to be a dose-related effect (i.e. higher opioid doses increase risk) but several factors, including age or co-prescribing, may exacerbate this risk.

Clinicians, either at initial assessment or prior to induction, can consider use of an ECG where they have concerns, in which case they can act in line with MHRA advice:

“... that patients with the following risk factors for QT interval prolongation are carefully monitored while taking methadone: heart or liver disease, electrolyte abnormalities, concomitant treatment with CYP 3A4 inhibitors, or medicines with the potential to cause QT interval prolongation. In addition, any patient requiring more than 100 mg of methadone per day should be closely monitored. Further advice is included in the product information.” (MHRA 2006)

Clinicians must make a balanced judgement for each patient according to current relevant guidance.

Monitoring will usually include checking other medications, general monitoring of cardiovascular disease (blood pressure and pulse), liver function tests and urea and electrolytes.

As the risk factors for QTc prolongation increase (such as with daily doses of methadone above 100mg or in the presence of multiple risk factors for QTc prolongation) clinicians will need to consider ECGs, and these may be carried out in some before induction onto methadone, and for others before increases in methadone dose (and then subsequently after stabilisation).

4.4.3 Risk factors for buprenorphine

At low doses, buprenorphine is a potent opioid agonist, producing morphine-like effects. However, due to its mixed agonist-antagonist properties, increasing doses become self-limiting and do not produce more intense opioid effects. This may be one reason some patients prefer methadone. Buprenorphine is widely considered to cause less respiratory depression than methadone, although there is no systematic review evidence showing a lower overdose risk for either drug. Buprenorphine has a greater potential for misuse by injection and intranasally but these latter risks may be reduced by using a combined buprenorphine and naloxone preparation – see [section 4.3.3](#).

However, as with methadone, concomitant use of buprenorphine with benzodiazepines, alcohol and other CNS depressant drugs can produce fatal opioid overdose, most commonly in individuals who lack opioid tolerance. Therefore, there is a risk of toxicity and the need for caution when initiating treatment with buprenorphine in someone misusing or co-prescribed CNS depressant drugs. Drug interactions can slow or speed buprenorphine metabolism, or can potentiate toxicity. See [annexe A5](#) for more information.

Buprenorphine can precipitate unpleasant withdrawals on induction. This risk can be reduced by leaving sufficient time after last use of an opioid before the buprenorphine is administered. This time will be longer if a long-acting opioid, such as methadone, has been used.

Buprenorphine is largely metabolised in the liver and the medicine's information recommends baseline testing and then regular monitoring of liver function.

4.4.4 Dose optimisation

Buprenorphine and methadone are long-acting drugs. One key aim of initial stabilisation and maintenance treatment is to keep blood concentrations of these drugs within a narrow range, within which patients experience no intoxication and no withdrawal. During induction with methadone or buprenorphine, signs and symptoms of intoxication and withdrawal fall progressively, reducing the subjective sensations that drive drug seeking and drug misuse. This is the key initial process of dose optimisation. If doses administered during induction are too high, intoxication will result. If doses are too low, they may not prevent the emergence of withdrawal symptoms and drug cravings for the full 24 hours between doses.

However, full dose optimisation involves aiming to help the patient achieve complete cessation of heroin (and other illicit opioid use). Better outcomes are seen for complete cessation of all heroin use with higher doses. Average doses of methadone between 60 and 120mg daily, and average doses of buprenorphine between 12 and 16mg daily are generally recommended. Clearly, there will be some who will require lower and some who will require higher doses but patients are entitled to be informed what is most likely to be effective.

While lower doses than the recommended ranges may extinguish withdrawal symptoms for a patient, they may still need a higher dose to minimise episodes of craving. Crucially, complete cessation of heroin use may not be achieved until a patient is stabilised within the recommended dose range. The effective dose may well be higher than the dose that helps a patient to 'feel OK'. This needs to be explained to patients, otherwise they could feel encouraged to stay on lower doses than they actually need for full benefit in stopping all heroin use or to adequately achieve their other goals. Suitably positive feedback should always be given for any progress that has already been made. However, patients may easily come to believe that any continuing intermittent lapses, perhaps as infrequently as once a week or once a fortnight, are due only to their lack of adequate willpower coinciding with availability of some heroin, when actually the dose still being too low may well be a decisive factor. Repeated intermittent lapse is a key factor in maintaining instability and needs to be treated seriously given the evidence for the effectiveness of OST when suitably provided in adequate dose. Cessation of all heroin use is a proper measure for monitoring dose optimisation on opioid substitution treatment given its establishment in the research literature as a suitable outcome of effective treatment. Set alongside the evidence that doses commonly used in the UK are substantially lower than the recommended dose range, this is an important focus of discussion not least to enable informed consent from patients. The use of supervised consumption can also increase clinician confidence in the compliance and non-diversion of recommended higher doses.

Sometimes, a patient may be unwilling to increase their prescribed dose into the recommended range that is more likely to be effective, and this may be because they intend to continue using heroin. This is likely to reduce the benefit that the patient derives from treatment and should be avoided, if possible. However, there can still be many other benefits of being on the medication and of engaging in treatment. For example, there may be large reductions of illicit heroin use and other evidence of improved wellbeing. Intermittent use on top is evidence of less benefit from treatment than was hoped for and should be addressed but it should not stop positive feedback to patients that recognises other important improvements they are achieving. Keyworkers, prescribers and services need to review how

they can ensure treatment is being optimised for such patients, increasing the input if needed, and incorporating this issue into the strategic reviews of the patient's treatment and recovery care plan.

4.4.5 Assessment for OST

4.4.5.1 Introduction

People who misuse drugs typically present for treatment at a time of crisis in their lives and may not respond well to an exhaustive interview at the initial stages. At the same time, clinicians need to gather sufficient information to properly and safely assess presenting problems, identify potential risks and guide treatment decisions. It is important to find a balance that allows for the necessary information to be obtained efficiently, without adding delay and without placing the patient at risk of dropping out of treatment. Subsequent, more comprehensive assessment can take place over the following weeks during treatment optimisation. However, within this overall approach, all patients need an adequate assessment. A previously unknown patient with evidence of complex needs and high risk will need a more extensive initial assessment than a well-known patient with continued evidence of low risk.

For those needing OST, it is appropriate to discuss recovery care plan goals and options early on. It is important that patients are aware of the option of early detoxification and the availability of support for abstinence-based recovery. For other recovery goals, it can be premature to focus unduly on this, particularly for a patient presenting in withdrawals.

4.4.5.2 Diagnosis of opioid dependence and assessment of tolerance

It is important that the clinician's assessment, prior to considering prescribing any opioid, provides adequate information to be able to match the treatment to the patient's needs and aspirations and to address the risks associated with their drug problem. The clinician must balance gathering sufficient information to make credible, safe clinical decisions while ensuring they move sufficiently swiftly to introduce these effective treatments.

It would not normally be appropriate to offer methadone or buprenorphine maintenance treatment to patients who do not meet the diagnostic criteria for opioid dependence. In recent years, however, it has been recognised that in the prison setting, where a patient who was previously on opioid substitution treatment in the community and was detoxified following imprisonment, a process of 're-toxification' may sometimes be justified prior to release, especially if the individual has a history of previous relapse on release. In such cases, a diagnosis of dependence should have been evident from history and signs at the time of imprisonment but the patient does not necessarily have to be using illicit opioids in prison prior to release. The decision should always be based on assessed need and a risk assessment by a suitably competent prescriber (see [section 5.3](#) for further discussion in the prison setting).

Assessment for drug treatment is discussed in detail in [section 2.2.2](#). However, the main points are summarised in the following paragraphs.

Establishing the diagnosis, nature and severity of dependence requires a full history of the patient's drug and alcohol use, including duration of use, frequency of use, route of

administration, risk-taking, periods of abstinence, and response to previous treatments. Exploring any history of relevant physical and psychiatric comorbidity is essential. Patients should be asked to give an account of their daily activities and social functioning, and should be asked about their offending history.

Corroborative evidence of opioid dependence should be sought, by physical examination, investigations (such as drug screens), or information from other people.

Collecting a urine or oral fluid specimen for toxicological analysis is essential to confirm (or refute) recent drug use. However, a positive test for opioids does not establish the diagnosis of dependence, nor does a negative test exclude the diagnosis. In situations of doubt it may be useful to repeat a screening test, or to conduct a confirmatory test (though this does not confirm dependence). If tests do not match reported use, this offers an opportunity to explore the person's understanding and insight into their current drug use and may also inform the degree of risk management required during induction.

One major risk factor for toxicity during induction is use of CNS depressants, especially benzodiazepines and alcohol. Each patient should be asked about all drugs used (including prescribed and over-the-counter medication) in the three days prior to the assessment interview. Within the NHS, clinical systems (often online) may supply details regarding current NHS prescribing. It is often possible, if this is requested in advance of the assessment appointment, to refer to a written summary of all recent medicine prescribed from the patient's referring GP. If available these sources should be consulted. Alternatively, after confirming patient consent to this, the community pharmacist is a useful source of intelligence.

4.4.5.3 Medical and psychiatric factors

At assessment, many applicants report depressed mood and disturbed sleep. However, mood often improves after stabilisation on methadone or buprenorphine, and it is not normally appropriate to initiate antidepressant treatment during induction. While some review of a patient's mental state should always be part of the assessment that is considered by the prescriber, significant concerns about the patient's psychosocial wellbeing may need further discussion or referral and close support during induction.

Patients already on antidepressants, may need particularly careful monitoring during induction as these medicines may affect methadone levels.

Antipsychotic medicines may potentiate the hypotensive and sedative effects of methadone, and might increase the risk of toxicity.

Prescribers also need to be aware of drug interactions with opioid substitutes and any contra-indications in the use of other drugs (see BNF, SPC and [annexe A5](#))

A high proportion of people who inject drugs are infected with hepatitis B or C, but this seldom poses problems during induction unless they have advanced liver disease detectable at clinical examination. Patients with end-stage liver disease should only be commenced on methadone or buprenorphine with extreme care and should be referred for a specialist opinion. Many HIV medications (and some medicines used to treat conditions common in people with HIV) interact with methadone and buprenorphine, and dose adjustments may

need to be made (see [annexe A5](#) for more on interactions). Consultation with the clinician prescribing HIV medications is recommended.

4.4.5.4 Provision of information

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

Risks to children of ingesting prescribed medication and the importance of safe storage must be emphasised at the first appointment and repeatedly thereafter. Those on supervised consumption will often still have take-home medication on Sundays and some bank holidays. Assessing a patient's engagement with these safety measures should form part of the decision-making in relation to dispensing and supervision arrangements. If children are in the home, the patient should be required to demonstrate that they understand the risks of medication to children and actions needed to address these, and they are willing to make any changes needed. These might include safe storage or otherwise restricting children's access to the medication, and preventing children observing consumption to avoid copying behaviour. Community pharmacists can play an important role in monitoring evidence of risks and in supporting and reinforcing safe use of the medication.

All patients being inducted onto OST medication should be made aware of overdose awareness training and supply of take-home naloxone. Some may wish to pursue this immediately, before initiation of OST, but others may prefer to focus on it later. The assessed likelihood of immediate risks may affect how strongly it is encouraged early on.

4.4.6 Converting from other opioids

For patients who are misusing other opioids, it is sometimes appropriate to stabilise them onto a prescribed opioid in the context of care-planned treatment and support. While the evidence base is limited, buprenorphine or methadone are often used although some patients instead are provided with a licit source of their drug of misuse or another prescribed opioid. For lower potency and over-the-counter opioids, if a substitute drug is offered, this tends to be buprenorphine unless contra-indicated (typically using induction with small divided doses across the day to identify a stabilisation dose). For higher potency drugs such as morphine and fentanyl, either methadone or buprenorphine may be considered. In most cases, it is not possible to predict accurately an equivalent dose of the prescribed drug, and this is especially true for street drugs where purity is notoriously variable.

An opioid dose equivalence table has not been provided as part of these guidelines because that could provide a spurious sense of accuracy that does not exist. It is also problematic to predict dose equivalences when the half-lives of the drugs are not equivalent.

It is acknowledged that clinicians will often take account of equivalence tables from published sources when making plans for conversion/induction for such cases. However, clinicians will

also need to take account of the context of the case, and especially the closeness of review and supervision arrangements they can offer. As a result, reference to any conversion table is insufficient on its own. Clinicians must apply their clinical judgment and monitor the progress of such treatment objectively especially during the early stages of treatment. Safe conversion from another opioid involves carefully following the dose induction process, observing for evidence of intoxication or withdrawal.

4.4.7 Methadone dosing

The guidance given here applies to patients within normal ranges of body weight, body mass index and liver and kidney function. Patients outside the normal ranges may need to have their dose adjusted up or down accordingly, although such variations are usually taken care of by normal induction flexibilities, which generally allow for wide variation between patients.

4.4.7.1 Commencement dose

Methadone should normally be prescribed as a 1mg in 1ml oral solution. Oral concentrates, containing methadone hydrochloride 10mg/ml or 20mg/ml, should normally be dispensed only after dilution as appropriate.

Methadone tablets, which are not licensed for this purpose, should not normally be prescribed at induction due to an increased potential for diversion and given the availability of the established oral solution (but see [section 4.4.7.3](#)).

Inappropriate dosing can result in overdosing in the first few days. As cumulative toxicity develops to methadone, this can lead to death. There is no uniquely fatal dose of methadone and deaths have occurred following doses as little as 20mg. The commencement dose should aim to achieve an effective level of comfort, both physical and psychological, while minimising the likelihood of overdose.

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

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

With heavily dependent misusers who are tolerant, and where the clinician is experienced, with access to close supervision and skilled keyworking support, a first dose can be up to 40mg but it is usually unwise to exceed this dose.

A supplementary dose on the same day may be considered where there is objective evidence of persistent opioid withdrawal after a suitable period of observation, mindful of a typical period of peak plasma level of 4-6 hours, and should not normally exceed 10mg in the community. Such cases must be carefully assessed by a prescriber with appropriate competencies.

The process of dose induction requires clinical judgement from the prescriber. Clearly those prescribers with more experience may feel able to take more and proportionate risks following thorough assessment. In general, more caution should be taken with high-risk patients but this caution is normally best managed, where possible, by assuring compliance and tolerance through supervised consumption rather than by providing low doses. More caution should be applied if the patient cannot be well supervised, for example, seen only weekly during this stage.

4.4.7.2 Optimal dose

First seven days

It is critically important to provide adequate information regarding the recognition of methadone toxicity and its management to patients and to any accompanying carers the patient has engaged in their treatment.

Opiate-dependent patients being managed in the community should normally attend most frequently at the beginning of treatment in order that their dose can be titrated against response. More frequent attendance allows for closer observation for any evidence of withdrawals or intoxication and can help identify evidence of changing risk, including for patients of particular concern. Community pharmacy dispensing does not allow the same degree of observation for the prescribing service as the on-site dispensing available in some services so frequent communication with the community pharmacist during the period of induction may be particularly helpful. With patients who can only attend infrequently, dose induction can take longer.

Where doses need to be increased during the first seven days, the increment should be no more than 5-10mg on one day. In any event, a total weekly increase should not usually exceed 30mg above the starting day's dose. Patients should be alerted to the risk of over-sedation and the risks with ongoing illicit use.

Subsequent optimisation

It is important not to under-dose patients who continue to use illicit opiates. There is a strong evidence base that higher OST doses are more effective (Faggiano et al 2003) and many biological, psychological and social factors will influence the dose required to achieve stability (Trafton et al 2006). Optimising the dose of oral opioid replacement is an appropriate strategy for the prescriber to use to address unsuccessful treatment.

To achieve optimisation, following the first week, doses can continue to be increased incrementally. A total target dose of between 60 and 120mg a day, and occasionally more, may be required based on the evidence of doses that are most effective. Some individuals will stabilise, with a sustained cessation of all heroin use, at lower doses. It is important to achieve a level at which the patient reports feeling comfortable and there should be a focus in discussion with the patient, on achieving a dose at which the person is no longer using illicit heroin, which may be substantially higher. Caution needs to be exercised when balancing any assessed risk with the need to optimise treatment effectiveness. It may take several weeks to reach the optimal dose. There should normally be a few days between each dose increase from the second week onwards (at this stage higher blood levels will already have accumulated and so daily increases are not recommended).

It is difficult to give a set rate of increase over the first few weeks as it is apparent that for some patients this will be associated with continued heavy use of injectable heroin, which in adequately monitored patients may well be less safe than a slightly faster rate of increase of methadone. The experienced clinician must judge this on a case-by-case basis. If proceeding at a faster rate than recommended, monitoring and review must take account of the risk of accumulation of doses, and this should be clearly discussed with the patient and documented.

4.4.7.3 Methadone tablets

Patients should not normally be inducted on to methadone tablets. They are not licensed for this purpose and should not normally be used as a first line treatment. When used, they need to be prescribed in line with the local policy on the 'off label' use of medicines. However, they may be justified for specific circumstances, such as to reduce nausea and vomiting during pregnancy, to reduce nausea when also in receipt of chemotherapy, during holidays abroad and where there is adequate evidence of intolerance to methadone solution. The prescriber should have an appropriate level of experience to prescribe the tablets and should undertake the necessary precautions to ensure they are being taken appropriately. Specialist advice should be sought before prescribing tablets and justification documented. There may be other exceptional circumstances (such as taking over the care of a patient already very well stabilised on methadone tablets) when the suitably competent clinician, weighing up the risks and benefits, agrees in discussion with the patient to provide them (and in line with policies and procedures for any off-label use of medicines).

4.4.8 Buprenorphine dosing

The guidance given here applies to patients within normal ranges of body weight, body mass index and liver and kidney function. Patients outside the normal ranges may need to have their dose adjusted up or down accordingly, although such variations are usually small and taken care of by normal induction flexibilities.

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

The two identified problems during buprenorphine induction are:

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

Following recommended, cautious schedules will reduce the risk of precipitated withdrawal but this needs to be balanced against achieving adequate doses and adequate agonist effect to continue to engage the patient in treatment.

Clinicians report that providing some initial flexibility in the dosing schedule over the first two days can often be helpful (for example, providing a number of 2mg tablets that can be divided across the first day or two), before instituting the recommended dose for daily supervised consumption. Once a daily dose that does not precipitate withdrawal is achieved, rapid increase up to the recommended dose range can be much quicker than is usually possible for methadone. Clinical judgement is required that takes into account all relevant factors in a particular case.

4.4.8.1 Precipitated withdrawal

Precipitated withdrawal occurs when buprenorphine is first administered to an opiate-dependent person with circulating opioid agonist drugs present. In this situation, buprenorphine can inhibit the opioid actions of the full agonist without adequately replacing them, leading to the appearance of withdrawal signs and symptoms. Precipitated withdrawal can be very unpleasant and may deter patients from continuing participation in treatment. There are three measures to minimise precipitated withdrawal:

- Administer the first dose of buprenorphine when the patient is exhibiting signs of withdrawal. The administering clinician/pharmacist needs to emphasise this point when supervising medication.
- If withdrawal is difficult for the patient to tolerate, delay the administration of buprenorphine until at least 6-12 hours after the last use of heroin (or other short-acting opioid), or 24-48 hours after the last dose of low-dose methadone.
- Provide the anticipated day's doses, for the first day or two, in divided amounts (typically using 2mg tablets) so the patient can manage the speed of the induction themselves.

In all cases, patients should be supported and encouraged, provided with information about precipitated withdrawal and informed that, if their discomfort is risking drop out of treatment, they could be seen for review early and treatment could be adjusted or could be changed to methadone.

Patients on more than 30mg of methadone daily may have greater difficulty tolerating a transfer to buprenorphine and will need additional support to manage this, and they may require inpatient treatment.

4.4.8.2 Starting dose and increments

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

A cautious approach is to initiate treatment with 4mg on day one, then 8-16mg on day two and thereafter. An experienced and competent clinician may increase the starting dose to 8mg on day one, then 16mg on day two and thereafter increase the dose more slowly if necessary.

Dividing the daily dose may be useful as it may reduce precipitated withdrawal. This option may be particularly helpful when starting in the community over a weekend. Such timing is not generally optimal but may be the best care for a patient to avoid delay in starting their treatment.

Thorough preparation, ongoing assessment, monitoring, regular clinical review and reassurance are likely to improve retention.

4.4.8.3 Symptomatic prescribing

There is limited evidence for the effectiveness of adjunctive medications alongside the OST agent of choice, for the management of symptoms associated with withdrawal. The prescribing of other opioids, or any other respiratory depressant drugs, during induction onto buprenorphine treatment is therefore not recommended.

4.5 Supervised consumption

4.5.1 When and how to use supervised consumption

Supervision of consumption by an appropriate professional provides the best guarantee that a medicine is being taken as prescribed.

Following the introduction of supervised consumption in England and Scotland, methadone-related deaths reduced fourfold (Strang et al 2010).

The GMC guidance on consent (2013) highlights that “for a relationship between doctor and patient to be effective, it should be a partnership based on openness, trust and good communication. Each person has a role to play in making decisions about treatment or care”. The patient is a key partner in decisions on the appropriate level of supervision. Supervised consumption should be viewed as a situation where therapeutic relationships can be built with patients. The principal reason for using supervision is to ensure the safety of the patient and to minimise the risk of toxicity. It should not be used or viewed as a punishment.

Levels of supervision should be based on an individual risk assessment for, and with, each patient. Clinicians and treatment providers should be familiar with opening hours of pharmacies that are accessible to the patient. For many on daily supervised consumption, providing a take-home dose for Sundays is the only practical option, but for others it may be feasible to access a pharmacy that opens seven days a week. Patients who are working can often take advantage of pharmacies that are late opening. It is important to consider the best option for each patient.

For most cases, it will be appropriate for new patients being prescribed methadone or buprenorphine to be required to take their daily doses under the direct supervision of a professional for a period of time to allow monitoring of progress and an ongoing risk assessment. The risk assessment should include a review of compliance and individual circumstances, including whether the home environment is suitable for safe storage of medications. In some cases, following this, the supervision will be needed for an extended period while for others it may be assessed as only being needed for a short period. Duration of supervision should be dependent on assessed clinical need and should not be applied in an arbitrary way.

The clinical need for supervised consumption should be reviewed regularly by the prescriber. Although, ultimately, the responsibility for the level of supervision for any prescription lies with the prescriber, decisions on when to relax or increase the requirement for supervised consumption should include consultation with the multidisciplinary team, the patient and liaison with the dispensing pharmacist. For example, long-term, daily supervised consumption would probably not be appropriate for a patient in regular, full-time work or education where supervision would be a clear barrier to retention in treatment and recovery. When a patient restarts methadone or buprenorphine after a break, receives a significant increase in the dose or during periods of instability when tolerance may be reduced, daily dispensing – ideally with supervised consumption – should be reinstated for a period of time and reviewed at regular intervals.

In patients whose treatment is failing, a period in supervised consumption can improve observation of progress and can be used alongside an increase in interventions to improve outcomes.

The level of supervision and the frequency of collection should be based on individual assessment of patient needs, including the risk assessment, and should be sufficiently flexible to respond to changing circumstances.

Particular issues arise when patients currently on supervised dispensing request special or exceptional arrangements for travel, holidays or family events. Patients should be advised at the outset of treatment that they will need to give advance notice of holiday, travel or other events that require altered prescribing or dispensing arrangements. Urgent requests will inevitably arise and services need processes to assess and respond to such requests. In some circumstances, even with advance notice, and especially for those early in treatment or significantly unstable, the prescriber may not feel able to safely provide a supply of medication to cover the event. The clinical rationale for this decision should be clearly explained to the patient. Legal arrangements relating to travelling abroad with controlled drugs are discussed at [annexe A6](#).

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

The aims of a community pharmacy based supervised consumption service include:

- ensuring the patient receives the prescribed dose
- reducing diversion of prescribed doses
- providing an opportunity for the pharmacist to make a regular assessment of patient compliance with treatment and of their general health and wellbeing
- providing an opportunity for the pharmacist to build a therapeutic relationship with the patient that is beneficial to promote health and harm reduction
- reducing the risks of drug related overdose and deaths
- minimising the risk of accidental consumption by children.

Pharmacies have expanded their services in recent years and pharmacy contracts have developed. Pharmacists have unrivalled expertise in the use and interaction of medicines and they should be used to support OST patients. Pharmacists should contribute to the treatment and care of patients through liaison with prescribers in the assessment of appropriate levels of supervised consumption.

There are no universally agreed standards for supervised consumption in community pharmacy. However, the Pharmaceutical Care for Patients Prescribed Opioid Replacement Therapy standards document, introduced in Scotland in 2015, provides a useful template for local services (NHS Scotland 2015). These principles are based on the General

Pharmaceutical Council (GPhC) standards for registered pharmacies, which apply in England, Wales and Scotland. In Northern Ireland, the pharmacy regulator is the Pharmaceutical Society of Northern Ireland (PSNI).

4.5.2 Stopping supervision

Relaxation of supervised consumption and instalment dispensing should be a stepped process in which a patient normally remains on daily dispensing with reduction or cessation of supervision and progression to less frequent instalment collection. The relaxation of supervision and collection is an important component of supporting further recovery in stable patients. It is recommended that no more than one week of take-home doses is supplied as a single instalment.

Supervised consumption should only be relaxed once the prescriber has good reason to believe that compliance will be maintained. The assessment of compliance and clinical progress is covered in [section 4.6](#). In general, the assessment should cover:

- compliance with prescribed drug treatment
- abstinence from or significant change in heroin or other drug misuse
- changes in drug-taking behaviours (such as cessation of injecting)
- compliance with other elements of the treatment and recovery care plan, for example, attendance at appointments.

Arrangements for daily consumption through instalment prescribing and, where appropriate, supervised consumption of other medicines, can be made.

To protect patient and community safety, take-home doses should not normally be prescribed where:

- the patient has not reached a stable dose
- the patient shows a continued and unstable pattern of drug misuse, including a significant excessive level of alcohol intake, the use of illicit drugs and/or misuse of benzodiazepines or other tranquillisers
- the patient has a significant, unstable psychiatric illness or is threatening self-harm
- there is continuing concern that the prescribed medicine is being, or may be, diverted or used inappropriately
- there are concerns about the safety of medicines stored in the home and possible risk to children.

4.5.3 Issues in supervised consumption

A range of different medications can be supervised. Oral methadone solution consumption can most easily be observed. Buprenorphine sublingual tablets can be more difficult to supervise because of the length of time taken for the tablet to dissolve. Some pharmacists have been crushing buprenorphine tablets before consumption to make the supervision process more straightforward. This practice, while technically off-licence, may sometimes be undertaken with appropriate clinical governance approval and protocols (also see [annexe A3](#)).

Buprenorphine products that dissolve more rapidly will be available and may require less supervision (see [section 4.3.4](#)).

Other medication such as benzodiazepines, antidepressants, antipsychotics and medication for conditions such as tuberculosis and HIV can be prescribed to be dispensed in instalments and consumption supervised where local contracts are in place.

The service should be delivered in a way that protects patients' privacy and dignity. Consumption should take place in a private consultation room or a suitably discreet area of the pharmacy. There should also be due regard to maintaining confidential communication with patients in the open pharmacy area before and after any supervised use.

While supervision of prescribed medication, even if directed on the prescription, is not a legal requirement, any deviation from the prescriber's intended method of supply should be documented and the justification for this recorded. Any such decision should be made in the best interests of the patient, ideally always involving the prescriber.

4.5.4 Competencies for supervised consumption

Staff supervising the consumption of medication need to be competent to do so. Such competencies are commonly specified in local service level agreements by commissioners. Standards that are required to deliver a quality OST supervised consumption service, and the training required by staff to deliver the service, are set out in the Scottish standards document, Pharmaceutical Care for Patients Prescribed Opioid Replacement Therapy (NHS Scotland 2015).

4.6 Assessing and responding to progress and failure to benefit

4.6.1 Principles

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

Treatment should also seek to maximise treatment outcomes across a range of domains including drug and alcohol use, health status, crime and social functioning with a view to continuously improving recovery and recovery potential. It is normal to review progress and agree new plans in response to the patient's progress or otherwise.

While drug treatment has been shown to be effective in reducing drug misuse, and opioid substitution treatment at adequate doses can help maximise cessation from illicit heroin use, patients may not cease all illicit drug use or intoxication-seeking behaviours immediately on starting OST treatment. Eliminating all illicit drug and alcohol misuse may take months or years. Often, this ongoing drug use is balanced by objective improvements in other domains. Clinicians, however, will frequently be faced with decisions concerning what action to take if a patient is failing to maintain benefit from a treatment programme. Any response should be based on the assessment of relative risks to the patient and staff, while maintaining the integrity of the treatment programme.

4.6.1.1 Reassessment and reformulation

If a patient appears not to be benefiting adequately from treatment it is important that clinicians endeavour to understand the reason for the failure to progress. All patients are unique and failure to re-assess the individual patient's goals and circumstances may mean that clinicians will not identify and address the main obstruction to progress in that case. The patient should be actively engaged in this process of re-assessment and formulation. Once this formulation is concluded a new plan should be proposed and agreed with the patient.

4.6.1.2 Optimising treatment

Clinicians should always consider optimising treatment by increasing the intensity of the programme rather than reducing it. Optimising treatment may include:

- ensuring medication is being/has been offered/tried at evidence-based optimal levels
- increasing intensity of keyworking/support
- increasing supervised consumption to assure its consumption (which will also increase patient contact with health professionals who may be able to influence their drug use or risk behaviours)
- changing to another evidence-based substitute medication
- introducing additional psychosocial interventions such as motivational interviewing, relapse prevention counselling or contingency management

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

A good therapeutic relationship between the clinician and the patient should allow for discussion about drug misuse without fear of expulsion from treatment. However, the clinician must be prepared to actively discuss their concerns and encourage management of identified risks. All clinicians should ensure their patient is fully aware of their own role in achieving effective drug treatment including correct use of medication.

Care planning and its ongoing regular review, as well as 'strategic reviews' with a suitably experienced colleague, provide the vehicle to check patient progress and agree direction of treatment and a course of action in partnership with the patient.

Clinicians are encouraged to chart progress in treatment systematically under four key domains of care planning – drug and alcohol misuse, physical health, mental health and social functioning (including interaction with the criminal justice system).

4.6.2 What constitutes failure to benefit?

A number of different scenarios may constitute failure to benefit from treatment, each of which may require a different response. It will be beneficial for clinicians to be aware of the behaviour of patients prior to drug misuse treatment to assess whether improvements (albeit slow) are being made. A good therapeutic relationship and good therapeutic alliance will enable illicit

drug use to be discussed and interventions agreed accordingly. If this does not exist, or if a clinician or service is perceived as rigid or having a punitive response to illicit use, a patient may not disclose such use and may not be able to elicit the help they require.

4.6.3 Common scenarios in failure to benefit

4.6.3.1 Drug and alcohol misuse on top of a prescription

Common drug misuse scenarios leading to failure to benefit are outlined in [table 3](#), together with their risks and some proposed responses.

4.6.3.2 Patient misses appointments

In instances where a patient is consistently collecting their medication but failing to attend appointments, as arranged with the clinician in line with the agreed care or treatment plan, the clinician will be unable to monitor progress against identified needs or identify risks. An urgent review needs to take place to enable the prescriber to review the patient's current situation and satisfy themselves that the medication is optimised and safe and any agreed plan is progressing as expected. Telephone contact can sometimes quickly reveal a current problem. A new plan should be formulated and agreed. Depending on the issues identified, many solutions may be appropriate. For example, the patient may be offered incentives to encourage attendance (contingency management) or more suitable appointments (e.g. evening appointments) or locations for contact may be offered if normal times/arrangements are inconvenient or affect work/educational prospects. In some cases, such as for some patients quite stable on medication, they may wish for, and may be suitable for, less frequent face-to-face contact at this time.

4.6.3.3 Patient misses daily pick-up of medicines for three days

If a patient has not taken their regular prescribed dose of opioid, there is the possibility that their tolerance to the drug could have reduced, increasing risk of overdose if the usual dose of medication is then taken. The risks of loss of tolerance and of consequent overdose are less with buprenorphine than with methadone. It is good practice for the pharmacist and prescriber to communicate about a patient failing to collect methadone or buprenorphine doses as it may be an indicator of instability or increasing risk.

Judgement is required over how to respond to single or repeated missed pick-ups. However, failure to collect medication should prompt the dispensing pharmacist to consider contacting the prescribing clinician, especially during induction. If the medication is not collected for three consecutive days, then the pharmacist should obtain advice from the prescriber on what action to take. A pharmacist should not normally dispense the fourth day's dose unless they have confirmed with the prescriber that it is appropriate to do so. Depending on what the prescribing service knows about the circumstances of the patient, and on their assessment of risk, this will result in advice to the pharmacist either to continue to dispense or to ask the patient to attend the prescribing service for urgent clinical review.

In some circumstances, it may be appropriate to reduce the dose and titrate back up to an appropriate maintenance dose (particularly if it is suspected the patient may not have taken their OST for a longer period).

When five days' supply has been missed, pharmacists would not normally be asked to dispense on the current prescription on the sixth day (unless, exceptionally, it was judged by the prescriber to still be a safe titration dose e.g. 20mg daily) until after the patient had been re-assessed. Normally such a situation would be assessed by an urgent face-to-face consultation with the prescribing clinician. Urgent assessments may also be indicated for other patients of particular concern, even where less than three days have been missed.

When deciding whether to recommend continued pharmacy dispensing or an urgent face-to-face prescriber review, this should take account of knowledge of the patient and their risks, any new information from the pharmacist, and the risks for the patient of not continuing their current medication.

Every effort should be made to limit the potentially harmful impact on the patient of being without prescribed medication until review and a new prescription can be established.

There are a number of reasons why the patient may have been missing their doses. The clinician must assess the patient's engagement with their agreed plan and may need to develop and agree a new plan. Sometimes, simple practical challenges such as accessing the pharmacy are the issue and may be resolved. The patient should be asked whether pick-up arrangements align with their lifestyle. When appropriate, these factors may be open to suitable adjustments.

It is good practice for pharmacists to alert the prescriber whenever there are significant concerns: such as when consecutive daily doses of OST have been missed, following repeated missed pick-up of single days (or even one missed day for certain patients) and when the pharmacist has any concerns regarding the patient's presentation (such as intoxication or apparent significant deterioration in health and wellbeing).

The appropriate Home Office approved wording should be written on instalment prescriptions to enable patients who miss one or more pick-up days, to collect their remaining instalments due, if this is the intention of the prescriber. See the prescriptions [annexe A4](#).

4.6.4 Clinical responses to patients failing to benefit from treatment

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

4.6.4.1 Information and feedback on risks to the patient

Patients who may be struggling in treatment must be actively engaged in a process to identify and address their difficulties and risks. The patient must be informed of the risks and consequences of continued chaotic drug misuse while established on a substitute opioid prescription. Risk management plans, and as appropriate the care plan, should reflect risk assessment and any actions to address these.

4.6.4.2 Informed drug testing regimens

Drug testing (for example, random focused periods of once or twice weekly testing as part of an individualised care plan) provides an opportunity to reflect back to the individual real evidence of good or continuing poor progress and to share information about the risks and about the concerns of use on top of the prescribing, whether that relates to heroin or other

drugs and alcohol. This can be combined with regular injecting site examination, observation for intoxication and assessment of wellbeing and progress.

4.6.4.3 Application of safe prescribing boundaries

Prescribers have a responsibility to make individuals aware of the criteria they apply as healthcare professionals, when deciding whether it is safe to continue to prescribe or when it is necessary to make a change to a prescription to manage documented risk.

4.6.5 Suspension and exclusion

It may be necessary, following a careful assessment of the risks to the patient and staff, to conclude that a prescription must be suspended or in rare cases withdrawn. This may occur, for example, following repeated attempts at induction on to OST that have continued to fail to achieve a stabilisation phase. There may, for example, be continuing concerns about risks of overdose from unstable tolerance in cases of repeatedly unsuccessful attempts at stabilisation. Other serious concerns about the safety and suitability of continued prescribing may also raise this question. Such decisions must involve the prescribing clinician and other members of the multidisciplinary team. Patients must be forewarned of the potential actions that the prescriber and the team may take where there is a failure to achieve suitable, usually minimum, treatment goals, and they should be offered the opportunity to set new goals or identify contingencies that might influence their progress from this point.

A decision to temporarily or permanently exclude a patient from a drug treatment service or provide coerced detoxification should not be taken lightly. Such a course of action can put the patient at an increased risk of overdose death, contracting a blood-borne virus or offending. It may also increase the level of risk to children and vulnerable adults in the home. If at all possible, patients excluded from a service should be offered treatment at another local service or setting in a way that minimises risks and maximises opportunities for patients to be retained in treatment. Other steps in line with Good Medical Practice paragraphs 38-40 (GMC 2013) must also be followed.

Table 3: Responses to drug and alcohol misuse on top of an opioid prescription

Scenario	Risks	Possible responses
Opioid misuse on top of an opioid prescription	<p>Overdose</p> <p>Blood-borne viruses and other infections if injecting</p> <p>Continued offending and involvement in drug misusing lifestyle</p> <p>Impaired engagement</p>	<ul style="list-style-type: none"> • Increase dose, if inadequate • Divide dose, in addition, if fast metaboliser • Offer to change OST medication • If patient on reducing regimen, re-stabilise patient on higher dose and review support and patient goals • Reintroduce daily supervised consumption, carefully titrating up the proportion supervised if appropriate, and monitor successful progress before relaxing this arrangement • Consider increase in other psychosocial interventions (e.g. increase frequency of keyworking and motivational support or medical review and/or provide more formal contingency management) • Ensure access to safer injecting advice and supplies • Reinforce advice and support for overdose prevention • Confirm suitability of medication collection and review arrangements.
Crack cocaine and cocaine misuse on top of an opioid prescription	<p>Blood-borne viruses and other infections if injecting</p> <p>More chaotic drug misuse</p> <p>Increased crime</p> <p>Psychological problems</p> <p>Overdose</p>	<ul style="list-style-type: none"> • Confirm adequate stability on current dose of OST • Increase frequency of keyworking or other psychosocial interventions • Ensure access to safer injecting advice and supplies • Review understanding of overdose risk and reinforce advice on reducing risk • Review for any comorbid mental health problems • Review level of instability and possible need for daily supervised consumption of OST.

Scenario	Risks	Possible responses
Alcohol or benzodiazepine misuse on top of an opioid prescription	<p>Overdose or 'near misses'</p> <p>Drug interactions</p> <p>Alteration of methadone metabolism</p> <p>Deterioration of hepatic functioning in those with hepatitis C</p> <p>Street drinking</p> <p>Intoxicated presentations</p>	<ul style="list-style-type: none"> Review evidence of alcohol/benzodiazepine dependence and the need for alcohol-focused keyworking support and/or assisted withdrawal Increase frequency of keyworking and psychosocial interventions and medical review Reintroduce daily supervised consumption, carefully titrating up the proportion supervised as appropriate, and agree the progress needed before relaxing the arrangements Do not reduce opioid dose simply because of alcohol/benzodiazepine use but review opioid tolerance and any evidence of opioid intoxication Consider whether breathalyser testing can be useful in monitoring progress (e.g. to confirm no evidence of recent alcohol use).

4.7 Opioid maintenance prescribing

4.7.1 Introduction

Many patients declare a desire to be drug free when they enter treatment. While a few patients can achieve abstinence rapidly, most require the support of prescribed medicines for longer than just a few months. The decision to maintain a patient on a long-term opioid prescription should be an active decision agreed between the clinician and patient. Longer-term prescribing should be reviewed at regular intervals (usually at least three-monthly, depending on clinical progress) and should be part of a broader programme of care-planned social and psychological support.

4.7.2 Maintenance treatment with methadone and buprenorphine

Opioid maintenance treatment is an effective management strategy for reducing harms associated with opioid dependence. The duration of maintenance should reflect the patient's own preferences and their clinical circumstances (which may include the opportunities available to them to support their recovery and management of risk).

It may seem to some observers that, in all cases, progress in treatment should lead towards detoxification and ultimately abstinence. Patients and their families (as well as some clinicians) may hold the view that this progression is required for treatment to be deemed to have succeeded. Complete abstinence from all drugs (prescribed and non-prescribed) may not be a realistic or preferred goal at various times in a patient's treatment journey and there

will be circumstances when prolonged periods of maintenance OST are indicated. In some cases, this will turn out to be lifelong OST. It is important to emphasise that this is not a failure. Many such patients will be fulfilling their social and family responsibilities while successfully avoiding drug-related risk and progressing their recovery opportunities. It should also be emphasised, however, that clinicians must ensure that patients are repeatedly made aware of all their treatment options, including at treatment entry, and are regularly given the opportunity to consider alternatives to maintenance treatment.

At entry to treatment or at other times, the visibility of peers who have achieved full abstinence and peers who have achieved good recovery maintained on methadone, may help individuals make more informed choices for themselves.

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

Any professional prescribing for heroin or other opioid users must be competent to provide maintenance treatment alongside suitable psychosocial interventions to optimise recovery, and local protocols and guidelines should be provided to assist in this.

If a decision to provide a long-term maintenance prescription is being considered, a number of factors that assist treatment effectiveness need to be incorporated into the plan and its delivery:

- The frequency of patient review should reflect risk assessment and progress against agreed goals. Patients on opioid substitution treatment will need to be seen more frequently (at least fortnightly) initially and then, if stable, less frequently, such as once a month. Depending on local service arrangements and quality of support available, prescribers may feel their patient can be reviewed as little as every three months. This should be constantly reviewed, reflecting risk assessment, with any deterioration triggering earlier review.
- Objective evidence of maintained stability or progress is essential. For example, physical evidence of reduced injecting, or a lack of reports from clinicians/other professionals of intoxication or overdose are useful indicators of stability. Random urine or oral fluid drug screening tests may be helpful. Their value will depend on the current status of the patient but they should be carried out at least twice a year.
- Coexisting physical, emotional, social and legal problems, as well as drug and alcohol misuse, should be addressed as far as possible and prioritised in agreement with the patient whenever possible.
- All patients should have their care plan reviewed appropriately with their keyworker, with the more thorough review of overall progress, the 'strategic review', involving the prescriber or a suitably experienced colleague(s). They should step back and consider what has been achieved and set any new direction or treatment and recovery goals identified from this process.

4.7.3 Dosing regimen for maintenance treatment

After careful dose induction and dose stabilisation (see [section 4.4](#)), there is a consistent agreement among experts that greater benefit is achieved by maintaining individuals on a daily dose between 60 and 120mg of methadone, although some individuals will stop using heroin at lower doses. In some instances, due to a patient's high tolerance, higher doses may be required but this is exceptional. The clinician may need to ensure that there is good compliance through supervised consumption. Higher methadone doses can help to reduce and stop heroin and other opiate consumption. However, caution is required in relation to unsupervised high doses if there is associated alcohol or benzodiazepine dependence or use of other depressant drugs such as pregabalin or gabapentin or some major tranquillisers. In these cases, it may be necessary to re-introduce daily supervised consumption: titrating up the proportion supervised, if appropriate, to ensure compliance and a stable tolerance.

There is less consensus about the effective dose levels of buprenorphine required to optimise outcome, once dose induction and stabilisation have taken place. Trials have shown that higher doses result in lower levels of opiate use and higher rates of cessation of use, and higher treatment retention. In general, daily doses of between 12 and 16mg (and up to 32mg in some cases) would seem appropriate for long-term prescribing. Alternate day dosing may suit some patients.

4.7.4 Other oral opioid pharmacotherapy

Methadone and buprenorphine are the oral opioid agents licensed for use in UK practice. They hold the strongest international evidence base of effectiveness in maintenance, and should continue to be the mainstay of treatment for the management of heroin dependence.

Though they are available as OST in other countries, the general or routine use of other medications such as dihydrocodeine and slow release oral morphine (SROM) as OST agents is not recommended in these guidelines because of the lack of evidence available. They are not licensed in the UK for the treatment of opioid dependence. So, it is important, if clinicians choose to use these medications, that they have first considered using the treatments licensed for this purpose (in line with governance on the use of unlicensed or 'off-label' medicines) and that they discuss the rationale for offering these treatments with the patient and record this in their clinical record.

4.7.4.1 Dihydrocodeine

There is some limited evidence that dihydrocodeine has been used effectively for maintenance in opiate dependent individuals (Robertson et al 2007). Dihydrocodeine tablets are difficult to supervise, are short acting (so need frequent dosing) and can be easily diverted and used illicitly. There is also a developing evidence base regarding the role of dihydrocodeine in overdose deaths (Zamparutti 2011).

Doctors working within the criminal justice system use dihydrocodeine, especially in police custody and on occasion for prison admissions, as a useful agent to give short-term symptomatic relief because of relatively lower potency and lesser risk of accumulation toxicity. In prison, this is particularly when methadone cannot be initiated (e.g. late at night with limited clinical staff available). Patients in prison found to be suitable for ongoing OST are usually

started on methadone as soon as possible (buprenorphine is currently much less used in the prison setting).

More exceptionally, dihydrocodeine is used for patients who have become dependent on prescribed dihydrocodeine and are unwilling to consider, or unable to tolerate, methadone or buprenorphine. There is no specific guidance in this situation, beyond the general guidance above.

Dihydrocodeine should only be prescribed by specialist, or suitably competent, clinicians, who have access to high-quality monitoring and support services. Such prescribing should comply with local off-label medicines procedures.

4.7.4.2 Slow-release oral morphine

There is some evidence that slow-release oral morphine (SROM) preparations can be useful in treating patients who fail to tolerate methadone or buprenorphine, and in maintaining patients. There is also some evidence that SROM may be useful in patients who are 'not held' on methadone. In the UK, SROM should only be prescribed when first line OST treatments have been considered and are judged to be inappropriate. The reasons for rejecting standard treatments should be recorded in the patient's record. SROM should only be prescribed by specialist, or suitably competent, clinicians, who have access to high quality monitoring and support services. Such prescribing should comply with local off-label medicines procedures.

4.7.5 Injectable opioid treatments

There is compelling evidence for making injectable opioid treatment (IOT), usually diamorphine (heroin), available for those who continue to be at risk despite optimised oral OST. A section of the OST treatment population, despite being given access to optimised treatment with oral opioid maintenance, can fail to make adequate progress and continue to be involved in high levels of injecting drug misuse and other risk-taking behaviour. These patients may benefit from specialist assessment and reconsideration of their treatment options.

In some instances, clinical benefit can be improved by correcting sub-optimal dosing or enhancing and targeting psychosocial interventions to better meet the individual's needs. For other patients, however, addiction specialists with the appropriate competencies (and a licence, if prescribing heroin), and with access to appropriate facilities and skilled support, could decide to trial IOT. The availability of IOT varies across different parts of the UK.

4.7.5.1 Heroin assisted treatment

Evidence has been published, from the UK and other countries, supporting the value of targeted injectable opioid treatment programmes (Rehm et al 2001, van den Brink et al 2003, Haasen et al 2007, Strang et al 2010). This evidence base has been systematically reviewed in recent publications (Ferri et al 2011, Strang et al 2015) and its cost effectiveness (despite high up-front costs) has been demonstrated (Byford et al 2013). These programmes differ in several crucial ways from how injectable opioids have been prescribed in the past in the UK. They include the absolute requirements that the patient must:

- attend in person for their prescribed injectable opioid maintenance treatment – daily or even more frequently, according to the treatment plan

- inject their dose under the direct supervision of a member of staff who is competent to do so
- be given no take-away injectable medication.

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

Supervised injectable opioid treatment is a high-intensity treatment that delivers prescribed heroin or other injectable opioids with explicit objectives of breaking links with illicit heroin use and improving outcomes not achieved with oral OST. It is distinct from 'injecting rooms' or 'drug consumption rooms', which offer a safer setting in which drug users – often not currently engaged in OST – can inject their illicit drugs. Here, they have health facilities at hand, clinical support and observation is available, and there are opportunities to offer treatment for their drug problem or for associated health and social problems. Drug consumption rooms are described in more detail at the end of [section 6.3.2](#).

4.7.5.2 Patients already receiving unsupervised injectable opioid treatment

A small and dwindling but significant number of patients are in receipt of injectable opioid treatment on an unsupervised basis. These patients usually receive a prescription regularly and pick up, sometimes very large, doses of medicines from community pharmacies. Many patients in receipt of this treatment have long-term chronic health problems. They often had to provide evidence of adequate stability to be prescribed a take-home supply in the first place. They should not be confused with the kinds of acutely high-risk, heavily-using and chaotic patients who can respond positively to 'supervised' injectable treatment as shown by research in the UK and other countries. It is not clear how many new patients have been started on this 'old system', unsupervised injectable opioid treatment on an exceptional case-by-case basis but it is likely to be a very small number.

The quality of care for such patients should be reviewed regularly. Where there is clear evidence of benefit, treatment should continue and be improved for these patients. They should not have their treatment withdrawn but should be reviewed to consider whether their current treatment meets their needs.

There may be some difficulty for service providers in continuing to provide for such 'old system' patients while, within another part of local development, the service may be moving to supervised-only IOT for new patients.

4.7.5.3 Relevant guidance for injectable opioid treatment

Various guidance documents (see resources and further reading) have been produced to assist those developing new provision for injectable opioid treatment. Several principles for provision have been established in the past decade and evidence from the UK and other countries has increased.

4.8 Opioid detoxification

4.8.1 Introduction

In dependent opiate users, detoxification is usually thought of as being a clearly defined process, supporting safe and effective discontinuation of opiates while minimising withdrawals. The process varies in duration from person to person, usually lasting about 28 days as an inpatient or up to 12 weeks as an outpatient. This reflects the main evidence base on detoxification, which informs good practice. Slower detoxification does occur and is supported by clinicians but has a limited evidence base.

The assessment process can establish whether a patient is suitable for detoxification. It should be remembered that detoxification alone is rarely successful especially at the first attempt. Patients who do not successfully detoxify should be offered seamless access back into maintenance or other treatment.

The following factors can guide the clinician's and patient's opinions about whether the patient is suitable for detoxification:

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

There is clear evidence that coerced detoxification against a patient's will is likely to lead to relapse and increased risks of harm such as overdose and blood-borne viruses.

A full programme of psychosocial support needs to be in place during detoxification. Access to drug-free support, including that provided by services and peers, is vital following detoxification. Overdose training is also important in case of relapse.

The research evidence does not support the case for clinicians requiring, coercing or encouraging patients who are on stable maintenance doses of OST to start a very gradual reduction. But patients may want to explore gradual reduction of their maintenance dose and the evidence should be one of the issues discussed to allow them to make an informed decision. If they do opt to reduce, they should be supported and encouraged in their decision but without creating a culture that suggests to other patients that their choice to maintain their dose indicates less success or engagement in treatment.

Clinicians and services should not measure their effectiveness in supporting recovery by the number of patients having gradual reductions of their doses.

4.8.2 Dosing regimen for detoxification

4.8.2.1 Methadone

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

4.8.2.2 Buprenorphine

Buprenorphine doses can be reduced initially by 2mg every two weeks or so, with final reductions being around 400 micrograms. Patients report being able to reduce buprenorphine doses more quickly than methadone.

NICE guidelines found that neither opioid medicine was more effective than the other in achieving good outcomes from detoxification. They concluded that detoxification should be carried out with the medicine on which the patient had stabilised (NICE 2007b).

4.8.3 Symptomatic treatment of withdrawal

4.8.3.1 Lofexidine

Lofexidine is a non-opioid alpha-adrenergic agonist and is not a controlled drug. It is authorised for the management of opioid withdrawal. Alpha agonists are not useful in detoxification for patients with substantial dependence but may be helpful in relieving symptoms of withdrawal in those who are using small amounts of opioids and are keen to achieve abstinence.

The treatment course is between 7-10 days with doses starting at 800 micrograms daily and rising to a maximum of 2.4mg in divided doses. The dose is then reduced over subsequent days. It is most likely to be successful for patients with uncertain dependence, young people and shorter drug and treatment histories. NICE's guidance (NICE 2007b) is that lofexidine may be considered for those who have decided not to use methadone or buprenorphine for detoxification, have decided to detoxify within a short time period or have mild or uncertain dependence (including young people).

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

The patient should be seen daily in the early stages of treatment to check for withdrawal symptoms, for blood pressure monitoring and to provide general encouragement. One of the disadvantages of lofexidine is that additional short-term medications may be needed to control other effects of opioid withdrawal, such as stomach cramps and diarrhoea.

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

NICE found that there was no evidence for any superiority of clonidine over lofexidine and, because of its greater side effect profile, suggests that clonidine is not used in routine practice.

4.8.3.2 Other symptomatic treatment

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

- Diarrhoea – loperamide 4mg immediately followed by 2mg after each loose stool for up to five days; usual dose 6-8mg daily, maximum 16mg daily.
- Nausea, vomiting, may also be useful for stomach cramps – metoclopramide 10mg eight-hourly (for a maximum of five days to minimise neurological and other adverse reactions) or prochlorperazine 5mg three times a day or 12.5mg intramuscularly 12-hourly.
- Stomach cramps – mebeverine 135mg three times a day.
- Agitation and anxiety, sleeplessness – diazepam (oral) up to 5-10mg three times daily when required (or zopiclone 7.5mg at bedtime for patients who have been dependent on benzodiazepines). In severe cases of anxiety and agitation, obtain suitable psychiatric advice from an addiction psychiatrist or the on-call duty psychiatrist.
- Muscular pains and headaches – paracetamol, aspirin and other non-steroidal anti-inflammatory drugs. Topical rubefaciants can be helpful for relieving muscle pain associated with methadone withdrawal.

NICE summarised some key clinical issues in 2007 that are still relevant. To obtain informed consent, staff should give detailed information to service users about detoxification and the associated risks, including:

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

The choice of medication for detoxification

Methadone or buprenorphine should be offered as the first-line treatment in opioid detoxification. When deciding between these medications, healthcare professionals should consider:

- whether the service user is receiving maintenance treatment with methadone or buprenorphine – if so, opioid detoxification should normally be started with the same medication
- the preference of the service user.

Ultra-rapid detoxification

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

The choice of setting for detoxification

Staff should routinely offer a community-based programme to all service users considering opioid detoxification. Exceptions to this may include service users who:

- have not benefited from previous formal community-based detoxification
- need medical and nursing care because of significant comorbid physical or mental health problems
- require complex polydrug detoxification, for example, concurrent detoxification from alcohol or benzodiazepines
- are experiencing significant social problems that will limit the benefit of community-based detoxification.

The following point is supplementary to NICE's guideline:

- there are cases in which detoxification in an inpatient or residential rehabilitation service might benefit a patient who has not previously attempted detoxification in the community.

4.9 Naltrexone for relapse prevention

Naltrexone is an opioid antagonist which, when taken regularly, blocks the effects of opioids completely.

When used following opioid detoxification, naltrexone is an effective treatment for opioid dependent people who are highly motivated to remain in an abstinence programme. It should only be started as part of a programme of supportive care. Subsequently, its effectiveness should be reviewed regularly and if opioid misuse becomes apparent, discontinuation of the naltrexone should be considered.

Due to the potentially hepatotoxic nature of naltrexone, liver function tests should be conducted before and during naltrexone treatment.

Naltrexone should only be administered under adequate supervision to people who have been fully informed of the potential adverse effects of treatment (including the risk of overdose from any attempts to overcome the blockade effect). If the patient has been using opioids prior to the administration of naltrexone then severe and prolonged withdrawal symptoms can follow.

Naltrexone should usually be used only after a patient is definitely opioid free, for example, at least 7-10 days after methadone dosing. This should be verified by drug tests being negative for opioids. Patients can probably be commenced on naltrexone within a few days of finishing a buprenorphine detoxification.

If a urine or oral fluid screen is positive for opioids, then no naltrexone should be given.

If it cannot be verified that the patient has been opioid-free, a naloxone dose challenge (400 micrograms given intramuscularly or subcutaneously) may be done to check the patient does not experience any withdrawal symptoms.

Once the prescriber is confident that patient has been opioid free, 25mg naltrexone is given on day one. The patient should be observed for one hour after this first dose (this is especially important if there has been no naloxone challenge). If there is no emergence of opioid

withdrawals, 50mg naltrexone daily can be initiated. Some clinicians provide a second 25mg dose of naltrexone on the first day when they consider it to be clinically indicated, with the aim of providing maximum opioid antagonism as quickly as possible.

The total weekly dose (350mg) may be taken as 50mg daily or alternatively may be given on three days of the week to improve compliance (e.g. 100mg on Monday and Wednesday, and 150mg on Friday).

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

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

In an attempt to overcome the problem of poor patient adherence with oral naltrexone, development work has included both implant and depot forms of naltrexone. A depot formulation has product approval in the US but, at the time of publication, there were no implant or depot forms of naltrexone licensed in the UK or elsewhere in Europe.

Psychosocial interventions with relapse prevention medication are discussed in [section 3.6.2](#).

4.10 Pharmacological management of dependence on other drugs

4.10.1 Benzodiazepines and z-drugs

4.10.1.1 Introduction

These medicines have their own potential for misuse and dependence and are often taken in combination with opiates or stimulants. Many drug misusers misuse benzodiazepines but the majority do not require long-term replacement prescribing or high doses. For those who are benzodiazepine dependent, sudden cessation in their use can lead to a recognised withdrawal state.

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

Development of local protocols that reflect the evidence base and clinical guidelines can help to promote consistency of practice within a service, alongside consistency of communication with primary care practitioners about the role for secondary care services in prescribing for patients.

4.10.1.2 Prescribing regimen

There is little evidence to suggest that long-term substitute prescribing of benzodiazepines reduces the harm associated with benzodiazepine misuse and there is evidence that long-term prescribing (especially of more than 30mg diazepam equivalent per day) may cause harm.

To prevent symptoms of benzodiazepine withdrawal, the clinician should continue a current prescription but the dose should be gradually reduced to zero. Only very rarely should doses of more than 30mg diazepam equivalent per day be prescribed. Initiating prescribing to assist detoxification should only occur where there is clear evidence of benzodiazepine dependence (from careful consideration of the patient's history and clinical records and/or observed symptoms of withdrawal and with support from current, and where available historical, drug testing). The aim should normally be to prescribe a reducing regimen for a limited period of time.

If the patient is also receiving a long-term prescription of methadone for concomitant opioid dependence, the methadone dose should be kept stable throughout the benzodiazepine reduction period. Concurrent detoxification from both medicines is not recommended in a community setting.

Particularly for those with a primary benzodiazepine dependence, and in cases of severe comorbidity (such as with depression and anxiety), a focus on initial stabilisation of physical and psychological health issues causing distress may improve chances of subsequent successful detoxification.

Clinicians may be faced with requests to continue a prescription for maintenance benzodiazepines. While most patients in receipt of structured drug treatment will either not require benzodiazepine replacement, or will be provided with a time-limited detoxification programme, there will be exceptional cases, following careful assessment, where individuals with dependence may be provided with longer-term prescribing of benzodiazepines. Factors such as long duration of previous benzodiazepine prescribing, clear evidence of relevant pre-existing and concurrent comorbid mental health problems, or clear deterioration following previous adequate benzodiazepine detoxification are factors that clinicians may consider are relevant in such cases. Any such longer-term prescribing of benzodiazepines should adhere to general principles of management of dependence (including identifying clear indications of benzodiazepine dependence, clear intermediate treatment goals and milestones, regular review of the approach and use of methods to prevent diversion).

Insomnia in patients receiving prescribed methadone may be best alleviated by reviewing methadone dose, encouraging cessation of any stimulant misuse and guidance on management of sleep disturbance.

NICE guidance (NICE 2004) is that the choice of shorter-acting benzodiazepine or z-drug (zaleplon, zolpidem and zopiclone) for the short-term "management of severe insomnia interfering with normal daily life" should be determined by cost. Patients who have not responded to one of these hypnotic drugs should not be prescribed any of the others. There is no evidence that intermittent, 'pulse' regimens (such as one week on and one week off) prevent dependence and these should be avoided in the management of insomnia.

4.10.1.3 Detoxification

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

While the research evidence on treatment is limited, it is accepted good practice to first convert sedative-hypnotics into an appropriate dose of diazepam. This is especially true for

patients highly dependent on short-acting, potent benzodiazepines and on preparations that do not easily allow for small reductions in dose.

Patients who are not heavily dependent may be withdrawn without conversion to diazepam. This is more likely if the patient is on temazepam, nitrazepam or a z-drug and doesn't need treatment in a specialist drug treatment service.

[Table 4](#) lists the approximate doses equivalent to 5mg of diazepam to be used for selected medicines. Inter-patient variability, differing sedative potencies and differing half-lives mean predicting the exact substitute dose needed is not possible. Switching to diazepam is therefore best carried out stepwise, with the first switch including the night-time dose. In individuals with marked hepatic dysfunction, specialist hepatology advice is needed before switching to diazepam.

Diazepam has several advantages over other benzodiazepines. It has a relatively long half-life and is available in different strength tablets. It can be given as a once-a-day dose, which may need to be adjusted against withdrawal symptoms. The clinician should aim for the lowest dose of diazepam that will prevent withdrawal symptoms.

The rate of withdrawal is often determined by an individual's capacity to tolerate symptoms. Benzodiazepines, including diazepam, can be withdrawn in proportions of about one-eighth (between one-tenth and one-quarter) of the daily dose every fortnight. In dependence on therapeutic doses, the dose can be reduced initially by 2-2.5mg and, if withdrawal symptoms occur, the dose can be maintained until symptoms improve. If the patient is not coping and is experiencing withdrawal symptoms that are too uncomfortable for them to tolerate, it may be necessary to increase the dose to alleviate the symptoms before making a reduction again. While full detoxification can proceed without difficulty within weeks or within 2-3 months for some patients, NICE expert review has noted that withdrawal may take three months to a year or longer in some cases. An optimal speed or duration of dose reduction is not known. However, in general, those patients who have a primary illicit drug problem (such as heroin or crack dependence) without severe comorbidity will need less prolonged detoxification.

Patients should be advised that the detoxification will be gradual, and the speed and duration will be reviewed to take account of any significant withdrawals that may emerge.

If very high dose prescribing is required, the patient should be referred for addiction specialist assessment. Addiction specialists need to exercise caution in their assessments and prescribing. If the patient is stable and free of withdrawal symptoms, at for example, 50mg diazepam-equivalent a day, the dose should be gradually reduced at a faster rate than suggested above, for example, by half over six weeks and then the planned rate of reduction should be again reviewed in line with the guidance outlined previously. This faster rate of reduction from very high doses led to no convulsions even in a group who had a high incidence of these during previous benzodiazepine withdrawals (Scott 1990).

Table 4: Approximate dosages of common sedative-hypnotics equivalent to 5mg diazepam (derived from the British National Formulary and NICE Clinical Knowledge Summary but equivalents will vary and should be titrated against patient response)

Drug	Dose
Alprazolam	0.25mg
Chlordiazepoxide	12.5-15mg
Clobazam	10mg
Clonazepam	0.25mg
Flurazepam	7.5mg to 15mg
Loprazolam	0.5mg to 1.0mg
Lorazepam	0.5mg
Lormetazepam	0.5mg to 1.0mg
Nitrazepam	5mg
Oxazepam	10-15mg
Temazepam	10mg
Zaleplon	10mg
Zopiclone	7.5mg
Zolpidem	10mg

4.10.1.4 Adjunctive therapies

Review of care should be sufficiently frequent to detect and manage problems early. While reducing the dose, structured psychosocial interventions, counselling, support groups and relaxation techniques can be helpful along with advice and support for any emerging anxiety, depression or insomnia.

While evidence for the effectiveness of propranolol (for severe physical symptoms of anxiety unresponsive to other advice and support during detoxification) is noted by NICE to be poor, it is recommended in the BNF for consideration in such circumstances.

4.10.1.5 Monitoring

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

Those undergoing a benzodiazepine detoxification need frequent monitoring to identify progress and difficulties, and to adjust treatment accordingly, in line with an agreed care plan.

4.10.1.6 Dispensing and supervision

Where practicable, dispensing and supervision should follow a schedule similar to that for other drugs of dependence, including daily dispensing (with unsupervised consumption) or daily supervised consumption where appropriate.

4.10.2 Stimulants

4.10.2.1 Introduction

The mainstay of treatment for stimulant misuse and dependence is psychosocial and non-pharmacological. Along with traditional stimulants, such as amphetamine and cocaine, there has been emerging use of methamphetamine and a range of new psychoactive substances with similar stimulant properties that are likely to pose similar or greater risks and may need similar responses adapted, if appropriate, to the context.

Many pharmacological agents have been tested to assess their utility in treating withdrawal from stimulants, particularly cocaine, and none have been demonstrated to be useful in promoting abstinence.

General support and reassurance will often be sufficient for symptomatic treatment, depending on severity and duration of distress. However, clinicians may consider that the degree of distress associated with, for example, agitation, psychosis or severe acute insomnia following recent use or recent development of stimulant withdrawals is sufficient to warrant symptomatic pharmacotherapy with close monitoring.

4.10.2.2 General measures

General principles of management, such as giving preventive advice about safer injecting practice, must be applied.

Symptomatic treatment of acute psychiatric complications is needed. In addition to general support and reassurance, which is sufficient for many less severe or short-lived problems, major tranquillisers are sometimes used for psychosis and agitation, and a non-benzodiazepine hypnotic is sometimes used for insomnia.

For problems with persistent cocaine misuse or dependence, studies have found that an abstinence-based psychosocial treatment approach, linking counselling and social support, has the greatest impact. Approaches incorporating contingency management (CM) have been found to be more successful at promoting abstinence, both with regard to primary cocaine use and also for patients in opioid maintenance treatment programmes who also use cocaine.

Where a patient exhibits persistent anxiety and agitation, the clinician should attempt to focus on stress reduction procedures. Patients who display persistent and severe psychotic symptoms may require admission to and treatment in a psychiatric unit. For persistent depression that meets the criteria for a major depressive episode, antidepressant treatment may be helpful (see [section 4.10.2.3](#)).

Withdrawal may be associated with significant symptoms of depression and the patient's mood should be monitored and the risk of suicide assessed.

Special efforts may be required to attract hard-to-reach populations into treatment.

4.10.2.3 Antidepressants

Antidepressants, such as fluoxetine, can be effective in the management of major depressive episodes associated with stimulant use.

Care should be taken if selective serotonin re-uptake inhibitors (SSRIs) are prescribed while cocaine or amphetamines continue to be taken, as toxic reactions have been described. MHRA has reminded prescribers to note the potential increased risk of bleeding when citalopram is prescribed to patients who are taking cocaine (MHRA 2016).

There is no evidence that antidepressants have any effect on the withdrawal symptoms from stimulants.

4.10.2.4 Substitute prescribing

There is no indication for the prescription of cocaine or amphetamines in the treatment of stimulant withdrawal and it is not recommended that other stimulants, such as methylphenidate or phentermine, are prescribed. However, there is evidence that, when providing maintenance treatments (methadone or buprenorphine) to patients with opioid dependence problems who also take cocaine, cocaine use may decrease or stop with the provision of effective opioid maintenance treatment, and, when it persists, it may respond positively to further improvement of the opioid maintenance treatment. However, those with a comorbid severe cocaine or crack dependence may need specific psychosocial interventions aimed at addressing the cocaine use even despite good stabilisation and cessation of heroin use.

There was previously thought to be a limited place for the prescription of dexamfetamine in the treatment of amphetamine misuse, and this still occurs in some parts of the UK. The evidence comes from reports that are typically small in number and weak in design, and the evidence of benefit is not convincing. Even though there may be individual patients for whom existing treatment should be continued for the time being, substitute stimulant prescribing should not ordinarily be provided.

4.11 Resources and further reading

The GMC's Good medical practice guidelines (2013) www.gmc-uk.org/guidance/good_medical_practice.asp

British National Formulary www.medicinescomplete.com/mc/bnf/current (requires registration)

Summaries of Product Characteristics (SPCs) and Patient Information Leaflets (PILs) www.medicines.org.uk/EMC

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Chapter 5: Criminal justice system

5.1 Key points

- Treatment and care for those with drug and alcohol problems in the criminal justice system (CJS) should aim to be excellent, safe, effective and broadly equivalent to that in the community.
- Commissioners and providers of community drug treatment and of healthcare in the CJS should support systems for rapid clinical communications at times of entry and departure, for planning support around release and for continuity of prescribing.
- In police custody, anyone confirmed as currently on OST should have their medication continued where possible. For others, emerging opioid withdrawals should be clinically managed to minimise symptoms and distress.
- At the time of prison entry, the reception process, assessment and initiation of prescribing and psychosocial interventions should be linked to plans for continued treatment during imprisonment.
- On the first night in prison any emerging withdrawals should be managed and any dependence disorder assessed and treated.
- Opioid dependence on the first day or night in prison is usually treated with continuation of community OST or initiation in prison, with regular monitoring and enhanced observation over the subsequent five days of stabilisation.
- Polypharmacy with two or more sedative or depressant medications should only be used with considerable caution on first night and for the first few days.
- Continued maintenance prescribing in prison, along with plans for seamless follow-up in the community, is usually the most appropriate and evidence-based approach for those with severe dependence in receipt of a short sentence.
- Detoxification in prison should be discussed with patients to enable them to consider the benefits and risks, based on the risks of relapse to heroin use after release.
- There should not normally be mandatory opioid reduction regimes for dependence.
- Withdrawals in prison should be actively managed using opioid substitute, adjunctive and/or symptomatic medication as equivalent to provision elsewhere.
- Commissioners should agree with prison health and community providers how best to facilitate support for naloxone provision on release.

The criminal justice systems of England and Wales, Scotland and Northern Ireland vary. What follows is a general summary of the ways in which clinicians will be involved with people in the CJS who misuse or are dependent on drugs.

5.2 Introduction

5.2.1 Drug use, crime and treatment

The link between drug use and misuse and crime is well established. The causal relationship between drug misuse and offending is complex but involvement of drug users in the CJS presents important opportunities for offering health interventions.

The CJS is increasingly used as a setting to offer treatment directly or as a gateway for referral to treatment in the community. Clinicians within criminal justice settings are therefore required to be able to assess clinical need in those with substance misuse problems and to deliver effective and equitable treatment. Clinicians outside the CJS need to be able to assess, support and respond to the specific needs and opportunities facing individuals referred to them from points in the CJS, such as police custody, courts, probation/supervision and prisons.

Drug dependence is associated with high rates of offending, and the consequent risk of repeated involvement in the CJS, including imprisonment for some. Helping to reduce this risk is a reasonable clinical goal for many patients and should be factored into the treatment and recovery care planning process.

5.2.2 Addressing health inequalities

Offenders in general and prisoners in particular are more likely to suffer from physical and mental health problems than the general population. These inequalities often occur alongside additional social inequalities, which can affect their recovery potential. Some of these problems precede problem drug use, some develop alongside and some are consequent. For any individual, there can be a complex interplay of factors.

The incidence of drug and alcohol misuse, and smoking prevalence, is much higher among this cohort. There is a much higher prevalence in the short term of self-harm, suicide and drug related death as well as longer-term premature morbidity and mortality. The rigorous application of the CJS's principles of equivalence in healthcare, and parity of esteem, is therefore especially important to this group. Access to timely and effective assessment and treatment interventions within, and subsequently outside, the CJS must be a high priority on clinical grounds to address health inequalities. This includes access to appropriate management of long-term conditions.

Transitions to, from and between criminal justice settings, such as between police custody and courts or at prison release, create the potential for interruptions in the delivery of required treatment and heighten the risk of relapse and of overdose deaths. The strong evidence for the level of these preventable risks places a clear responsibility on all clinical assessment services and treatment providers, in the wider community and in all custodial settings, to ensure that there are effective and timely referral routes and channels of communication to

address these risks and to enhance safe continuity of care. The rapid exchange of suitable patient information can be crucial to facilitate continuity of prescribing.

5.2.3 Commissioning criminal justice based interventions

Commissioners of community treatment services and of healthcare for people in the CJS need to commission pathways of provision that can deliver prompt and urgent assessment, management of risk, equitable treatment and care, communication with other CJS and community providers, and careful planning of release or transfer with support for a prompt or immediate transition of care.

It is important that clinicians use the range of initiatives and systems commissioned for offenders, when appropriate, to support their patients' drug treatment and recovery. Some initiatives may be focused primarily on reducing reoffending, however, they may offer additional resources and support to those with problem drug use, which may help their recovery with their drug dependence. Compliance with patient consent and confidentiality should not pose a barrier to accessing appropriate support and, in some situations, this should be reflected in agreed information sharing protocols.

Community drug services have an essential role in:

- developing systems for communicating effectively with community criminal justice agencies and with the courts to support their patients
- communicating promptly with those assessing and providing early support in custodial settings
- supporting those planning aftercare arrangements for drug misusers exiting custody
- developing and providing prompt and effective throughcare arrangements back in to the community.

Organisational and staffing arrangements need to be in place that support continuity of prescriptions on release and immediate or very prompt community assessment for individuals identified as at risk (including those not on medication for drug dependence at the time of release). These arrangements should be part of the commissioning and funding of community services.

5.2.4 Assessment, identification, liaison and diversion for all health needs

Many offenders within the CJS have complex health needs and vulnerabilities that are not routinely identified. Offenders with mental health conditions, learning disabilities, problems of substance misuse and other vulnerabilities need to be identified early and provided with supported access to appropriate services. Given the high levels of comorbidity in those with drug problems, assessment and treatment of the comorbid conditions can be crucial to effective care.

Systems to identify and assess problem drug use (and other comorbid problems) are important. They ensure that people's diagnoses and vulnerabilities are communicated within the CSJ, enabling better charging and disposal decisions by police custody staff and sentencers. Assessment and referral to appropriate treatment and support means that

substance misuse, mental health conditions, learning disabilities, and other vulnerabilities can be more effectively addressed. This could improve health and reduce reoffending.

CJS initiatives that specifically address common comorbidities, such as substance misuse and mental health, may provide a more joined up approach for this service user group.

Healthcare practitioners need to be aware of, and understand how, developments within the CJS could impact positively on their practice. This includes recognising how initiatives aimed at treating comorbidities and reducing reoffending can improve patient care and achieve better health outcomes.

5.3 Criminal justice systems in the community

5.3.1 Police custody

5.3.1.1 Introduction

Substance Misuse Detainees in Police Custody: Guidelines for Clinical Management (RCPsych 2011), also known as the Blue Book, is an additional source of detailed authoritative guidance on managing clinical issues in police custody.

It is important for the safe management of drug use and dependence in police custody that competent staff provide a comprehensive assessment, appropriate monitoring and re-assessments (particularly of mental health and of capacity issues) and identify any emergence of intoxication or withdrawal symptoms and signs. The timing of arrest and its relationship to recent consumption of psychoactive drugs is an important factor in risk assessment and in monitoring for any delayed drug effects. The clinical picture may change in hours and may need prompt management. Intoxication and withdrawal can put detainees at risk of medical, psychiatric and even legal complications. Accurate assessment of any suspected health problems related to drug use (including the severity of any dependence) and assessment of the need for medical intervention is therefore essential.

Criminal justice drug workers working in police custody suites may provide information, referral to treatment or other assistance to people in custody who use drugs. Referral for treatment of someone who uses drugs is an opportunity but should be purely voluntary (whether or not the decision is linked to an individual's choices about bail or sentencing options).

Key components of effective management of drug use and dependence for those in police custody include:

- adequate and competent assessment of need and risks, including obtaining any key background information from the custody officer and other sources
- close attention to the rights of the detainee, with careful attention to the issue of consent
- provision of the same standard of medical care as for any other patient, including appropriate prescribing
- attention to sustaining any continuity of treatments and care needed
- good communication with relevant services and/or prison reception.

5.3.1.2 Management of opioid dependence in police custody

Wherever possible, methadone or buprenorphine maintenance should be continued for anyone arrested and already stable on such medication in the community. Where a patient's recent compliance with supervised consumption of methadone or buprenorphine medication in the community can be adequately confirmed, that patient's medication can be used to provide continuity of care (by being collected and administered at the community prescribed daily dose). Healthcare professionals (HCPs) in police stations should support this continuity of care. The confirmed daily dose can be divided in the custody setting if considered appropriate.

Where it is determined with the person in police custody that continuing their supply of controlled medication from their community pharmacy is most appropriate, it is important to understand responsibilities to communicate effectively and to record decisions and actions taken. Further guidance on the mechanics of arranging for such supply to police custody suites in England is contained in Access to supervised doses of opioid substitution for people in police custody (PHE 2015).

For any patients in police custody whose community opioid substitution treatment is unsupervised (or whose treatment is supervised but their recent doses cannot be adequately confirmed) the initial amount of opioid substitute to prescribe should be determined with caution. The person may have been consuming a lower dose than the one they were prescribed and if then provided with that entire dose at once in custody they could overdose due to inadequate tolerance. Overdose during induction can occur either very soon after administration or can be delayed by a day or two or more because of the long half-life of the medication used. Patients must therefore always be inducted carefully on to opioid substitution treatment. Assessment for opioid substitution in police custody is described in the Blue Book and is consistent with the principles described for prison reception below ([section 5.4.6.3](#)).

There is limited published evidence to aid choice of opioid substitute to manage dependence and withdrawals that is specific for the context of police custody. The evidence base for heroin dependence consistently indicates that where a need for opioid substitution is identified, and where safe induction on to methadone or on to buprenorphine is possible for this, that is the most appropriate intervention for stabilisation and management of the patient.

In choosing medication in the context of police custody, clinicians may have to take into account the circumstances for the individual, the possibility of rapid transfer out of the police cells, risks associated with transportation of the individual between different custodial settings, and the clinician's ability to monitor, identify and manage any emerging intoxication or emerging withdrawals associated with an opioid induction in this context. For managing opioid dependence in police custody, those who have been confirmed already to be in receipt of prescribed methadone or buprenorphine in the community may continue this.

It is important for clinicians in potential cases of opioid dependence to avoid the emergence of opioid withdrawals in police custody or to minimise them appropriately. The common practice of experienced clinicians in police custody is to use non-opioid symptomatic medication or dihydrocodeine. Dihydrocodeine has perceived safety advantages in short-term use, being a lower potency opioid agonist with a short half-life, with a consequent reduced likelihood of

accidental dose accumulation and of overdose (dihydrocodeine modified release has a longer half-life and patients on it typically take their medication twice daily). While some guidelines suggest dihydrocodeine should not be routinely used for managing withdrawal symptoms, experienced clinicians sometimes prescribe it in the circumstances of the police custodial environment. It is important that clinicians prescribing in police custody document their rationale for prescribing and their clinical management and risk plans, and that they keep up to date with relevant clinical guidance.

Where dihydrocodeine is used in police cells, regular attention is needed to monitor and adjust the dose and to avoid inadequate provision and risk of withdrawals. The decision as to the necessity and timing of any reassessment is the prescriber's responsibility and should be based on the severity of dependence and other aspects of the clinical findings. Clear recording of doses and the times given is crucial. Patients on dihydrocodeine who are due to leave police custody, particularly those transferring to court and to prison, need consideration of the limitations of dihydrocodeine in these circumstances when its lower potency and short duration of action could contribute to the patient becoming unstable during transfer and displaying severe symptoms of withdrawal if not adequately or promptly treated. Actions to help mitigate the risks include:

- timing of doses prior to any planned transfer
- giving clear advice to the patient about duration of the effects of their medication
- providing appropriate information to the custody officer
- ensuring the recorded information provided for prison healthcare staff gives clear doses and timing.

Some patients will be released back into the community from police custody after receipt of dihydrocodeine or non-opioid symptomatic treatments for withdrawal. It is important to discuss carefully with these patients the management of their risks and the treatment options available to them.

5.3.2 Arrest and bail

Some police forces may use available powers such as drug testing on arrest, required assessments and restrictions on bail to facilitate referral, assessment and treatment. Implementation of such provisions will vary from area to area. Clinicians may be involved in such referrals, which may sit within agreed local protocols. While usual duties of consent and confidentiality apply as for any healthcare, patients may consent to sharing of relevant information with probation professionals or others.

5.3.3 Probation, supervision, reoffending and rehabilitation services for offenders

Professionals involved in reducing prisoner reoffending and in rehabilitation are encouraged to establish effective working relationships and open channels of communication with substance misuse providers and healthcare staff in custody and in the community to ensure that treatment requirements and conditions are met and that continuity of care arrangements are supported. This may be established in protocols or care pathways or in commissioning arrangements. Clinicians can assist their patients in using such arrangements and making effective use of the additional support that this can offer to those engaging in the process

of recovery. The usual duties of consent and confidentiality apply but in such cases some patients will want active communication between professionals and services.

5.3.4 Community sentences with treatment conditions

Bail options and community sentences with treatment conditions, which are available in some countries, can encourage engagement in assessment and treatment. Similar alcohol or mental health options also exist. These arrangements can include an agreement by the offender to attend structured treatment and to have regular drug testing as part of a community order or suspended sentence order.

The amount and intensity of the drug treatment delivered under these arrangements should be clinically driven and tailored to individual need regardless of the seriousness of the offence.

Any formal review of a community sentence will include the results of drug tests the offender agreed to as a requirement at the outset.

5.3.5 Interfaces between treatment and the criminal justice system

Detailed clinical guidance on the treatment of drug misusers remanded in prison or given a custodial sentence is covered in the next section. However, the broad interface between treatment providers in the wider community and the increasingly complex network of criminal justice based structures and points of intervention provide numerous treatment opportunities.

Healthcare practitioners should familiarise themselves with the relevant structures locally. They should ensure that there are proper lines of communication and information exchange in the interests of their patients that can facilitate effective treatment and recovery care planning and coordination.

5.4 Prisons and other secure environments

5.4.1 Introduction

The purpose of healthcare in prison, including care for drug and alcohol problems, is to provide an excellent, safe and effective service to all prisoners, equivalent to that of the community. This section focuses on the prison environment but clinicians can apply the principles when appropriate to other secure environments.

Screening, assessment and treatment for problem drug and alcohol use should address the wide range of substance use, and other, often related, physical and mental health needs identified, and should address identified disability. It should have a public health perspective and focus on reducing harms and promoting recovery.

Care should be delivered by professionals and allied staff who are suitably competent, well led, properly supervised and operating within a clear quality and clinical governance framework supporting safe and effective delivery.

Treatment should be regularly reviewed. There should be access to suitable psychosocial interventions to support treatment and recovery. Where medication is indicated, its provision should be suitably optimised, particularly in those with difficulties achieving stability.

Clinicians should be broadly aware of the main psychoactive drug types, of current and emerging trends in drug and alcohol use and harms, and of the risks from prescribed drugs. They will also need to keep abreast of changes in prescribing practices that may affect risks of misuse of prescribed drugs or from polypharmacy. Clinicians should be able to adapt evidence-based treatments from the wider community to the prison estate and regime, and be able to work with security staff and systems to reduce harm and to manage risk, particularly the risk of fatalities and self-inflicted harm. Management of risk for those with problems with substance use includes a good understanding by clinicians of the risks from inadequately addressed comorbidities, from unnecessary or unsupervised polypharmacy, from inadequately addressed intoxication or withdrawal, and of delayed symptoms of intoxication or withdrawal that may affect risk of self-harm and suicide, particularly in the first weeks following reception. They also need a clear understanding of the nature of dependence and of risks of relapse in the period after release. This is particularly important for those with heroin dependence who have become drug-free during imprisonment who are not in receipt of opioid substitution treatment, who then have a very substantially increased risk of overdosing and dying soon after release (Larney et al 2014, Degenhardt et al 2014).

To provide an adequate and suitably safe service, it is crucial to integrate reception, initial assessment, and the initiation of prescribing and psychosocial interventions at entry with continuing availability of recommended evidence-based pharmacological and psychosocial treatments during further imprisonment, and with systems for throughcare, aftercare, and risk management planning that support release and integration back in to the community. Exactly how these three elements are organised may vary but clinicians need to plan for, and contribute when appropriate to, all these elements to ensure 'equivalent' and proper care. It is important that clinicians do not focus unduly only on the initial period of need but on the opportunities and the risks that will face a patient with dependence across this whole pathway, including immediately after release.

It is the responsibility of any commissioners and of managers to ensure clinicians within prisons are adequately resourced and supported in their roles to meet service demand and to manage tensions between optimal healthcare and peak demands of the prison reception process and prison security.

5.4.2 Features of the prison environment

This environment presents a positive opportunity to engage with offenders with drug problems, whether or not they are currently in treatment at the time of entry, and especially to offer support for those who are vulnerable with multiple comorbidities.

Care in prison can offer a valuable opportunity for various assessments and for integrated and holistic care plans.

Imprisonment may be short-lived in certain prison environments while other environments manage prisoners over many years. Both environments give a positive opportunity for initiation or maintenance of treatment, matched with clear discharge pathways for further engagement in community (whether to sustain pharmacological treatment or to support continued abstinence).

In providing equivalent, effective assessment and treatment in the prison system there are some important elements that require additional or particular attention in making sure that care is as safe and effective as possible. All these issues necessitate suitably skilled staff who:

- understand the nature of drug dependence
- have a thorough understanding of the key risks involved during imprisonment and after release
- are engaged in supporting integrated working
- focus on continuity of comprehensive care at entry, during imprisonment and across periods of transfer and release.

Skilled risk assessments, clear discharge planning and systematic links with community services are essential.

There are some common clinical scenarios specific to the prison environment that all clinical staff need to be prepared to manage. They involve individualised care equivalent to that provided in the community and prioritising safety, alongside adaptation to the prison setting if appropriate. Such scenarios include:

- during reception and first night, identifying, recording and acting on all known risk factors (including any risks from intoxication and withdrawal and of suicide or self-harm) and ensuring there is an active plan to reduce the risks
- the high numbers needing rapid assessment at reception
- high levels of significant comorbidities and vulnerabilities (including multiple drug, alcohol and tobacco use/dependence and serious physical and mental health comorbidity)
- over-representation of those with unstable and untreated long term conditions and significant social care needs
- lack of verifiable clinical data at the time of reception
- addressing veracity of 'self-reported' high levels of community-prescribed polypharmacy
- the need for careful medicines management in the first few days given the risks of diversion and abuse of prescribed medicines (including medicines for pain)
- difficulties in making decisions about managing any confirmed polypharmacy for reported coexisting conditions in the prison setting (taking account of known added risks but also the opportunity for closer clinical monitoring)
- difficulties accessing wider community services at peak times of reception assessments (GP, specialist drug treatment service, dispensing pharmacy, etc.)
- in certain cases, lack of clarity about which local treatment providers to approach
- the concern about the risk of self-inflicted deaths following prison-entry
- responding to clinical impact of current trends in substance use (e.g. toxic effects of new psychoactive substances such as synthetic cannabinoid receptor agonists)
- need for adaptations from community formularies to maximise safety in the prison setting (e.g. greater first line use of methadone over buprenorphine).

There are several periods of transition for those entering and leaving prison. All those involved in clinical management in prisons need to consider carefully how to address:

- the package of assessment and care in the initial weeks following entry
- subsequent points of transition (to court or to other prisons)
- exit planning (aiming for uninterrupted engagement with community support).

The challenges associated with transitions include:

- variable models of care and delivery in different parts of the system
- an increased risk of self-inflicted deaths following prison-entry (with the need to minimise such risks through effective clinical management, individual support and close observation)
- the increased risk of overdose fatalities in the month following prison release (with the need to actively engage with pre-discharge planning)
- the vulnerability to self-inflicted harm of revolving door, recalled prisoners (with a need for prompt and accurate information to be provided about the reasons for the recall, for the risk of suicide to be kept under review, and for prompt communication with community treatment providers to secure safe and seamless continuity of care)
- supporting offenders who have been separated from their family and supporting the affected families.

The workforce requires support in maintaining skills relevant to the prison environment, where there are particular needs:

- despite capacity issues at peak times, a wide skill mix needs to be available – with clinical and non-clinical therapeutic staff delivering assessments and treatment that should be in line with established competencies (such as professional prescribing competencies and DANOS), and this should sit within suitable systems of supervision and governance
- high-risk periods require deployment of key staff to address need and risk (e.g. a focus on reception, the first month of treatment, and prior to and on release)
- clinical staff need to be able to confidently assess clinical risk in the prison environment, and to work with other teams, particularly mental health, to reduce risk.

As well as addressing the various clinical and therapeutic priorities of patients, clinical and non-clinical therapeutic staff need to deliver care, equivalent to the community, within the constraints and opportunities of operational management of prisoners. This includes:

- managing treatment, in some cases, alongside a high risk of violence
- being able to manage treatment in segregation units
- organising the timely and safe administration and supply of medicines alongside security requirements
- maintaining adequate observation and access aligned with the prison regime
- developing care plans when only limited observation may be possible

- organising healthcare staff whose need to access cells has an operational impact
- working in an environment where high levels of complaints and litigation can be expected.

5.4.3 Standards of excellence and quality assessments

A clinical and quality governance strategy, and its implementation, should address all issues of competence and training for clinical and non-clinical staff, and for operational staff in the prisons. The close reliance of clinical and operational staff for the delivery of safe and effective care and for maintaining a safe environment is such that there should be a mutual understanding of priorities and needs.

All staff should act professionally, ensuring appropriate confidentiality and consent within a patient focused environment, while complying with all proper information sharing agreements that support a safe environment. It is important that all healthcare practitioners understand their duty of care and confidentiality to the patient while also recognising that patients will usually be content with any sharing of clinical information that is in their interests and contributes to their safe and effective care.

The effectiveness of well delivered, evidence-based treatment for drug and alcohol dependence is well established. Treatments impact positively on levels of drug use, offending, overdose risk and the spread of blood-borne viruses. Other guidance documents have been published in recent years that focus on specific clinical issues in the prison environment, and these should be referred to. Appropriate local protocols need to be developed, updated whenever appropriate, to adequately reflect the current evidence base, these Clinical Guidelines and any other suitable authoritative guidance on implementing treatment within the prison environment.

5.4.4 Prison and drug treatment

5.4.4.1 Clinical pathways of care

Providers of drug and alcohol services in prison, alongside those providing mental health and primary care, must work in an integrated and collaborative way to support delivery of effective and safe care. These providers will also work with other health and social care providers such as health trainers and peer mentors and those who have a key role in supporting prisoners and their families. Effective understanding of these systems, and ongoing regular communication when needed, is essential. Excellence in recording and maintaining healthcare records is important because different healthcare providers may have shared access to the digital records of a prisoner.

5.4.4.2 Meeting the needs of prisoners who misuse or are dependent on drugs

Integrated clinical pathways in prisons necessitate accurate assessments, timely interventions, physical observation, monitoring, holistic care and communication with all relevant healthcare and security staff.

Some people who use drugs are particularly vulnerable to harm. They need to be identified and actively managed, preferably by a multidisciplinary team. These individuals include those with polysubstance misuse or dependence, those with significant comorbid mental health disorder, those with comorbid physical health problems (which are often multiple and

complex), and others such as pregnant women and those receiving complex regimens of prescribed medication. Clear and well communicated plans developed with these prisoners should address their multiple health and social care needs, and risk management. A shared care model of provision, with integrated care pathways and links with a range of services is necessary. These pathways should be underpinned by minimum quality standards that support consistency and continuity of care.

For a patient with heroin dependence to be able to give adequately informed consent for their chosen care pathway, the advice from their clinician must take account of the evidence of the protective effect on reducing opioid-related deaths of providing treatment – and particularly opioid substitution treatment – within prison and after release. Whatever care pathway is agreed with a patient in prison, and with opportunities for its review before release, the choice should have been informed by the known benefits and risks of each pathway that takes account of the post-release period.

5.4.5 Screening, initial risk assessment and comprehensive assessment: reception in prisons

5.4.5.1 Principles

The principle of equivalence: the provision to individuals in prison of care equivalent to that provided to individuals in the community (including evidence-based and clinically-effective interventions and pathways), should always be appropriately applied.

Screening and assessment should focus upon health improvement, disease prevention and current medication. This includes addressing key issues such as weight control, smoking cessation and managing other 'lifestyle' behaviours, alongside specific harm reduction approaches to address infection prevention and control.

Screening and assessment for evidence of drug (and alcohol) use and dependence, and of the risk of withdrawal, is crucial at reception, and for any longer-term direct physical and mental health consequences of drug and alcohol use. Identifying and responding to other comorbid physical illnesses is becoming increasingly significant, particularly with an ageing cohort of heroin users. Comorbid mental health conditions (including personality disorder) require assessment, and crucially at this reception stage, identifying and managing self-harm and suicide risk. Assessment of current prescribed medication is needed, including consideration of the evidence for its suitability and, where appropriate and possible, confirmation of adherence to the medication prescribed. Other comorbid physical and mental health problems should be assessed and addressed in line with guidance provided elsewhere in these guidelines.

Risk assessment and management is key at this stage, focusing on risks to physical health, reducing the risk of self-harm and active treatment of any mental and/or physical health crises.

Effective positive engagement of individuals as they arrive in prison, both with professional staff and with any mentors, can be crucial in reducing deterioration in mental health and in any substance use problems, and can help identify the risk factors for self-inflicted deaths. This engagement process should ensure that all individuals have a point of contact and are provided with information on services at point of entry. It is acknowledged that entry can be a distressing time, so advocacy, information and support are crucial from the start. A diagnosis

of personality disorder should not be a diagnosis of exclusion from treatment and care. Rather, it should highlight the need to help an individual to focus on their problems and how they may solve them within an atmosphere of hope and recovery. This holistic approach to integrated care and management is required for those with complex comorbidities.

5.4.5.2 Comprehensive substance use assessment

The purpose of assessment is to achieve a holistic and thorough assessment of need across all domains (including substance use, and physical, psychological and social). With the patient, this should lead to a care plan that addresses all their relevant treatment and recovery goals, that describes the actions to achieve them and the roles of all involved in supporting this.

[Section 2.2.2](#) of the guidelines highlights the main components of a comprehensive drug assessment.

It is important in the prison context that all information relevant to care is sought at the earliest possible time – from substance misuse, mental health, primary care, pharmacy and social care services, and from carers and families and other third sector services, as appropriate.

Some issues will need initial assessment on first day or night, including:

- recent alcohol and drug use, the risk of acute toxicity and the risk of any withdrawal syndromes (using any screening test results as appropriate)
- findings from physical examination and observation of mental state
- evidence for any acute or long-term physical or mental health disorders
- medication requirement, particularly to enable continuity of any critical medicines (taking account of the evidence for adherence to any prescribed medication and the findings of the medicines reconciliation process)
- safeguarding issues for children or vulnerable adults at home
- the evidence for an increased risk of suicide or of self-harm.

To inform decisions on medication, contact needs to be made with the community/relevant pharmacy and with the community substance misuse teams. This to verify adherence to medication, supervision of dispensing if any, dates dispensed, any missed days, receipt of other medication and recent general compliance. Increasingly, this can and should be done on first night, as part of the formal medicines reconciliation process, given many community pharmacies remain open outside normal working hours.

Those providing psychosocial interventions should review patients initially on the day following reception (or as close to this as possible), and alongside their active engagement with the clinical team. This means an integrated care plan can begin, focusing on treatment and recovery for all patients including those on remand and serving shorter sentences, and release planning can commence. The integrated care plan should cover substance use goals and actions. It should also address physical and mental health needs and social goals (such as skills development and housing need), the provision of medications and of psychosocial interventions, and other actions such as engagement with advocacy and with peer mentoring, and engagement in any family work.

Communication and networking with agencies that will provide support 'beyond the gate' allows for the development of an integrated care plan that can incorporate agreed actions and detail plans following release.

5.4.5.3 Continued monitoring following initial reception

Where a history of drug dependence is disclosed and diagnosed, and the prescribing clinician initiates medication, the patient should be reviewed regularly in the first five days. These reviews should involve the nurse and the prescribing clinician, who will support informed prescribing decisions with the patient. Following induction on to opioid substitution treatment, these reviews are needed to decide whether to reduce, maintain or increase the dose with a view to achieving adequate stability, and whether then to maintain the dose or reduce the dose as part of a planned detoxification. Monitoring and reviews are also important for identifying and addressing adherence issues, and for identification and management of any emerging withdrawals. Monitoring, and its frequency, will be determined by clinical assessment decisions and by the findings from any assessment and monitoring tools used. It is considered crucial that clinical reviews, normally by a nurse, are held at least twice daily in the first few days. However, this will need to be more frequent with more vulnerable and complex cases of physical and/or mental health problems, or when otherwise advised. The monitoring frequency should be discussed with, and the rationale understood by, the multidisciplinary team.

Screening and assessment tools may be used to support the assessment and monitoring process and may help to standardise care, by providing it in the context of clear protocols. Examples are given in [sections 2.2.2.4](#) and [3.7.1](#).

5.4.5.4 Toxicology/drug testing

Drug testing is important before initiation of some medications in prison (such as induction on to or continuation of supply of methadone), for monitoring following such prescribing and to obtain evidence of reduction or cessation of other drug use (evidence of stabilisation). This is discussed in [section 2.4](#).

The sensitivity and specificity of various types of testing can result in false negatives or false positives. Staff performing these tests must be competent in taking the samples, and in interpreting the results. Special care must be taken when interpreting screening tests, which are often done at night. Issues can include the timing of the sample, the timing of use of drugs prior to the test and the veracity of the offender. For example, an offender may have been prescribed diazepam and codeine in the police cells and both will be positive.

Testing does not confirm dependence or the degree of past use but provides useful corroborative information. Steps should be taken to limit the opportunities to tamper with specimens and to check their integrity.

Urine screening tests are the most versatile and the usual tests. Such screening tests can be used for heroin/morphine/many opioids, benzodiazepines, methadone, buprenorphine, cocaine, amphetamines and cannabis. Clinicians making use of screening tests need to understand their limitations and how to interpret the results and to understand the range of tests decided on locally. Some opioid drugs and many new psychoactive substances,

including synthetic cannabinoid receptor agonists, are not normally identifiable on screening tests although work is underway to develop tests for some synthetic cannabinoids.

A urine drug screen should be offered to all those who, at the initial verbal screening, answer 'yes' to past or present use of drugs.

A urine test should always be taken before starting opioids for the management of drug dependence in prison. The result should normally be positive if opioids are to be prescribed, and should be interpreted in light of the history and of physical and mental health assessments.

Occasionally, an individual entering prison may have evidence of significant opioid withdrawals, a strong history of use, but test negative on screening. This may be related to having been in cells for some time with no treatment or having recently dropped out of community treatment, and it may include some individuals who metabolise their methadone very rapidly. In such cases, care is required when beginning opioid treatment, particularly to titrate the dose carefully against response and to follow the recommended safe induction schedules. Patients whose fast metabolism of methadone may have contributed to a negative urine screen at entry may, in due course, need higher doses than others to achieve adequate stability. Suitable clinical competence is needed for prescribing in such cases.

5.4.6 Pharmacology for dependence at reception and first week

5.4.6.1 Medication for management of mental health crises in the first week

If, on screening, any prisoner is deemed to be actively psychotic, or has active suicidal ideation or intent, mental health services should be urgently requested to review. A prisoner assessed as having active suicidal ideation or intent should be managed under the local suicide strategy until mental health services can assess. If these scenarios occur at a weekend or in reception out of hours, then primary care clinicians and those assessing should seek advice from the mental health urgent/crisis/out-of-hours system available within the prison.

Treatment and monitoring will need to be initiated regardless of the possible cause of the psychosis (whether relapse or development of a new psychotic disorder or a drug induced or toxic psychosis). There should be active management of an agitated intoxication using suitable protocols and monitoring to ensure safety of the person and others.

If the history and presentation is suggestive of distress or agitation secondary to an emerging withdrawal syndrome that has developed after the initial reception assessment did not identify the risk, the prisoner should be seen by a healthcare professional to assess if urgent treatment is now needed. Such patients may need to be placed in 'safe cells' with intensive supervision and joint working to facilitate clinical access for monitoring, careful assessment and recording of consent and capacity.

5.4.6.2 Prescribing analgesic and other medication with abuse potential over the entry period

Some prisoners develop a problem with misuse of prescribed medication in prison. Misuse and diversion of prescribed medication in prison requires careful monitoring of prescribing and dispensing practices.

Significant care is required if the person entering prison is in receipt of opioid analgesics (or other analgesics with habit forming potential, such as tramadol, pregabalin or gabapentin), hypnotics, antidepressants, and/or antipsychotics. These drugs may precipitate CNS depression when prescribed in conjunction with opiate maintenance, benzodiazepine or alcohol withdrawal regimes. Unless clear medicines reconciliation and full adherence is confirmed, prescriptions of more than two drugs with sedative potential should be avoided on first night and/or for the first few days.

Indeed, reception into prison provides an ideal opportunity to review analgesic prescriptions initiated in the community since experience shows that many prisoners present symptoms of pain as a 'respectable' form of drug-seeking behaviour (RCGP and RPS 2011). They may present with symptoms of pain that have not been formally assessed, investigated and diagnosed and may not have been subject to regular medication reviews. Depending on assessment and diagnosis, management of such behaviours should be in accordance with the principles for managing opioid dependence on prescribed drugs (see [section 7.3](#)), or in line with pain management principles (see [section 7.2](#)). Also, see [section 5.4.11](#) on pain management in prison.

Antidepressants, hypnotics and antipsychotic medication should be reviewed with establishment of clear diagnoses and the rationale for these prescriptions, and confirmation of medication adherence where possible. Management plans including the continuation or cessation of the medications should be determined. Integrated care planning with forensic mental health is often required in such circumstances.

5.4.6.3 First night assessment for prescribing

To provide appropriate 'equivalent' treatment for drug dependence in prison as that provided for patients in the community, any withdrawals need to be properly managed on the first night and any dependence disorder needs to be assessed and treated appropriately.

The form of treatment and monitoring will be informed by:

- the screening/assessment
- the toxicology result
- knowledge of any recent treatment from police cells
- past knowledge of the patient in prison
- information from community teams, and from the community pharmacy, if it was possible to acquire such information on first day.

Where community treatment for dependence involves substitution pharmacotherapy, such as for heroin dependence, this may require initiation of substitution medication in prison or may require the appropriate continuation of community prescribing. Particular care is required during assessment in the prison setting to try and confirm recent consumption of prescribed medication in the community; and, if prescribing in prison, only to give weight to evidence of recent medication consumption in the community that has been clearly confirmed to have been supervised.

Prisoners who in the community have been diverting or storing their prescribed medications may be less tolerant to opiates than their drug history might suggest, creating a potential risk of overdose if the history were relied upon.

There also needs to be awareness of possible 'body packing'/'sequestering' of drugs by someone entering prison, with a need for adequate monitoring for unexpected overdose occurring despite carefully prescribed medication.

Monitoring is crucial to be able to observe possible withdrawal symptoms and signs during the first night. However, if there is already sufficient evidence to anticipate that withdrawal symptoms requiring pharmacological treatment may well develop during the first night, then a doctor or other suitable prescriber needs to assess this during reception and should manage the identified potential for distress by prescribing in advance suitable 'as needed' treatment or symptomatic relief.

Risk factors initiating medication in the prison setting

An average large remand prison will need to assess and stabilise 200 or more new patients per month, a rate unknown in any other clinical substance misuse setting. Robust protocols and carefully focused resources are therefore needed for adequate assessment of those dependent on opioids and other substances.

Dose induction is made more complicated by the unusual dynamic of treatment being offered to an individual who may not have requested it, the possibility of reduced tolerance following a break in consumption during police custody, observation inhibited by locked cell doors, peaks in workload, challenges in maintaining timely access to doses of medicines and the involvement on non-specialist clinical colleagues in the delivery of care. This, alongside the possibility of use of various illicit drugs and/or subsequent diversion of prescribed medication, alongside particularly high levels of mental and physical health problems, can add to increased risks.

5.4.6.4 Initial treatment responses for drug use and dependence at reception and first week

It is important to initiate early treatment for dependence and withdrawal, which should be first night treatment unless entry is very late at night.

An intoxicated individual may require monitoring and reassurance and may lead to the need for assessment and management of sedation, or to the need for symptomatic management of over-arousal and agitation.

It is important to aim to provide seamless continuity between establishments, and between prisons and the community, to ensure equivalence of care and to reduce risks.

Regardless of the circumstances prior to reception, the first few days is a period of high risk of suicide and self-harm. Where there is any concern, the use of relevant risk management procedures should be considered (such as a Concern and Keep Safe Form when using the Assessment, Care in Custody & Teamwork (ACCT) system).

Most prisons have 'first night' services that offer opioid substitution using methadone and occasionally buprenorphine, with most having policies that currently favour the

use of methadone (unless, for example, continuing a community prescription). In some circumstances, non-opioid symptomatic treatment of withdrawals or dihydrocodeine is used instead of methadone or buprenorphine. While there is not an established evidence base for use of dihydrocodeine for the management of drug dependence, nor is it licensed for this use, in some exceptional situations (e.g. very late night entry) it might be pragmatic to use this medication to treat withdrawals. However, subsequent early management on to a licensed preparation such as methadone should still normally occur in such cases, and the use of dihydrocodeine should not be used as an alternative to proper systems for the provision of methadone and buprenorphine.

When a prisoner has been received without former access to a regular opioid prescription but needs this, the immediate stabilisation phase usually lasts for a minimum of the first five days of custody. In this context, the 'stabilisation' phase refers to the period focused on control and elimination of effects of intoxication and of any withdrawal symptoms.

The principles of induction on to substitution treatment, both for opioids and/or benzodiazepines, involve the gradual increase of doses to allay withdrawals, while avoiding intoxication, with regular assessment and continued monitoring. OST should be available on first day/night reception in all UK prisons. Whenever the comprehensive assessment warrants either initiation or continuity of this treatment, in line with equivalent community standards for such treatment, this should be provided.

Examples still occur of a patient's OST prescription being disrupted upon admission into prison or a delay in starting required treatment from scratch. At a weekend, a delay can be for up to three days. Such a disruption contravenes the principle of equivalence with community and hospital treatment and may compound underlying risks of self-harm and suicide. Where it is not possible to induct patients onto OST on first night due to late reception from courts into prison, or lack of competent staff on duty, then next day OST prescribing should be a priority. In such a circumstance, the patient should be offered symptomatic relief on the first night (for example, through the process of a Patient Group Direction or through nurse or pharmacist prescribing). If the most suitable treatment has not been initiated, additional care is required to increase monitoring and assess for any risk of self-harm or suicidal ideation or intent.

The main purposes for prescribing OST in prison are:

- following initial prison entry, to provide opioid dependent patients with the most effective, evidence-based treatment at an appropriate dose to help them achieve stabilisation (with cessation of illicit opioids and wider stability)
- following the initial stabilisation, to maintain the OST:
 - either continuing it throughout the imprisonment and seamlessly following release (with the benefits to health and offending behaviour from such clinical throughcare)
 - or continuing the OST in prison only until the patient decides, either early on or subsequently, on a supported detoxification (which option should only be considered after properly discussing with the patient the substantial increased risk of relapse and of mortality from this path but then actively supporting the decision of informed patients who do opt for this).

OST in prison can help to:

- deliver a significant protective effect on mortality while in prison and following release by maintaining or increasing tolerance to opioids (reducing but not eliminating the risk of fatal overdose)
- reduce injecting risk behaviours
- reduce self-harming and suicidal behaviour
- engage some patients in psychosocial interventions to support their recovery.

When initiating OST, particular care is needed in managing the risk for opiate dependent prisoners who have not been reliably confirmed to be on stable community OST programmes. Fatalities from methadone poisoning have been reported at doses as low as 20mg (Humeniuk et al 2000). Non opioid-dependent individuals are at risk from 20mg doses or higher, and the risk is exacerbated with simultaneous prescription of a benzodiazepine or other CNS depressant drug. Methadone deaths tend to occur on the second or third day of treatment as a result of cumulative toxicity. These deaths occur as a consequence of inadequate assessment, failure to confirm previous opiate use by clinical testing for drugs, failure to confirm dependence, treatment in the absence of withdrawal symptoms and a lack of monitoring, and often multiple uses of other CNS depressants. Illicit drug use in prison, including access to illicitly procured prescription medication such as medicines for pain or antidepressants, will exacerbate these risks. Physical and mental health comorbidities add to the complexity and risk. Such tragedies can be avoided by adherence to the following principles of treatment:

- an adequate assessment of past history including previous history of overdose and self-harm
- an opioid positive drug test result (although if opiates have been recently prescribed and dispensed in the police cells, this positive test is not helpful for a diagnosis of dependence or as evidence of likely tolerance)
- ongoing monitoring using consistently applied monitoring scales by competent and trained staff according to agreed protocol
- MDT discussions initiated early for complex cases
- use of suitable self-harm risk management procedures (such as ACCT) with close monitoring and working with all healthcare and security
- where there is doubt regarding the presence of dependence, a prescription to be made only in the presence of objective signs of opioid withdrawal (described in [section 4.2.2](#))
- gradual dose induction in increments of 5 to 10mg of methadone (methadone oral solution, 1mg in 1ml)
- regular monitoring of the patient and, in the event of any sign of drowsiness, the withholding of the due dose of methadone and any other sedating medication, pending reassessment
- supervised consumption of prescribed methadone followed by the administration of at least 200ml of water to reduce the potential for diversion

- appropriate supervision of buprenorphine to minimise diversion, including crushing buprenorphine tablets prior to administration where this is agreed practice
- great care if managing dependence on alcohol and opiates and use of other CNS drugs, for example, antidepressants. Consider using no more than two CNS depressant drugs in the first few days of titration.

(Gilvarry 2013)

5.4.6.5 Stabilisation on to opioid substitution in the first week

Induction and stabilisation on methadone

Opiate-dependent prisoners should be stabilised on licensed opiate substitute medication for a minimum of five days to enable any withdrawal symptoms to be adequately controlled.

Detailed assessment should continue over the initial stabilisation phase. Treatment and recovery care plans that are agreed with the patient should be developed over this five-day period to allow time for any additional information from external sources to be ascertained.

Titrated induction on to methadone at entry

To ensure patient safety, methadone treatment for prisoners who have not had access to community OST should be established through a process of dose induction. The total daily dose of methadone in the first 24 hours should not exceed 30mg and in some circumstances, where the patient is not displaying signs of severe withdrawal, it is wise to split the dose (for instance, day 1, 10mg; day 2, 10mg bd; and day 3, 10mg tds or 15mg bd).

Where the above regimen appears to be insufficiently rapid to manage a patient's withdrawal, a substance misuse specialist doctor with experience in prison practice or other equivalently competent non-medical prescriber taking account of the risk factors, may prescribe doses in addition to this usual regimen (titrating any increased doses alongside careful withdrawal monitoring and record-keeping). Additional careful titration of between 2 and 10mg per day may be indicated. Consideration is also needed in such cases of any other acute medical condition that could be confusing the clinical picture.

Divided dosing should be the preferred treatment regime at least until clear stability on the suitable stabilisation dose has been achieved. For those needing doses of 60-120mg daily, review should take place to ensure stability is sustained, and to optimise care. In the event of a patient continuing to experience withdrawals at higher doses, or who has not stabilised (and who may have other comorbidities), specialist advice and support from an addiction specialist with prison experience would be required.

Patients should be subject to enhanced observation over the first five days of methadone treatment. This monitoring should be at least twice a day, with unrestricted observation where possible. Such effective management of withdrawal symptoms may reduce the possibility of impulsivity associated with self-harming behaviours, and detect it more easily when it occurs.

The timing of observations should take account of expected peak plasma levels, particularly during initial induction and subsequently where there is any suspicion of dose accumulation. In those who are considered susceptible such as with polypharmacy, or where there are concerns about opioid tolerance despite other tests and clinical signs to the contrary, it

is particularly imperative for observation to include the peak plasma levels, approximately 2-4 hours after last methadone dose, to prevent any initial accidental overdose. Any indications of over-sedation or drowsiness due to the medication or other signs or symptoms that suggests the patient is under the influence of other substances, for example, from new psychoactive substance (NPS) use, must result in the nurse withholding methadone and other CNS depressant medicines pending medical reassessment.

Continuing the current community methadone prescription after entry

Patients received into prison who are currently receiving a community methadone prescription should have the prescription continued and prescribing should be available on first night in all prisons in such cases. However, to ensure safety, continuation of methadone at the daily dose prescribed in the community may only be provided in circumstances that meet all of the following criteria:

- the patient is receiving methadone under supervised consumption conditions
- the patient has been receiving methadone regularly for the previous seven days – and this is confirmed with the dispenser
- the patient last had a full supervised dose of methadone within the past 48 hours
- the patient's treatment details have been verified with the prescribing doctor or the supervising pharmacist who must confirm that the patient has been picking up his or her medication consistently
- no new risk factors have been identified.

Prison clinical staff need to confirm these issues with the community pharmacist, including the daily dose, duration of methadone dispensing from the pharmacy, last dose received and last supervised dose received, date of next dose due, and recent supervised dispensing regime. A brief description of the patient should be sought from the pharmacist to verify correct identity (to protect patient confidentiality, mechanisms should be put in place to ensure pharmacists can confirm the identity of the healthcare team they are talking to before giving out this information).

Upon confirmation of all the points above, the patient's methadone can be continued at the total daily dose prescribed in the community. However, as a further safeguard, for example, because of uncertainty about any other illicit sedative drugs that may have been or may be used by the prisoner following their entry in to prison, it is recommended that the first two days' doses of methadone be evenly divided in two, with at least six hours' gap between the supervised consumption of each dose.

Methadone continuation can be dispensed on the first night if the patient has not received their methadone medication that day, though this must be confirmed as noted above. If already received, then methadone is prescribed and administered for the following day.

A drug test must be positive for methadone metabolites prior to any continued prescribing of a community methadone prescription. Where the patient is methadone positive but confirmation of community prescribing and dispensing arrangements cannot be obtained on first night (typically because the patient is received into prison outside of the opening hours of the community pharmacy) the community dose of methadone should not be provided

and the patient should be offered the standard induction dose (10mg initially and then 10mg six hours later if withdrawal symptoms are apparent). If confirmed the next day, with all of the criteria described above confirmed, then the usual community dose can be prescribed. If the patient's current tolerance to methadone is not adequately confirmed in this way, then further assessment is needed, so that dose titration can still be offered if appropriate.

Buprenorphine induction and stabilisation

Buprenorphine can be misused and diverted in prisons and it takes greater time to supervise its consumption sublingually compared with oral methadone. Buprenorphine could be considered in:

- those patients who are currently prescribed buprenorphine as part of a community programme and for whom release is imminent
- mild cases of dependence in opioid users, for example, in some younger non-injecting heroin users
- clinical exceptions agreed in partnership with the clinician and the patient.

Buprenorphine induction in prison should be similar to the community, with a review of liver function, and advice given about the possibility of precipitated withdrawal. Patients should normally have been heroin-free for around 12 hours and methadone-free for at least 24 hours prior to the initial dose of buprenorphine, and should be exhibiting clear signs of opioid withdrawal. Adjunctive symptomatic support or additional buprenorphine may be required in the early stage of treatment.

To reduce the potential for diversion, buprenorphine tablets should usually be crushed prior to administration. Although crushing is considered off-label use it does not affect the bio-availability of buprenorphine. Relevant protocols can be put in place to support the crushing of buprenorphine in secure environments (RPS 2005).

Buprenorphine is usually initiated at 4mg on day one, ideally when signs of withdrawal have become apparent. The dose can be increased to 8mg on day two, assuming that acute precipitated withdrawal has not occurred on day one. The final stabilisation or maintenance dose can be determined by the patient's subsequent response (usually with cessation of all withdrawals and stable elimination of the use of any non-prescribed opioids).

While it is possible to prescribe buprenorphine to a maximum of 32mg, in practice most patients stabilise on a lower dose, generally between 8 and 16mg.

A buprenorphine-naloxone combination product may be used as an alternative to buprenorphine alone in exceptional cases if there are concerns that a prisoner might snort or inject buprenorphine. Buprenorphine-naloxone might prevent vulnerable prisoners being pressurised to divert their medication as buprenorphine-naloxone has a lower currency than buprenorphine in prison and in the community (Wright et al 2014) so may be a choice where diversion of crushed buprenorphine alone has been demonstrated. The choice of buprenorphine-naloxone might restrict the options with regard to the dose of buprenorphine as it does not offer the option of prescribing 400 microgram tablets which might be useful when down-titrating the dose of buprenorphine.

In future, the choice of opioid substitution medication within the prison setting could be affected by the introduction into UK practice of new forms of buprenorphine: rapid-dispersal and long-acting (see [section 4.3.4](#)).

Pharmacological management of specific opioid withdrawal symptoms

Equivalence of treatment and care with the community necessitates the active clinical management of the effects of withdrawal symptoms, including using adjunctive and symptomatic treatments to reduce discomfort and distress and to improve wellbeing.

Vomiting and diarrhoea should, therefore, be managed by effective prescribing of carefully monitored anti-emetic and anti-diarrhoeal medication, but with transfer to outside hospital if symptoms are not adequately controlled within 24 hours. Where there is a clear indication earlier than this that dehydration or other medical complications such as a diabetic crisis are developing, transfer to outside hospital should be arranged immediately.

Malnutrition, anorexia, hypothermia and hypoglycaemia are common problems during the early stages of drug withdrawal. Patients must have access to food, naturally sweetened drinks, adequate fluids and extra blankets during this phase. Additional food (and fluids) at night is necessary during the recovery phase of withdrawal, when the appetite returns, and sleep problems occur.

Insomnia is a common and often striking symptom of opiate, alcohol and benzodiazepine withdrawal. Protracted sleep loss has a detrimental effect on thought, mood and behaviour. Insomnia should therefore be regarded as a potential risk factor for self-harm and suicide. Insomnia management should include a range of non-pharmacological interventions such as relaxation classes and in-cell radio or TV. Prescription of hypnotics should not be necessary during the stabilisation phase. If, as any reduction progresses, insomnia becomes a problem, a short-acting hypnotic may be prescribed for a limited period and reviewed according to patient response in line with insomnia clinical guidance (such as from NICE). The possibility of interaction between opioid agonists and hypnotics, and the liability of hypnotics to misuse and dependence, should also be considered when deciding on insomnia treatment. Sedating antihistamine medication (e.g. promethazine) is a useful alternative to benzodiazepines or z-drugs as it is less likely to be diverted. The prescription of sedating antidepressants (e.g. mirtazapine or trazodone) for insomnia in the absence of depressive symptoms should be avoided.

5.4.6.6 Planning detoxification from OST in the first week (and thereafter)

While some prisoners, particularly long-term prisoners, will wish to use their time in prison to become abstinent from both illicit and prescribed opioids, any plan for reduction and cessation of OST should be based on the clinical judgement of the prescriber in collaboration with the prisoner and the wider team. Reduction and cessation should not be on an arbitrary or mandatory basis but rather requires careful clinical assessment and review.

It is difficult to justify on the basis of clinical evidence, a required withdrawal of OST from a prisoner based on a particular duration of imprisonment (not least in circumstances that their prescribing clinician and team consider that continuing OST is judged to be the treatment they still need). For example, some prisoners with severe heroin dependence, a history of multiple

relapses and high-risk behaviours may reasonably be expected to require opioid substitution treatment on release even after a long sentence. For these prisoners, it may well be safer to remain on a maintenance dose for the duration of the sentence with an active transfer of treatment to the community services on release.

For those who do choose to reduce their medication with the aim of abstinence in prison, this reduction needs to be carefully monitored and if relapse of any drug use occurs (not just of opioids) further optimised care needs to be offered.

In respect of pharmacologically assisted withdrawal for opioid dependence, the decision about which pharmaceutical agent(s) to use, and when, should be made on the basis of a combination of four factors:

- the patient's severity of dependence
- the patient's wishes and needs
- the opinions of clinicians involved in the patient's care in the community and within the prison
- the timing and length of sentence.

If a detoxification regime is to be provided, it is advisable to implement this sufficiently slowly to minimise the symptoms of withdrawals, to be able to assess progress carefully, and to keep the plan under review (NICE 2007). For a planned detoxification, the reduction is normally completed within 12 weeks or less, but this time can be extended depending on response. Should there be any use of opioid drugs in addition to the prescribed medication, or other significant loss of stability, then the reduction programme must be reviewed with consideration of the need for possible dose increase and subsequent treatment review and optimisation.

In the context of comorbid severe polydrug or alcohol dependence, careful multidisciplinary decisions need to be taken with the patient and reviewed frequently. A particularly graduated approach will be necessary, given the potential risks of relapse, and this may include agreeing to continue the opioid substitute prescription instead. Such careful management and review can also assist in reducing the risk of impulsive self-harming behaviour.

There should not be any mandatory reduction regime. Continued maintenance prescribing, for example, is usually the most appropriate and clinically evidence-based approach for those with severe dependence and short sentences, along with plans for clear seamless follow up in the community. While many such patients may be most appropriately maintained on a suitable dose of opioid substitute in prison, prison does offer the opportunity for others to be supported in their goal to achieve a period of abstinence from all opioids, which intervention needs to be offered and managed positively. It is essential, however, that the potential risks and the potential benefits are discussed with the patient first regarding these choices, based on a clear understanding of the evidence base including the natural history of the disorder and the risks of relapse, as well as the positive support available for achieving and sustaining abstinence, to be able to obtain properly informed consent. There should also be continued review to ensure continued stability during reduction and the treatment, medication and psychosocial support, should be optimised appropriately.

For patients who have been stabilised on methadone, a methadone assisted withdrawal involves a gradual reduction in methadone doses. Likewise, for any patients who have been stabilised on buprenorphine, a buprenorphine assisted withdrawal involves a gradual reduction in buprenorphine doses. For patients who have been stabilised on methadone, a buprenorphine assisted withdrawal should not routinely be offered currently due to the problems with buprenorphine diversion in the prison setting.

Because of the potential pharmacological advantages of buprenorphine, with lesser toxicity in overdose, if a suitable form is developed that enables rapid absorption that is considered appropriate in the prison environment, the guidance on use of buprenorphine for detoxification may need to be updated. Clinicians should maintain awareness of the clinical situation in this regard.

Following the initial five-day stabilisation period on an opioid, for those patients who have requested a non-opioid assisted withdrawal or for those in whom such an approach is considered indicated by the prescriber, lofexidine can be used for managing withdrawals because of its effect on relieving a number of opioid withdrawal symptoms. It does need to be used alongside the availability of other drugs used for symptomatic relief for different opioid withdrawal symptoms (those not helped by lofexidine). Regimes may need to be adapted to address an individual's particularly prominent symptoms. Lofexidine may also cause bradycardia or hypotension in some patients so that monitoring of this risk is needed. These factors restrict its availability to those prisons where healthcare or substance misuse services can provide the level of monitoring needed. Such symptomatic relief may also be useful either for the first night or when assessing those with an, as yet, unclear tolerance and so undergoing a particularly careful titration on to an opioid.

Clinicians should be aware that, whatever the duration of assisted withdrawal, withdrawal symptoms will frequently persist beyond the cessation of all medication. It is important to provide support for individuals in the first few days after stopping an opioid agonist and for some time afterwards. Where individuals are transferred from a withdrawal management unit to an ordinary, residential prison location, clinicians should ensure that the residential manager is aware of the increased risk and the need for his or her staff to provide support to the prisoner at this time.

With the exception of a planned decision to initiate a re-induction regime pre-release (see [section 5.4.13.1](#)), methadone or buprenorphine should never be prescribed to a patient who has tested negative for opiates, unless they exhibit clear objective signs of opiate withdrawal or there is adequate evidence of confirmed compliance with a community prescription up to the time of reception.

5.4.6.7 Benzodiazepine assisted withdrawal in the first week (and thereafter)

Assessment of benzodiazepine dependence should be informed by self-reported history, confirmed prescribing history if applicable, withdrawal monitoring and drug testing. Benzodiazepine withdrawal may well take more than 72 hours to become established, with risk of seizures and other potential medical problems in the most severe cases of dependence. A careful history is required including exploring whether benzodiazepines have been provided in the short-term during police custody; whether the patient's reported

dependence is on prescribed benzodiazepines, illicit benzodiazepines or a combination of the two; and the veracity of the account.

Withdrawal prescribing (that is, assisted withdrawal) should be initiated on the day of admission where there is a history of benzodiazepine dependence (either prescribed or regular illicit use) and the presence of objective symptoms and signs of withdrawal already present.

Benzodiazepine dependence requiring treatment is not common in polydrug users and does not normally need pharmacological treatment in those using benzodiazepines in the context of heroin or crack dependence. Where clinical assessment does, however, indicate a previous history of regular benzodiazepine use that suggests substantial dependence that could require treatment of withdrawals (for example, use of sufficiently high doses over a long duration, and/or with previous withdrawals requiring treatment such as fits), a benzodiazepine assisted withdrawal regimen should be prescribed. Each prison should have treatment guidelines for the management of benzodiazepine withdrawal in line with current guidelines, and developed in conjunction with a clinical specialist. The usual drug used is diazepam (Lingford-Hughes et al 2012). Clonazepam is not recommended. This drug, licensed for use in very specific cases of epilepsy should only be continued if there is clear evidence and confirmation of epilepsy from a GP or secondary care neurologist who has treated the patient.

Great care is required if there is a history of concurrent alcohol, benzodiazepines and opioid dependence, which then requires skilled assessment, pharmacological expertise and close monitoring and management of the stabilisation phase and initial treatment planning phase.

Chlordiazepoxide or diazepam are drugs that can be used both for management of benzodiazepine withdrawals and for the management of alcohol withdrawals. Careful assessment and identification of alcohol and of benzodiazepine withdrawal symptoms and signs will underpin decisions about suitable doses for each patient. Close monitoring and review is needed. Following successful completion of the alcohol detoxification, usually slower reduction using diazepam is needed in line with the standard advice on managing benzodiazepine withdrawals (see [section 4.10.1.3](#)).

Benzodiazepine dependence and withdrawal can be associated with serious suicide and self-harming behaviours, and these should be managed accordingly with due caution, which may in certain instances require a slower reduction than indicated normally. In general, all other treatable mental health problems should be addressed before any withdrawal is started (in line with established guidelines on managing benzodiazepine dependence).

It may be necessary to prescribe alternative psychotropic medications, such as antipsychotics or antidepressants (Ford and Law 2014) in the light of the prisoner's subsequent mental health presentation.

Primary benzodiazepine dependence and iatrogenic dependence, particularly if involving high doses over many years, may require a much more cautious approach because of the sensitivity to dose reductions sometimes reported (see [section 4.10.1](#)).

Patients with a confirmed history of epilepsy will require cautious rates of reduction for benzodiazepine dependence, informed by ongoing monitoring. An increase in the levels of any currently prescribed anticonvulsant medication may be required.

As with other Schedule 4 controlled drugs, benzodiazepines should be administered under supervision. Where there are concerns that a patient may be diverting prescribed diazepam tablets, clinicians should consider using the alternative liquid formulation.

5.4.6.8 Management of stimulant withdrawal in the first week

Prisoners with a substance misuse problem, even those who do not require pharmacological management for this, should still be admitted to the 'first night' or 'induction' centre in establishments whenever this or equivalent provision exists.

If not available, they should be observed for fluctuations in mood or behaviour. Among this group of prisoners will be stimulant users (including crack users) and those who use NPS (see [section 7.7](#)). Withdrawal from stimulants can cause marked swings in mood, leading to potential acts of violence towards self or others. A short but profound depression is a recognised withdrawal symptom, which may necessitate treatment. Psychotic symptoms either related to intoxication or to a drug induced disorder can occur with use of NPS, cannabis and other drugs or from combinations of these. Psychotic symptoms caused by mental illness can also be precipitated by use of NPS or stimulants. Physical and psychiatric consequences can be persistent, with the priority of first stopping use to be able to assess this adequately. The mainstay of clinical NPS treatment is management of crisis, and in particular physical and mental health consequences of acute intoxication, keeping the patient and staff safe, intensive monitoring and observation during the acute phases of intoxication, symptomatic treatment of intoxication (typically, if needed, short-term use of a major tranquilliser, or with particular caution, brief use of a benzodiazepine), and addiction psychiatry and mental health teams working together with drug and alcohol teams, and subsequently management of longer-term problems. Clear systems must be in place to identify those in need of care from emergency and hospital services. In countries where it is used, teams should be aware of the system of National Early Warning Scores (developed by The Royal College of Physicians) that can be used by primary care, ambulance and hospital staff to assess and reassess patients acutely intoxicated and to decide on the need for hospital treatment and support.

Cocaine use is associated with serious medical problems, particularly cardiovascular complications, and sudden death, occasioned by intracranial bleed/thrombosis or cardiac arrest. It is recommended that patients reporting recent heavy stimulant use and who test positive on admission for either cocaine or amphetamines are admitted to the withdrawal management unit, where blood pressure monitoring for signs of hypertension, and neurological observations should be carried out for the first three days of custody. Any abnormalities would warrant full medical assessment, and in the event of continued concern, transfer to outside hospital. Where there is evidence of agitation or volatility in those withdrawing from stimulants, consideration may be given to short-time pharmacological symptomatic relief.

For those with psychotic symptoms and agitation related to NPS treatment, symptomatic treatment, including antipsychotic medication may be required to ease agitation with close monitoring. Close working with forensic teams need to be available and, on some occasions, a prisoner may need transfer to health units internal to prison and/or to external mental health units.

A full mental health assessment should be conducted for any prisoner demonstrating signs of psychosis, severe agitation and/or suicidal behaviour. A full range of supportive resources (e.g. NHS, mental health in-reach, listeners and drug team) should be available within the establishment to meet the needs of this group of prisoners. Concerns for a prisoner's safety as a consequence of his or her mental distress should result in the activation of the prison service's multidisciplinary risk-management process, such as the currently widely used ACCT system.

Stimulant users should have access to specialist assessment and stimulant groups and relaxation classes. Continuity of service is central to good outcomes for stimulant users. Introduction should be provided with pre-discharge planning to any community stimulant drug services within the prisoner's home area.

5.4.6.9 Management of alcohol problems in the first week

Assessment of alcohol must occur in conjunction with other illicit and abuse of prescribed drugs. Misuse and dependence are not uncommon in this population and need to be managed alongside illicit or prescribed drugs. Management can also increase risk, for example, benzodiazepines may exacerbate sedation related to methadone, as can antidepressant prescribing (which is commonly present in patients with harmful and dependent patterns of drinking).

However, there is a risk that on first night some prisoners who are not alcohol dependent will purport to be so in an effort to obtain medication for their own use and/or for subsequent diversion. Where there are objective signs of alcohol withdrawal, detoxification/assisted withdrawal should be initiated on the first night of custody using either chlordiazepoxide or diazepam. Symptom triggered detoxification is considered to be first line (NICE 2010) though this requires continued supervision and competent staff. In the absence of objective signs of alcohol withdrawal, it is prudent to withhold prescribing and monitor the patient for the first 24 hours. Appropriate monitoring of detoxification is needed, with management of complications such as severe withdrawals, seizures, and Wernicke's encephalopathy or developing delirium.

In the treatment of concurrent opiate and alcohol dependence, no planned reduction in the opiate agonist should normally be commenced until the alcohol-assisted withdrawal is complete, unless there are clear clinical indications for doing so. The management of polydrug and alcohol dependence requires specialist skills.

Discussion is needed on treatment or other recovery support after release and the need for throughcare for some more severe cases. Mutual aid is also an important resource about which it is important to provide information and advice.

5.4.7 Patients unstable in receipt of OST

For those who become unstable (such as through using illicit opioids on top) when on maintenance OST or when on an opioid reduction regime, additional care is required in managing prescribing safely. Just as advised for community services, the patient should be reviewed and their treatment optimised. This may need an increase in the dose of methadone

prescribed and a review of adequacy of the package of psychosocial support interventions and other more general social support provided (see [section 4.6](#)).

If a person is currently intoxicated, he or she should be managed in a safe environment and monitored closely. At that time methadone or other drugs should not be dispensed but subsequently they should normally continue thereafter.

Stopping OST prescriptions after an episode of acute intoxication or following drug test or other evidence of a period of instability, may increase rather than reduce the risks of continued use of illicit drugs and the risk of fatal overdose, and cannot be justified as a general response to such situations.

5.4.8 Relapse prevention for opioid dependence

For those who come off opioids successfully in prison and plan to stay abstinent on release, plans need to be put in place to help them sustain abstinence and to manage any relapse. This might include use of naltrexone, information on overdose risk and provision of take-home naloxone.

For others, who feel they will be unable to stay heroin-free on release, clinical assessment of their risk of relapse and of fatal overdose may lead to consideration of re-toxification back on to OST prior to release or to a request for immediate (preferably same-day as release) assessment by a community drug service that could offer prescribing.

For those who reduced their dose of methadone in the prison environment, but where the clinician and patient consider that, based on assessed risk and history of use, they will need a higher dose on their return to the community to avoid heroin use, the dose may need to be increased prior to release. This consideration should be reflected in the throughcare and aftercare plan discussed with the community service. The effects of any recent increase in dose will need to be monitored in prison and following release. This requires careful review prior to discharge and effective communication with the prisoner and community service.

OST is now well established in prison populations in the UK. Maintenance programmes from the community should be continued in prison following stabilisation, unless the patient or the existing community prescriber indicate otherwise. To ensure continuity of treatment upon release, continued contact and referral to community services should be made through the prison-based drug treatment team, with appropriate discharge planning.

Where a period of remand extends beyond 13 weeks, the drug treatment team should review the maintenance programme for evidence of continuing stability and the need for any adjustments. The review will cover wishes, needs and treatment goals and an update of the care plan to support future stability. This can take account of the benefits and risks of maintenance prescribing and of detoxification.

Methadone or buprenorphine maintenance should be prescribed alongside the offer of ongoing psychosocial support and rehabilitation support, including educational and occupational rehabilitation. Some who are established and stable on methadone may not wish to continue engaging in any specific psychological and drug-support work and this is not required for them to continue to benefit from their medication. Some might still be

interested in limited relapse prevention support. Others may be interested in non-drug-specific rehabilitation support, such as for education and training and employment support.

Near release date, consideration should be given to suitability of the current dose of OST. A dose that has proven adequate in prison may be insufficient to maintain stability on release. Normal recommended daily maintenance doses for OST in the community are between 60mg and 120mg. This may be particularly important in prisoners with severe dependence and with a long history of injecting and/or high-risk drug use prior to imprisonment, when it can be reasonably anticipated that higher doses will be needed and careful transition planning to community services is needed.

In contrast, some individuals will have elected to withdraw completely with a view to engaging in drug-free rehabilitation, either in prison or back in the community. It is essential to ensure that these individuals are aware of their loss of tolerance to opioids and of the risk of a potentially fatal overdose if they use opioids again. Great care is required in clinical management of risk, with possible useful involvement of families, and a need for clear communication and discussions with any involved primary care and community drug services. Planning for naltrexone use may be considered for those who are willing to continue to engage in psychosocial support.

Programmes for the provision of take-home naloxone may help save lives after release. Commissioners should agree with prison health and community providers how best to ensure provision of naloxone.

For those at highest risk wanting community support, access the same day as release or very early contact with community drug services, particularly if they may benefit from medication, may be crucial to help manage their increased risk in the community.

5.4.9 Preventing and managing overdose

Protocols should be in place, with relevant staff training, to ensure the effective handling of opioid overdose in prison by healthcare and by prison staff. Early warning symptoms/signs of opioid overdose are described in [section 4.2.2](#).

5.4.9.1 Managing an opiate overdose in prison

All staff, including non-healthcare staff and operational/security staff, should have training in recognising and responding to opiate overdose, including using available naloxone.

Naloxone is administered according to the regime described in [section 6.4](#). In an emergency, any competent member of the healthcare team (or any other competent person) may administer naloxone by injection without the need for a prescription.

Naloxone should be available in resuscitation kits and risk-assessed areas in the prison so that it can be accessed and administered by clinical or non-clinical staff as per the local protocol.

An emergency ambulance transfer to an outside hospital must be arranged. The patient must be observed closely for 24 hours following return from hospital, as a secondary episode of respiratory depression can follow as the short-lived duration of naloxone's effects fade.

In the event of a suspected buprenorphine overdose, substantially more naloxone may be required than for heroin or methadone but the naloxone dose given should still be titrated up as recommended.

5.4.9.2 Minimising the risk of drug related deaths in custody

The following steps can reduce the risk of drug related deaths and harm, including suicide, in custodial settings:

- Exercise extreme caution in prescribing two or more medications that have sedative potential, particularly upon first night and for the first few days when many patients are not at steady state.
- Take caution over doses of sedative medication (including using opioids such as methadone) in cases of significant acute cardiorespiratory illness.
- Do not provide a dose of a sedative medication (e.g. methadone) to someone who is already sedated – instead observe and monitor.
- Initiate ongoing monitoring with unrestricted observation for patients who are not stabilised on methadone and/or are still using illicit drugs.
- Avoid any practice of withdrawing maintenance medication simply because of behavioural difficulties.
- Continue a methadone programme or initiate treatment of illicit drug use as early as possible.
- Train staff to recognise and manage drug emergencies, (including the use of naloxone and seeking urgent ambulance or medical assistance).
- Administer substance misuse medicines from stock supplies instead of named patient supplies (to minimise medicine selection errors).
- Supervise people receiving their substance misuse medicines carefully (custodial staff should be aware that distracting behaviours by prisoners while queuing for medicines can lead to increased risks of diversion).
- Use automated methadone dose measuring equipment to facilitate efficient and accurate dose preparation where there are high numbers of patients (e.g. more than 25).
- Manage controlled drugs safely in line with agreed local protocols and relevant guidance.

5.4.10 Management of new psychoactive substances (NPS)

Over the last few years there has been a rapid increase in the misuse of new psychoactive substances (NPS) in prison settings. The effect on the prison and local resources can be significant especially if there are several prisoners affected at one time. Prisons can experience:

- disruption to the regular regime
- confrontational and violent behaviour to staff and prisoners
- excessive demands on resources, especially on staff time

- related episodes of psychosis and self-harm
- emergency hospital admissions for toxicity, with ambulance call outs and time in the emergency department having escort and bedwatch implications.

The main appeal to prisoners of NPS over other drugs is that currently their use escapes detection by mandatory drug testing. Prisoners using NPS can present as extremely intoxicated and agitated. The acute presentation is potentially life-threatening, particularly when NPS use is combined with other prescribed or illicit drugs. Therefore, this constitutes a medical emergency with a need for urgent clinical assessment. Where there is evidence of cardiorespiratory instability (e.g. tachycardia with low blood pressure and raised respiratory rate) emergency hospital admission is indicated. Where admission is indicated, the patient should be monitored closely including for any deterioration using the National Early Warning Score or other suitable measures until stability returns. Medication can be given to treat acute symptoms of anxiety and agitation (using second generation antipsychotics for short term only (Kalk 2016) or sometimes benzodiazepines) but care is needed with any benzodiazepine use because of potential for misuse and dependence.

In some patients, NPS use can trigger symptoms of psychosis, either from a drug-induced toxic psychosis or exacerbation of a pre-existing condition. In such circumstances, emergency psychiatric assessment and treatment is indicated. Local protocols and procedures should be available in all prisons to support acute management, with integrated care, and emergency training in responses. A toolkit for prison staff was produced by Public Health England and is available at [www.nta.nhs.uk/uploads/new-psychoactive-substances-in-prisons\[0\].pdf](http://www.nta.nhs.uk/uploads/new-psychoactive-substances-in-prisons[0].pdf)

5.4.11 Pain management

The management of pain during imprisonment presents a serious challenge given the misuse potential of opioid analgesics and of high doses of medicines such as pregabalin and gabapentin.

Clarity about the need for adequate and appropriate treatment of pain that takes account of both the context and risk of dependence, and the principles underlying pain treatment, is essential (see [section 7.2.4 on pain management](#)).

Use of local protocols that reflect guidelines on prescribing, within the context of multidisciplinary care, can assist in delivering safe, effective and equitable pain management for prisoners. An example is the 2016 Prison Pain Management Formulary, in England, available at www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2015/12/Prsn-pain-mngmnt-formlry-pub.pdf

5.4.12 Image and performance enhancing drugs (IPEDs)

Image and performance enhancing drugs are increasingly used in prisons, especially anabolic steroids which, apart from the health effects of their unregulated use, also carry significant risks of blood-borne virus transmission. In addition, they can lead to problems due to aggressive behaviour, placing a strain on custodial as well as on healthcare staff. See [section 7.8](#). A briefing to help provide effective services to prevent and treat people who use IPEDs is available at www.nta.nhs.uk/uploads/providing-effective-services-for-people-who-use-image-and-performance-enhancing-drugs.pdf. Although the briefing is intended

for commissioners in the community in England, many of the principles described will be applicable to secure environments and other countries.

5.4.13 Continuity of treatment

Arrangements need to be in place with agreed protocols for those in transition, attending courts and so on. All prisoners should receive their opioid substitute medication in the mornings, prior to any attendance at court, to restrict the emergence of withdrawal symptoms if they are released later in the day. Local protocols should be negotiated between the prison, escort contractors and court administrators for the secure administration of medicines that are prescribed in more frequent doses.

Prisoners who are on a maintenance opioid programme may transfer to another prison. Patients on a maintenance programme in England can transfer to open conditions after 28 days of commencement of clinical management. The receiving prison should continue treatment at the existing dose, assuming clinical stability. Prisoners should not be denied transfer because they are being prescribed such opioid maintenance treatment.

The period immediately following release is a time of considerable vulnerability. For patients leaving prison receiving maintenance opioid substitution treatment, contact should be established with a community service at the earliest opportunity after reception, with ongoing discussion to facilitate release planning, so that, for example, an appointment is already scheduled in the community before release. Close working between the prison drug treatment and community treatment providers is central to the securing of good integrated care. This should include arrangements for out-of-hours or late Friday/weekend releases.

It is the responsibility of the prison healthcare/drug team to ensure that the community service/prescriber is notified of a patient's release from prison. The patient should be reviewed in the community drug service on day one whenever feasible, or otherwise within days of discharge. For unplanned weekend release (including short-term release on temporary licence), a community pharmacist should be located to provide an interim dispensing service and a prescription should be provided to the patient on release requesting supervised daily dispensing as preferable. A risk assessment should be conducted to help determine how many days (if any) take-home medication should be issued to the individual or whether a prescription should be issued. For other planned discharges, the community service could organise daily dispensing with a pharmacist until the patient can be reviewed in the service. On a holiday weekend, a further day's medication may be required, although it is recommended that normally a maximum of three days' take-home medication is given in such a circumstance. Local protocols with community and prison services are essential.

5.4.13.1 Re-induction

Prior to release some patients who have stopped opioid prescription while in prison request re-induction onto opioid substitution treatment. Re-induction could be considered for those who are about to leave prison, with a clearly identifiable risk of overdose, and high likelihood of relapse. This decision should only be made by competent staff. Those with the most significant risk include those with a history of injecting opiate misuse immediately prior to custody, long-standing opioid dependence and polydrug dependence, and often history of overdose (Farrell and Marsden 2005). Re-induction may be considered after relapse

prevention interventions have been offered, and once the implications of restarting opiate misuse have been explained. Given the high relapse rates for heroin dependence and the high mortality rates from overdose following prison release, it is important to recognise this request may be a sound judgement and may support effective re-engagement with community services. Safe induction procedures should be followed.

5.4.13.2 Naltrexone

Naltrexone prescribed prior to release from prison for users abstinent from opioids and committed to abstinence may be a useful adjunct for those who engaged in psychosocial support provided to them in prison. It should normally be discussed with the community service that will be involved in providing support following release.

The outcome of naltrexone treatment is improved by a programme of supervision, which can involve carers and families to ensure compliance with the regimen. There is developing evidence for use of sustained release naltrexone in this population (Lee et al 2016).

5.4.13.3 Take-home naloxone

Take-home naloxone for previously heroin-dependent prisoners is important as they leave prison and enter a very high-risk period.

Commissioners of prison health and community treatment services should consider with their providers how best to support the provision of naloxone and overdose training in the community for those who do not attend for OST following prison release.

5.4.14 IT systems

All systems need to adhere to appropriate governance, security and standards for prisons. All records should follow principles of confidentiality though there should be clear information sharing protocols with clinical teams and appropriate others.

5.5 References

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Chapter 6: Health considerations

6.1 Key points

- Treatment services and public health services need to maintain the broad range of public health interventions that help to reduce drug-related infections including adequate availability of needle and syringe/equipment programmes and access to drug treatment.
- Reducing potential harm due to overdose and due to blood-borne viruses and other infections should be a part of all patient care.
- All at-risk drug misusers should be offered vaccination against hepatitis B (and against hepatitis A and tetanus, when indicated).
- All at-risk drug misusers should be offered testing and, if required, treatment for hepatitis C and HIV infections.
- Staff working with people at risk of injecting-related bacterial infections should be able to recognise when urgent assessment for antibiotics or emergency surgical interventions may be needed.
- Retaining patients in high-quality treatment is protective against overdose. This protection may be enhanced by other interventions including training drug misusers and their families and carers in the risks of overdose, its prevention and how to respond in an emergency. Care planning for those leaving treatment should address the risk of overdose.
- All services involved with the care of individuals with drug use problems should make their proper, active contribution to reducing their high risk of premature death, including identifying and responding to the risks of overdose, infections, cardiovascular and respiratory diseases and mental health problems.
- Drug misusers who are also misusing alcohol should be offered alcohol treatments.
- Drug misusers who smoke tobacco should be offered smoking cessation interventions.
- Services need to be able to provide adequate information and advice on optimising oral health, particularly for those taking opioids, and encouraging and supporting involvement with dentists as appropriate.

6.2 Blood-borne viruses and other infections

6.2.1 Overview of infections related to drug use

Four viruses are currently of particular concern in the context of drug misuse: hepatitis C, hepatitis B, HIV and, more sporadically, hepatitis A. Despite recent improvements in testing

and immunisation, continuing vigilance is needed. Blood-borne viruses are likely to spread when treatment services and public health services lose focus on ongoing risks and are not sufficiently responsive to emerging risks.

Prevalence of hepatitis C in people who inject drugs remains high throughout the UK. Increased identification of cases and assessment for treatment is crucial. There have been added concerns around those injecting stimulants and among homeless persons who inject drugs.

Hepatitis B infection is now rare among people who inject drugs, probably due to increased uptake of immunisation, but up to a quarter have still not been immunised (PHE 2016a).

New cases of HIV infection among people who inject drugs are now unusual, although clusters of cases are occasionally reported and continued vigilance is needed. Around one in every 100 people who inject drugs is living with HIV (PHE 2016a). The uptake of HIV-related care, including antiretroviral therapy, is high among diagnosed individuals (PHE 2016a).

There is evidence of a decline in the direct sharing of needles/syringes over the past decade in most areas of the UK. There is also some evidence to suggest a decline in the sharing of other injecting equipment (filters, mixing containers and water), although these behaviours remain more prevalent than the sharing of needles/syringes (PHE 2016b).

Sporadic cases and outbreaks of clusters of bacterial infections such as *Clostridium novyii*, anthrax and botulism continue to pose a serious risk for people who inject drugs. Tetanus remains a rare but potentially dangerous infection in this group. Superficial skin and subcutaneous infections have increased recently, with some cases associated with the use of new psychoactive substances (PHE 2016a).

6.2.2 Prevention and testing for infections

Adequate availability of needle and syringe programmes, information and advice, and access to a range of effective immunisation and drug treatments (including medication and psychosocial interventions) is essential. There is now good evidence to show that best results in reducing the risk of infection transmitted by injecting are obtained when a combination of such interventions is available (Turner et al 2011).

6.2.2.1 Prevention

There are some general measures that clinicians working with people who use drugs should take:

- Provide people who inject drugs with sterile needles, syringes, foil and other injecting paraphernalia sufficient to meet their needs (without being subject to a requirement to return used equipment), and provide advice on safer injecting.
- Make available needles in a range of lengths and gauges, and syringes in a range of sizes.
- Offer sharps bins and advice on how to dispose of needles, syringes and paraphernalia safely.
- Encourage people who inject drugs to mark their syringes and other injecting equipment, or to use easily identifiable equipment, to reduce the risk of accidental sharing.

- Offer, and encourage the use of, low dead space injecting equipment to reduce infection and transmission risk.
- For opiate-dependent patients, whether injecting or not, encourage access to relevant advice and information or counselling, which includes strategies for avoiding exposure to blood-borne virus infection and contamination.
- Make all patients, especially those engaged in sex work, aware of the risk of infection from sexual contact.
- Where appropriate provide sexual partners and household contacts with advice, support and testing or provide advice on how to obtain this.

6.2.2.2 Testing

Anyone who injects or previously injected drugs should be encouraged to be tested for hepatitis C infection, and HIV where local or cohort incidence is high, even if they regard themselves as unlikely to have acquired an infection. Services should aim to have such testing available for patients at first assessment. Advice should be provided on the potential importance of their partners being tested.

People having tests for blood-borne viruses should be made aware of the potential implications for disclosure (see [section 6.2.3.5](#)).

Repeat testing should be considered when the risk of exposure continues. When risk is assessed as high, testing may be carried out up to once or twice a year (EMCDDA 2011).

6.2.2.3 Responding to recent exposure to infection

Prevention of avoidable exposure to infection is of prime importance but when exposure to infection does occur, it is vital to respond urgently and for appropriate protocols to be in place for dealing with such incidents.

6.2.3 Viral infections

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

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

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

6.2.3.1 Hepatitis A

The risk of hepatitis A for people who inject drugs has decreased in recent years but there is an elevated risk for men who have sex with men. There is also risk of added damage from hepatitis A infection in those people who are already living with liver disease caused by injecting drug use or with active hepatitis C infection.

Based on current evidence, it has been recommended that all people who inject drugs are vaccinated against hepatitis A and B. While a combined A+B vaccine is available to assist this, the standard schedule for delivering it is longer than if providing hepatitis B vaccine alone (PHE 2013). Given also that the benefits of hepatitis A vaccination are modest and the benefits of hepatitis B vaccination are substantial, there are pressures against immunisation for both viruses in drug treatment services. In such circumstances, those people who have injected drugs should still be encouraged to complete hepatitis B immunisation.

6.2.3.2 Hepatitis B

Hepatitis B infection is now rare among people who inject drugs, probably due to increased uptake of immunisation, but around a quarter have still not been immunised (PHE 2016a).

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

The percentage of people who inject drugs with evidence of past or current infection with hepatitis B virus has halved to around 14% recently (PHE 2016a), and only around 0.5% are living with active hepatitis B infection (PHE 2016a).

Testing for hepatitis B is recommended in various settings (alongside hepatitis C testing) but testing for hepatitis B antibodies, indicating past infection, is not required before starting vaccination (NICE 2013).

In drug treatment services, hepatitis B vaccination should be encouraged and completed as soon possible after initial presentation for anyone who injects drugs and for anyone considered likely to progress to injecting (for example, those who are currently smoking heroin and/or crack cocaine, and heavily dependent amphetamine users). Vaccination is not recommended routinely for drug users who are not considered to be likely to progress to injecting.

Contacts of those at risk (specifically non-injecting users who are living with current injectors, sexual partners of injecting drug users and children of injectors) are all recommended to be offered hepatitis B vaccination. Drug services should inform the drug user of these recommendations so they are in a position to advise their contacts or to make any suitable arrangements (e.g. with primary care).

Systems are needed to monitor and assure that hepatitis B vaccination courses are completed. A record of vaccinations given should be kept. Incentives for completion of hepatitis B vaccination can be offered as part of a package of treatment.

Accelerated courses may be appropriate in people who use drugs depending upon timing of appointments and assessments. Three doses may be given on days one, seven and 21. These courses are considered particularly suitable for chaotic or difficult to engage service

users but a fourth dose should be administered 12 months after the first dose for the individual to be considered protected.

A combined vaccine formulation for both hepatitis A and B viruses is available. It can be given as three standard-spaced doses (initial dose with subsequent doses one and six months later). However, when early protection against hepatitis B is required, or patients may not return for the later doses of the standard schedule, an accelerated schedule (initial dose followed by doses seven and 21 days later) can also be provided with the combined vaccine. When this schedule is used, a fourth dose should be administered 12 months after the first dose for the individual to be considered protected.

It is recommended that individuals at continuing risk of infection, for example, those continuing to inject, should be offered a single booster dose of vaccine, once only, around five years after primary immunisation. Measurement of anti-HBV levels is not required either before or after this dose.

Opinions and protocols for testing after vaccination courses are varied. The European Consensus Group considers that post-vaccination testing and repeated boosters are not necessary even when antibody responses are poor, unless there is concern regarding any immunological deficiency (European Consensus Group on Hepatitis B Immunity 2000). The Green Book (PHE 2013) also recommends against testing except those at risk of occupational exposure and patients with renal failure.

6.2.3.3 Hepatitis C

Most people who have hepatitis C in the UK have acquired the infection from injecting illegal drugs (around 90%).

In most of the UK, around half of those who inject psychoactive drugs have been infected with hepatitis C (only around a quarter in Northern Ireland). Around a quarter clear the infection so about 40% are currently living with the infection (PHE 2016a).

Among people who inject psychoactive drugs, self-reported uptake of voluntary confidential testing for hepatitis C is around 90% in the UK, but only about half of those surveyed are aware of their status (PHE 2016a).

The prevalence of hepatitis C infection among people who inject image and performance enhancing drugs is much lower than people who inject drugs generally, at around 4-5%, with only a third of people who inject IPEDs reporting voluntary testing (PHE 2016b).

Men who have sex with men (MSM) are also at higher risk for hepatitis C infection.

Dried blood spot testing has made screening for evidence of hepatitis C virus infection much easier as it does not require clinically trained staff to conduct the test. Patients should be given information and advice on the hepatitis C virus (HCV), the risks of infection and its effects, and the role of testing and treatment. Those at risk should be offered access to antibody screening testing and to PCR testing to confirm active hepatitis C infection. Testing should be repeated annually for those whose behaviour still puts them at risk.

Local pathways need to be in place for additional assessment and advice on management of chronic infection.

The potential for availability of high efficacy treatments for hepatitis C is now such that the case for testing and for encouraging treatment referral and treatment uptake has increased.

Acute infection and chronic infection

During initial infection with HCV, individuals may suffer from an acute illness resulting from inflammation of the liver. Symptoms include nausea, vomiting, fever and jaundice lasting for a variable amount of days but usually resulting in recovery and improvement in symptoms. Many patients become infected with few or only minor transitory symptoms that pass unnoticed. If blood tests are taken at this time, there will be signs of liver inflammation and the appearance of antibodies to the virus. These antibodies persist in the blood for life, providing a marker for anyone who has been infected with hepatitis C. In 75-80%, the illness may become chronic, (while 20-25% will eliminate the active virus). The continuing active infection is measured by the polymerase chain reaction (PCR) test, which measures the presence of active viral RNA indicating the presence of replicating viral particles.

Chronic infection may persist for many years with damage to the liver depending on individual factors and additional problems such as alcohol use, HIV and other liver diseases. Acute hepatitis A viral infection can cause serious additional problems to an already damaged liver. Chronic hepatitis due to HCV infection is slowly progressive over many years and 20% of patients with chronic hepatitis will develop liver cirrhosis over 20 years especially if drinking. Most studies indicate that the proportion developing cirrhosis continues to rise after 20 years. Of the patients with cirrhosis, 4-9% will develop liver failure and 2-5% will develop primary hepatocellular carcinoma every year.

Genotypes

Many different strains of HCV have been recognised by virological testing. These have been grouped into six categories known as genotypes 1 to 6. There are significant geographical variations in the prevalence of the different genotypes in different parts of the world. In the UK, genotype 1 is the most common, followed by genotype 3 and genotype 2. There are small numbers of patients in the UK infected with hepatitis C virus of genotypes 4, 5 and 6, most of whom acquired the infection overseas.

Routes of transmission

Most people with HCV in developed countries are infected by sharing injecting equipment.

While there is only a very small risk of people with diagnosed HCV infection transmitting infection to their sexual partners through sexual or other close contact, expert advice is that condom use should be considered where the infected person is PCR positive. The risks of transmission to others by sharing equipment when injecting drugs should be explained to those who are infected.

Transmission by needlestick injuries to health or social care workers is probably less than 2% and depends on the severity of the injury.

The risk of women who are HCV infected and RNA positive transmitting infection to their babies in utero or during childbirth is approximately 5%. The rate is twice as high for those co-infected with HIV. The baby's risk of acquiring HCV from a mother infected with HCV is not

increased by mode of delivery or breastfeeding. Drug services should provide information to women with hepatitis C about the importance of testing babies and children who might have been at risk during pregnancy (Hepatitis B and C: ways to promote and offer testing to people at increased risk of infection NICE 2012).

Investigations

Blood tests including HCV antibody, PCR and liver function tests (LFTs) are used to help diagnose HCV infection and to assess the current state of progression of any liver disease.

Dried blood spot (DBS) tests, used for HCV antibody (and sometimes PCR) tests, can be conducted outside medical settings. For any positive antibody screening, a confirmatory PCR test will be needed to confirm active disease. PCR testing is increasingly available at the same time as the antibody test – it may be done on an additional DBS spot taken or on an additional small EDTA blood sample taken or arranged. A negative PCR test indicates lack of active ongoing disease and means unnecessary referrals to specialist hepatology services can be avoided.

However, further investigations, often including the LFTs, are typically organised through the general practitioner or following any referral to specialist hepatology services.

An ultrasound scan of the liver may then be recommended to determine the stage of the disease, unless blood test results have provided sufficient indication of the course of disease.

If staging of the degree of liver fibrosis in HCV infection is required to determine eligibility for treatment this will be done with an imaging based technique (such as Fibroscan or ARFI imaging), or blood-based tests of fibrosis.

Before and after testing, information and advice should be available for patients. A range of written materials and information helplines are now available across the UK. If relatives or carers who have been at risk of infection need advice, this should be offered or they should be supported to obtain it.

Organising care to maximise adherence with HCV treatment

A common problem for drug service users is a failure to attend, or lack of engagement with, specialist HCV assessment clinics. This may be for a variety of reasons including a lack of understanding of hepatitis and its risks, a current low priority given to personal health problems, practical difficulties of getting to specialist clinics or previous poor experience of such referrals. Attention to these issues may improve engagement.

Increasing efforts are being made to share the care of patients with hepatitis C who are in need of testing and follow up. Antibody and PCR testing can be carried out in GP surgeries or other non-specialist clinics, as can follow up of patients under observation or who have finished active treatment. As many service users find hospitals give them poorer care than they expect or deserve, having co-located treatment services, as close to service users as possible (and even treatment taken out to those who need it in places like hostels) has been shown to work and improve outcomes.

Adherence to hepatitis C treatment in drug-misusing patients prescribed substitute opioids may be significantly improved if the consumption of both medicines is supervised together.

Patients whose care passes from one service to another are at risk of disruption of testing and treatment for hepatitis C infection. For patients leaving custody and for those changing drug treatment services, those responsible for initiating testing or referral for HCV treatment that will subsequently need to be continued or re-initiated by others, need to communicate appropriately with the GP or with the destination service about this. The new GP or new drug treatment service will then need to support re-establishment of required actions.

Treatments

Improved drug combinations are giving better results for HCV treatments and, depending upon the genotype, success rates are increasing.

There are now several drugs for the treatment of hepatitis C infection which are more effective, are safer, have fewer side effects, have shorter durations of treatment, are easier to tolerate and are usually injection free, in comparison with earlier treatments that patients may be concerned about. The pace of change for delivery of this new treatment is rapid and evidence for options such as delivery of treatment through pharmacies is already being developed.

Treatment for HCV infection in prison settings is now possible, enabling access to important treatment for some patients previously resistant to or out of touch with treatment services.

Those who continue to inject drugs or misuse alcohol should not, simply because of those behaviours, be excluded from provision of antiviral treatments for the management of hepatitis C infection, although clearly not addressing such issues may impact on the effectiveness of treatment in particular cases. Relevant NICE technology appraisals make clear that those who inject drugs (or misuse alcohol) should not be excluded from such treatments. The Scottish Intercollegiate Guidelines Network has also produced a guideline, which states, "current injecting drug users infected with HCV should not be excluded from consideration for HCV clinical management, including antiviral therapy, on the basis of their injecting status" (SIGN 2013).

Antiviral treatments for mild, moderate and severe cases of hepatitis C infection should always be explored, including referral for specialist advice. Early referral of all active disease, with the patient's consent, is now commonly recommended, irrespective of injecting status, as the disease is more responsive to treatment earlier in disease progression and reinfection rates are low. Patient choice about treatment is important.

Provision of antiviral treatments and specialist investigations is often carried out in specialist centres although, increasingly, treatment may be provided in primary care.

Patients should be screened for hepatitis B before starting treatment for chronic hepatitis C with direct-acting antiviral interferon-free regimens as these may reactivate hepatitis B.

Advanced disease

Hepatocellular carcinoma, cirrhosis and transplantation are all longer-term consequences for a minority of patients with hepatitis C. In individuals who have had active infection for many years screening may be necessary to detect early liver cancer.

6.2.3.4 Hepatitis E

Hepatitis E is a potential problem for people who inject drugs. At present this is not prevalent in the UK and is mainly of clinical importance to liver specialists.

6.2.3.5 HIV

HIV diagnoses among people who inject psychoactive drugs in the UK have remained low and constant. In England, Wales and Northern Ireland around 1% of people surveyed who inject drugs have been found to be infected with HIV. Among those attending needle and syringe programmes in Scotland the rate was nearly double this. The prevalence of HIV in those who inject image and performance enhancing drugs is lower than in those injecting psychoactive drugs but higher than in the general population (PHE 2016a).

Protocols and guidance for testing for HIV infection have changed in recent years, with easier access to testing and less requirement for counselling and follow up visits. Easier access to sexual health clinics, primary care practices and home testing kits makes testing more available and results can be obtained more rapidly.

Diagnosis

HIV infection is diagnosed with a blood test or dried blood spot test, but this generally only shows the presence of the virus once it has become established (three months or so after infection). Blood testing can be done by a GP or in a specialist sexually transmitted infection (STI) clinic and some drug services can offer this. Acquired immune deficiency syndrome (AIDS) is usually only diagnosed on the basis of an AIDS-related condition combined with a positive HIV result.

Patients should be reassured that having a negative HIV (or hepatitis C or hepatitis B test) does not have any implications for medical reports for financial purposes. However, a positive HIV (or hepatitis C or hepatitis B) test may have similar implications to other long-term health conditions. STI clinics offer confidential testing, and individuals may choose to keep their records private from their GP. It is important that individuals understand that there may be legal implications if they do not disclose all relevant health information on financial application forms.

Routes of transmission

Men who have sex with men remain the behavioural group at greatest risk of acquiring HIV within the UK with only a small percentage of people acquiring HIV infection through heterosexual contact (PHE 2016c).

Factors that have previously been identified with possible increased risk for HIV infection for people who inject drugs are:

- combined heroin and cocaine injecting (speedballing)
- injecting into the groin (femoral vein)
- homelessness.

While overall prevalence remains low, sporadic localised outbreaks of HIV infection among people who inject drugs have occurred. In Glasgow, such a cluster has been characterised by homelessness and stimulant injecting alongside heroin use; and in Dublin, with the injecting of new psychoactive substances.

Women may transmit HIV infection to their babies in the uterus, at birth and through infected breast milk. However, early diagnosis is now much more common and allows interventions to prevent mother to child transmission during pregnancy, labour and delivery.

Transmission by needlestick injuries to health or social care workers remains very low.

Treatment

Treatment for HIV infection is highly effective and disease progression is slowed and halted by antiretroviral drugs. Survival rates have increased accordingly. People living with HIV infection can expect a near normal life span if they are diagnosed early. People diagnosed later continue to have a ten-fold increased risk of death in the year following diagnosis compared to those diagnosed promptly.

6.2.4 Bacterial and other infections

There is a wide range of bacterial infections causing problems in those who inject drugs. These may occur in minor epidemics or clusters, for example, the *Clostridium novyii* outbreak in the early 2000s (McGuigan et al 2002), the anthrax outbreak in 2009 (Palmateer et al 2012), and more recent outbreaks of *Clostridium botulinum*.

Commonly, there are superficial skin infections at injection sites. Sometimes these develop into a more generalised septicaemia. Bacterial endocarditis also remains a risk for anyone injecting drugs.

Around a third of those injecting psychoactive drugs in England, Wales and Northern Ireland reported they had experienced an abscess, sore or open wound (all possible symptoms of an injecting-site infection) during the last year. Among those attending needle and syringe programmes in Scotland, the figure was a fifth. Smaller, but still substantial, numbers of people injecting image and performance enhancing drugs report abscess, sore or open wound problems over a year (PHE 2016d).

Severe illnesses among people who inject drugs due to bacterial infections, including those caused by *Staphylococcus aureus* and Group A streptococci, continue to occur. Wound botulism, tetanus and anthrax cases continue to present in individuals or clusters of cases among people who inject drugs in the UK.

Bacterial infections remain common among people who inject drugs with around 10% admitted to hospital each year due to a bacterial infection (PHE 2016).

One way of addressing bacterial infections is through needle and syringe programmes and wound care services.

People who inject drugs are still at risk from tetanus and the consequences of infection can be very serious. Tetanus immunisation status should be actively checked in people who inject drugs and advice provided on how to obtain adequate immunisation if needed. Patients need appropriate urgent referral, usually to the emergency department, for potentially serious injection site infections and human tetanus immunoglobulin may be needed for some of these patients.

6.2.4.1 Tuberculosis

People who use drugs account for only a small number of cases of tuberculosis (TB) in the UK but they do have a higher prevalence of TB compared with the general population. This has been linked with an effect of HIV infection or otherwise to sharing or other social risk factors such as homelessness and imprisonment (WHO 2013).

If service users report symptoms suggestive of TB (that typically might include fever, loss of appetite, weight loss, night sweats and lassitude, along with a persistent productive cough in the case of respiratory TB), it is important that clinicians arrange for further assessment.

If a drug service user is a contact of someone with respiratory TB and is unvaccinated they will need to visit their GP to receive assessment for possible receipt of the BCG vaccine. The vaccine is not, however, recommended in those known to be or suspected to be HIV positive, regardless of clinical status.

6.2.5 Resources and further reading

Annual updates regarding infections among people who inject drugs in the UK is provided in Shooting up: infections among people who inject drugs in the UK at www.gov.uk/government/publications/shooting-up-infections-among-people-who-inject-drugs-in-the-uk

Detailed information about immunisations is contained in Immunisation against infectious disease (the Green Book) available at www.gov.uk/government/collections/immunisation-against-infectious-disease-the-green-book

Details of testing and treatment for hepatitis C are available from the National Institute for Health and Care Excellence (www.nice.org.uk) and Scottish Intercollegiate Guidelines Network www.sign.ac.uk

European Centre for Disease Prevention and Control and European Monitoring Centre for Drugs and Drug Addiction (2011). Prevention and control of infectious diseases among people who inject drugs. Stockholm: ECDC http://ecdc.europa.eu/en/publications/Publications/111012_Guidance_ECDC-EMCDDA.pdf

European Association for the Study of the Liver (2015) EASL recommendations on treatment of hepatitis C 2015. Journal of Hepatology 63: 199-236 www.easl.eu/medias/cpg/HEPC-2015/Full-report.pdf

The Hepatitis C Trust is the national UK charity for hepatitis C www.hepctrust.org.uk

The British Liver Trust provides a range of publications on individual liver conditions and offers support to patients with liver disease and those who care for them www.britishlivertrust.org.uk

Information about TB in drug users is provided in Managing tuberculosis in people who use and inject illicit drugs, Bulletin of the World Health Organization 2013, Getahun et al www.who.int/bulletin/volumes/91/2/13-117267/en/

6.3 Preventing drug-related deaths

6.3.1 Introduction

People who misuse or are dependent on drugs – and heroin and other opiates in particular – have mortality rates in the range of 1-2% per year, representing an excess mortality 10 to 20 times greater than expected.

The main cause of premature death among people who use drugs in the UK is drug overdose. The vast majority of these deaths are potentially avoidable. The other main causes of drug-related deaths are suicide, violence, accidents and physical health complications of drug misuse. Opioids are present in the majority of overdose deaths. Heroin is most commonly implicated and other opioids are sometimes found (most commonly methadone but also tramadol, codeine and others). These deaths often occur in combination with other substances such as alcohol or benzodiazepines. Increasingly, a wider range of other substances are identified as being present post mortem, including gabapentinoids and new psychoactive substances. Even though certainty concerning causal attribution in the presence of multiple substances can be difficult, being able to provide clear general advice for those who use drugs of the added risks of combining different psychoactive substances is important. It is helpful for clinicians to keep abreast of new trends in the substances found in overdose deaths.

Approximately 90% of overdose deaths occur in those aged over 25 years, with the average age of such deaths rising, suggesting an ageing cohort of individuals with problem opioid use at particular risk.

There are marked local, city and regional variations in mortality rates, and local factors need to be considered by those advising people at risk and those developing local prevention plans, which may include intelligence on changing purity, levels of street homelessness, levels of injecting, changing markets and changes in substances used.

Increases in overdose deaths in the UK pose a pressing challenge for clinicians and services working with individuals at risk. They need to try to optimise preventive interventions and to reflect on whether all reasonable actions are being taken organisationally and within individual care planning to reduce risk.

6.3.2 Preventing deaths from overdose

Clinicians can help to reduce drug-related deaths in their patients through careful assessment and monitoring, by delivering evidence-based treatments that are known to reduce risk of fatal overdose, and by providing specific harm reduction interventions and overdose prevention initiatives that reduce risk or can save lives by intervening to prevent death in cases of overdose.

Clinicians and treatment services may help reduce risk of drug-related deaths by identifying patients known to be at higher risk and taking actions to engage such individuals safely in the protective effects of treatment, including:

- older patients, males, heroin users in the first four weeks of their treatment, those with co-existing alcohol and mental health problems, individuals with a recent overdose (Gjersing 2015)
- those who use heroin who are currently out of treatment
- opioid dependent individuals with high risk due to recent reduction in their opioid tolerance – such as following prison release, discharge from hospitalisation or residential care, a planned detoxification programme or following recent cessation of naltrexone.

Being in opioid substitution treatment (OST) is associated with markedly reduced risk of overdose death, and so clinicians and services should provide:

- clear advice to patients considering OST on the protective effects of optimal doses of OST for reducing their risk of overdose
- prompt access to careful induction and dose optimisation (with methadone and buprenorphine choices available to patients in all treatment services)
- access to supervised consumption, flexibly, in line with guidance and to daily and frequent dispensing linked to the assessed risks
- where the current risk of overdose is assessed as particularly high (e.g. chaotic polysubstance use and high dose groin injecting), frequent reviews of progress in stabilisation on to their choice of OST
- clear advice to patients on the dangers of combining OST with other drugs, including benzodiazepines, opioids and alcohol, as well as newer drugs, and particularly in the early stabilisation phase of treatment
- early advice on the future increased risk of overdose after any subsequent loss of opioid tolerance (such as after missing prescribed doses for a few days or more or after a planned detoxification or period of abstinence from all opioids)
- for those continuing to use drugs illicitly on OST, review of the optimisation of OST and of other psychosocial care provided
- education to patients about how the use of their methadone by others is extremely dangerous
- a requirement that, before they are provided with take-home methadone or buprenorphine, patients with children at home show that they understand the risks of OST and the need for safe storage and other arrangements to protect the children
- for those leaving custody who will require continuation of their OST, prompt or same-day access to community assessment and suitable treatment (and also for those otherwise considered at high risk who want clinical support such as those who became abstinent in prison but are clinically identified as at high risk of relapse to heroin use)
- careful monitoring in patients with evidence of compromised respiratory function

- suitable support for any planned exit from OST (including offering a period of aftercare support that explicitly addresses the increased overdose risk from any subsequent lapse or relapse to heroin use).

Recognising the added risks of overdose and other deaths for those with complex needs, clinicians and services should be able to:

- identify and support individuals with complex medication regimes, multiple diagnoses, social isolation and/or risk of suicide
- make full use of local GP and pharmacist skills and support, including for complex and multimorbid cases, many of whom will often have complicated polydrug prescribing (with potentially increased risk of side effects and interactions)
- liaise actively with any other specialist services when appropriate
- arrange for or conduct mental health assessments in patients when it is considered they may present a suicide risk.

Clinicians and services need to be able to provide suitable advice on other important or emerging risks, such as:

- providing advice on the risks of overdose from use of GBL or GHB
- providing information and advice on the risks of sudden death due to cardiac effects from use of cocaine and crack cocaine
- encouraging people who may be using NPS persistently in a problematic way, to consider attending for assessment by drug treatment services, especially for those who show evidence of dependence and those using by injection.

Clinicians and services can improve the effectiveness of responses to opioid overdose by:

- providing education and training to people who use drugs and to their families/carers, and others such as hostel staff, on what increases the risks of overdose, and how to respond effectively to an overdose, including on the use of naloxone
- offering all opiate users in the community access to a take-home supply of naloxone with instructions on its use and with training on managing suspected overdoses
- supplying naloxone kits to known opiate users on discharge from custody and after detoxification in hospital or residential care.

Given the potential for reversing opioid overdoses to save lives, training in the use of naloxone should be widespread, particularly in first responders likely to be available to administer naloxone. Legislation allows anyone to use naloxone available in an emergency to reverse a suspected opioid overdose.

Drug consumption rooms have emerged in several European cities when circumstances have supported a new or additional response. These circumstances have included persistent public injecting, often in a city centre, acute public awareness of such injecting, risks from discarded injecting paraphernalia, and increased overdoses or transmission of infections. The response is to reduce the dangerousness of the continuing behaviour, to reduce risk to the public, and to address public nuisance and fear.

Such facilities may be solely for people who inject drugs or they may allow users of any drug to attend and use their drug in a safer environment. Users will often be given health advice, monitored during their drug use, and encouraged to contact treatment services.

6.3.3 Deaths from causes other than overdose

6.3.3.1 Other causes of deaths

There are a wide range of causes of deaths related to drug use other than through overdose:

- blood-borne viruses, HIV and other infections
- liver cancer and liver failure that follow chronic viral hepatitis
- other liver disease (including with heavy alcohol use)
- suicide, accidents, injuries and homicide
- prolonged smoking, which leads to high risk of chronic lung disease (including COPD) and cardiovascular disease, and to deaths from respiratory and vascular complications
- disease due to sustained heavy alcohol use
- comorbid mental health problems associated with increased risk of comorbid physical health problems, and of suicide, and with antipsychotic and polydrug prescribing that carries an independent risk of premature death.

6.3.3.2 Preventing death from other conditions

All treatment services and those involved with the care of people affected by drug use should consider ways to reduce the risk of premature death from the extended range of causes related to current or past drug taking or from common comorbid physical and mental health problems, particularly given the ageing cohort of those in treatment with heroin dependence who present with premature morbidity and mortality.

Comprehensive drug assessments should include, over time, basic identification of the presence of comorbid conditions that could contribute to premature mortality. Services need a range of clear pathways for further assessment and care for such conditions (usually through the GP but this may involve direct referral where appropriate). Some preventive interventions could be provided within drug treatment services, and others may require joint working or treatment provided elsewhere. This may depend on commissioning arrangements and the nature of local services.

People who use drugs and who continue to smoke or have smoked previously at high rates are a core group where preventive interventions could be highly successful. Effective interventions for smoking include provision of smoking cessation services and the use of harm reduction approaches. An assertive approach by drug treatment services may be crucial for reducing preventable mortality (and morbidity) for this population who may also have other relevant respiratory, cardiovascular and metabolic risks.

Increasingly complex physical, mental and social problems and disabilities, in what is now an ageing group of heroin and crack users attending drug treatment services, make skilled coordination of care essential. Clinicians need to understand the reluctance of some of these patients to engage fully and to have confidence in the health and social care services they

need (that may be based on previous negative experiences and stigma from such services). The keyworker and coordinator of care have an important role to identify and meet these needs, and to support communication and engagement with other professionals to help build patient confidence and address barriers to engagement.

6.3.4 Potential impacts on mortality in the future

The increasing use of new psychoactive substances, their unknown and variable composition, sometimes high potency, and uncertain harms, may lead to more deaths in future, both among drug-naïve younger people and among apparently experienced older people who use drugs.

Of recent concern is the emerging evidence of the use of highly potent stimulants by injection, which may need clinicians and services to consider how best to respond to the needs of those at risk. It is important that services keep alert to the possibility of changing trends in use and the potential scale of subsequent harms, including fatalities.

6.4 Naloxone

6.4.1 Naloxone and its use

Across Europe, illicit opioid users are 10 times more likely to die than their peers of the same age group and gender, and 6100 deaths were attributed directly to opioid overdose in 2012. Poisoning deaths in the UK involving heroin and/or morphine have significantly increased in recent years.

Naloxone is a potentially life-saving medicine when used in settings associated with opiate misuse and overdose. Systematic reviews conclude that pre-provision of naloxone to heroin users can be helpful in reversing heroin overdoses. There is also evidence for the effectiveness of training family members or peers in how to administer the drug.

Naloxone is an opioid/opiate antagonist and is licensed for use in:

- complete or partial reversal of central nervous system depression and especially respiratory depression, caused by natural or synthetic opioids
- treatment of suspected acute opioid overdose or intoxication.

6.4.2 Who can administer naloxone?

Anyone can administer naloxone for the purpose of saving a life.

6.4.3 Who can supply what naloxone when?

Before October 2015, naloxone could only generally be prescribed directly to a named patient (typically, “someone who uses, or has used, opiates and is at risk of overdose”), or supplied to an individual by means of a patient specific direction (PSD) or a patient group direction (PGD). There were arrangements in Scotland and Wales to allow more widespread supply. Naloxone continues to be available through these mechanisms.

New legislation came into force in October 2015 that enables naloxone to be supplied to individuals by drug services without prescription. Naloxone remains a prescription-only

medicine (POM) but the Human Medicines (Amendment) (No.3) Regulations 2015 outlined the following exemptions from the restriction on supply of a prescription-only medicine in the case of naloxone:

1. Who can supply naloxone?

“Persons employed or engaged in the provision of drug treatment services provided by, on behalf of or under arrangements made by one of the following bodies:

- (a) an NHS body
- (b) a local authority
- (c) Public Health England, or
- (d) Public Health Agency”.

This extends to pharmacists commissioned to provide services for people who use drugs such as needle and syringe programmes.

2. What can they supply?

“A prescription only medicine for parenteral administration containing naloxone hydrochloride but no other substance that is classified as a product available on prescription only”.

3. Under what conditions can they supply?

“The supply shall be only in the course of provisions of lawful drug treatment services and only where required for the purpose of saving life in an emergency”.

This change therefore has the effect of making it easier for drug treatment agencies to distribute naloxone to ‘at risk’ opiate users, and also making it easier to supply the drug to family members, friends and peers. The example of a hostel wishing to provide naloxone to residents who may accidentally overdose on opiates illustrates the implications of these changes.

Box 3: Naloxone and hostel scenario example

Hostel scenario example using the Human Medicines (Amendment) (No.3) Regulations 2015*

- A hostel that is not a commissioned drug treatment service cannot supply naloxone to individuals.
- A drug treatment service cannot supply naloxone to a hostel (an organisation).*

BUT

- A drug treatment service could supply naloxone to an individual in a hostel, such as its manager.
- The hostel manager could then arrange for the naloxone to be available for staff or resident use in case of an overdose in the hostel.
- An outreach worker from a drug treatment service could also supply individual staff or residents in the hostel.
- A hostel might be commissioned as a drug treatment service.
- The hostel's doctor or residents' GPs could prescribe naloxone to individual residents at risk of opiate overdose.
- Hostel residents in treatment could be provided with naloxone by prescription or supply from their drug treatment service.

*Note: The Lord Advocate's guidelines in Scotland do allow staff of drug treatment services to supply, with stocks of naloxone, any service including hostels likely to be in contact with those who may overdose. These supplies are made as service stock and not individual staff supplies.

6.4.4 Naloxone dose

An NHS England Patient Safety Alert in November 2014 highlighted risks associated with inappropriate naloxone use:

“Naloxone must be given with great caution to patients who have received longer-term opioid/opiate treatment for pain control or who are physically dependent on opioids/opiates. Use of naloxone in patients where it is not indicated, or in larger than recommended doses, can cause a rapid reversal of the physiological effects for pain control, leading to intense pain and distress, and an increase in sympathetic nervous stimulation and cytokine release precipitating an acute withdrawal syndrome. Hypertension, cardiac arrhythmias, pulmonary oedema and cardiac arrest may result from inappropriate doses of naloxone being used for these types of patients”.

A UK Medicines Information (UKMi) Q&A document on naloxone highlights that there are two distinct scenarios where naloxone may be used, and two possible dosing regimens:

The first scenario is palliative care and is not the focus of these guidelines.

The second is the case of drug misuse and dependence where naloxone is used in emergency situations. When presented with an individual who has used sufficient opioid to reduce their rate of respiration to life-threatening levels, prompt administration of naloxone can reverse these effects and restore adequate levels of oxygen in the bloodstream. However, the risks of giving too much naloxone when it is not required are well documented. Acute withdrawal syndrome from opioids can have both unpleasant and potentially serious effects. Physical effects such as vomiting, agitation, shivering, sweating, tremor and tachycardia are unpleasant, and may lead to aggression and a refusal to accept further treatment (i.e. refusal to go in ambulance or to stay in hospital). Furthermore, life threatening withdrawal reactions may also occur in as many as 1% of cases of naloxone administration, with the potential to cause a sympathetic excess and resultant pulmonary oedema and ventricular arrhythmia.

The UKMi information is clear that, in the reversal of acute opioid toxicity with severe respiratory depression or arrest, “Higher initial dose regimens” are of particular value. The recommended intramuscular dose is 400 micrograms initially, with further 400 microgram doses given incrementally every 2-3 minutes until an effect is noted or the ambulance arrives. Total available naloxone in a community overdose situation before an ambulance arrives is unlikely to exceed 2mg (five 400 microgram doses), which is the amount at which the BNF recommends the diagnosis of opiate overdose should be reviewed.

The UKMi Q&A on naloxone doses to be used in adults to reverse urgently the effects of opioids or opiates is available at www.sps.nhs.uk/wp-content/uploads/2015/11/QA227_3_Naloxone_final_Oct2015.pdf

6.4.5 Naloxone products

Several products are licensed for use in reversing acute opioid overdose, and all have advantages and disadvantages in terms of assembly, dose, dose calculation and ease of administration. Consideration should also be given to storage and transportation of the product when identifying the appropriate product to supply.

A UKMi In Use Product Safety Assessment Report on naloxone products for emergency opiate reversal in non-medical settings found two presentations in the UK: “Both ampoules and prefilled syringes are available for supply in take-home naloxone services. However, as the use of ampoules requires greater manipulation than pre-filled syringes to deliver the naloxone, prefilled syringes are the presentation of choice, although ampoules may be an option depending on local circumstances.”

The UKMi report provides a useful summary of the available products in the UK at March 2016 www.ukmi.nhs.uk/filestore/ukmiaps/Naloxone%20product%20safety%20review_FINAL.pdf

There have been some experiments with naloxone nasal sprays improvised from pre-filled syringes and a spray device but it has been found that only approximately 10% of the naloxone is absorbed. This unlicensed practice has consequently attracted criticism as unreliable (Strang et al 2016). A recent development has been the production of concentrated naloxone nasal sprays with approximately 40-50% absorption and, in 2015, product approval was granted in the US to one such nasal spray. However, in the UK/European context, at the time of writing, there are no approved nasal sprays.

6.4.6 Training in delivering take-home naloxone

Training should cover the identification of overdose and how to then respond to overdose, including first calling an ambulance.

Where a naloxone product is also supplied a minimum level of training in how to assemble and use that product should be given.

People being trained in how to respond to opioid overdose, including using any available naloxone, should be able to demonstrate an understanding of the following after training:

- overdose risks: using sedating drugs (e.g. benzodiazepines) or alcohol in addition to opiates, getting older, when opiate tolerance has reduced (e.g. after leaving prison or rehab)
- how to identify a suspected opiate overdose – lack of consciousness, shallow or no breathing, reduced rate of breathing, ‘snoring’, blue lips or fingers
- when to call 999
- rescue breathing, cardiopulmonary resuscitation (CPR) and the recovery position
- what naloxone is:
 - what it does – it reverses an overdose of opiates
 - what it can’t do – reverse the effect of other drugs or alcohol
 - its short acting nature
- using naloxone:
 - when to administer it
 - how to administer it – address fears about needles and injecting
 - the importance of staying with a casualty.

The WHO document ‘Community management of opioid overdose’ (2014) provides additional guidance on resuscitation:

“Because the key feature of opioid overdose is respiratory arrest, ventilation is a priority and the GDG suggests the following description of the steps recommended for resuscitating an individual with suspected opioid overdose.

- Apply vigorous stimulation, check and clear airway, and check respiration – look for chest rising and falling.
- Call 999 and ask for an ambulance if evidence of an overdose.
- In the presence of reduced consciousness but continued breathing, even if shallow, turn the patient on their side, and, if necessary, clear the airway of any vomit.
- Then administer naloxone and rescue ventilation where needed.
- If there is unconsciousness and no breathing, or if there are no signs of life, commence CPR with chest compressions, if able to do so. Where possible, without significantly delaying starting or continuing the CPR, administer naloxone too.

- Re-administer naloxone after two to three minutes if necessary.
- Continue life support or, if the person has come round, continue to watch them until professional help arrives.
- Where available, CPR mouth barriers should be used for rescue ventilation.”

6.4.7 Resources and further reading

The ACMD’s ‘Consideration of naloxone’:

www.gov.uk/government/uploads/system/uploads/attachment_data/file/119120/consideration-of-naloxone.pdf

The Scottish Drugs Forum’s www.naloxone.org.uk

The NTA’s report on its overdose and naloxone training programme for families and carers:

www.nta.nhs.uk/naloxone-report-2011.aspx

Harm Reduction Works overdose and naloxone DVD (HRDVD6N):

www.harmreductionworks.org.uk/6_booklets/overdose.html

The World Health Organization’s 2014 guidelines on ‘Community management of opioid overdose’: www.who.int/substance_abuse/publications/management_opioid_overdose

SMMGP’s e-learning, ‘Naloxone saves lives’: www.smmgp-elearning.org.uk

An international website supporting naloxone distribution with free resources:

www.naloxoneinfo.org

6.5 Alcohol in drug treatment

6.5.1 Introduction

Alcohol consumption is a significant cause of death among young people (particularly through alcohol poisoning, accidents or violence) and among adults and older people (through a wide range of conditions including heart disease, cancers and liver disease). It contributes to wide-ranging morbidity and to consequences for children and family members, especially in cases of alcohol dependence.

Alcohol problems increase the risk of dropout from treatment and exacerbate mental health problems. Drinking increases the risk of hepatic cancer in people who are hepatitis C positive. Most of these risks are increased when alcohol and other drugs are taken in combination.

6.5.2 Drinking and drug misuse

A significant minority of those in drug treatment drink at hazardous or harmful levels. Around one-third of patients receiving methadone have been found to have a current drink problem and a further one-sixth to have a history of a drinking problem (Senbanjo et al 2006). A substantial proportion of drug-related deaths are reported to involve alcohol.

Clinicians working with people who use drugs require alcohol competencies, including:

- giving educational and harm reduction messages about hazardous, harmful and dependent use of alcohol

- detecting drinking problems and dependence
- recognising that addressing alcohol misuse should be integrated with the treatment of drug misuse
- managing drinking problems alongside pharmacotherapies such as substitute prescribing.

It can be clinically helpful to categorise patterns of drinking associated with drug misuse:

- lower level drinking that is largely independent of other drug misuse
- drinking that is linked to the misuse of other drugs and that may be used interchangeably with drugs
- dependent drinking that occurs on top of other drug misuse or dependence, including by those on a substitute prescription.

Categorising and responding to the cumulative effects of high-risk behaviours and of polydrug and alcohol use can require clinical experience and the application of clinical judgements.

6.5.3 Treatment interventions

6.5.3.1 Heavy drinking on top of OST

Opiate misusers who are chronically intoxicated with alcohol can be particularly difficult to manage safely. Some strategies to deal with the problems are outlined in the section on responding to failure to benefit from treatment ([section 4.6](#)).

The risks of prescribing (and supplying) opioids for heroin dependence alongside high levels of alcohol use need to be balanced against the benefits of retaining the patient in and on treatment. It could be riskier for patients if they were not provided with a continued, stable dose of OST. Specialist competencies are required to make this judgement.

People who use drugs and who are dependent on alcohol should be offered alcohol treatment interventions. This involves support for alcohol reduction and cessation either in the community or as an inpatient followed by psychological and pharmacological interventions to prevent relapse.

The standard treatments for alcohol dependence and misuse apply to those who also misuse other drugs. These include psychological interventions specifically directed at alcohol misuse, and pharmacology to prevent relapse, such as acamprosate or disulfiram or – if not maintained on OST – naltrexone.

The more that the drinking behaviour is intertwined with drug misuse or dependence, the more the two are likely to need dealing with together, and they may require a more intensive intervention.

Concern often arises about heavy drinking on top of OST. Because of the protective effect of tolerance to opioids as a protection against respiratory depression, there is unlikely to be any advantage to keeping doses of OST low because of alcohol misuse. A likely effect of inadequate doses of OST is to increase the risk of greater topping up with heroin alongside a less effective tolerance to opioids. Therefore, ensuring safer consumption of OST, usually by daily supervised consumption, becomes particularly important to consider for such situations. Enforced or coerced transfer to buprenorphine could create similar risks if it leads

to disengagement or to missed doses. Specialist competencies are particularly important in working with a patient who may be alcohol dependent and in need of high dose OST, to ensure safe prescribing and avoidance of under-treatment.

If heavily-drinking patients are attending the pharmacy, it is important to communicate relevant aspects of the treatment plan to the pharmacist in advance. There is no contraindication to providing OST to a patient who has simply been drinking. Strategies to deal with situations of gross intoxication and significant impairment should be agreed in advance and the patient informed that in these circumstances supervised or take-home doses will not be dispensed.

Good communication with the dispensing pharmacist is essential.

6.5.3.2 Difficulty supervising daily consumption of OST alongside heavy drinking

If the heavily-drinking patient is also homeless or for other reasons it is difficult for them to access daily supervised consumption of OST, an exceptional decision about less-than-daily supervised consumption could be made. However, given an absence of research evidence to guide this, such a decision should only follow expert clinical risk assessment of the balance of potential harms, which should be clearly documented.

6.5.3.3 Where multiple assisted withdrawals from alcohol and from other drugs are needed

Polypharmacy for patients with alcohol and other drug dependence should be minimised and consideration given to the order in which to address withdrawal from multiple substances. In the community particularly, it is recommended to carry out detoxification from one substance at a time. When a patient plans to become abstinent from all substances including opioids, it is normally recommended first to focus on detoxification from alcohol, and then from sedative-hypnotics if they are also a problem. The dose of substitute opioids on which the patient has already stabilised should be maintained until detoxification from alcohol (and any sedative-hypnotic) has been completed. Only then should opioid detoxification start. However, if after suitable discussion, a patient opts to detoxify from opioids first, this should be supported, while monitoring for and managing the risk of deterioration in alcohol or other drug use.

6.5.3.4 Assisted withdrawal from alcohol alongside OST

Before initiating a planned alcohol detoxification, always consider the degree of supervision required for its safe management alongside OST. Inpatient services may be needed or intensive community support through frequent home visits, through ambulatory support or using day-care supervision.

6.5.3.5 The use of breathalysers

Regular use of breathalyser readings may be useful in monitoring the amount of alcohol recently consumed and in programmes assisting patients to reduce their use.

Breathalyser readings can also be useful to provide objective evidence of continuing drinking by someone on OST, which could lead to review by a clinical colleague.

Because of widely varying tolerance levels between individuals, careful interpretation and use of breathalyser readings is needed. No single breathalyser level has been identified that reflects definite severe impairment or substantial acute risk from alcohol intoxication. Use of OST in alcohol-dependent patients who are still drinking is neither contra-indicated nor uncommon. As a result, the delivery of safe and equitable care may be challenged if keyworkers or other staff are automatically required to obtain additional clinical review or advice before issuing or continuing an OST prescription in cases where routine breathalyser testing finds any particular cut-off level (such as the drink-drive limit). If additional review or advice is needed following a breathalyser reading, it should be available at short notice to avoid an inappropriate interruption in the supply of medication and the attendant risks to patients (e.g. use of more dangerous opioids to avoid withdrawals).

6.5.3.6 Patients on OST too intoxicated from drinking to assess

Patients who are very intoxicated when they attend review (for example, too intoxicated to engage sufficiently in discussion about their progress and about their continued medication supply) may need to be asked to return when more sober (later in the day or the following morning). The assessment of whether a service user is too intoxicated to receive a prescription is a clinical one. Such a clinical presentation can reflect a very high-risk patient requiring priority review and care. It is likely to be helpful, in such situations, to discuss with the dispensing pharmacist whether the patient attends for medication collection similarly intoxicated. Judgement is needed by the keyworker and experienced clinicians on how to proceed regarding immediate OST supply, level of monitoring and frequency of review. This sometimes involves a complex individual risk assessment with competing risks to be balanced.

6.5.3.7 Provision of vitamin supplements for those drinking heavily

Patients drinking heavily may suffer from vitamin deficiencies and associated health consequences. Providing appropriate supplements, primarily thiamine and other B vitamins, may help prevent future problems.

Further information on the treatment of alcohol dependence can be found in Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence (NICE 2011).

6.5.4 Non-drug interventions

A range of resources for primary alcohol problems may be useful for those with combined drug and alcohol problems, including one-to-one motivational work with keyworkers and locally available support groups (such as groups for managing dependence or more specific alcohol support and relapse prevention groups). The chapter on psychosocial interventions provides detail on interventions that may be equally relevant for the alcohol use problems of this group.

Advice should also be given on locally-available peer support and mutual aid groups. See [section 3.7.4.1](#) and other resources on facilitating access to mutual aid, such as from Public Health England: www.nta.nhs.uk/uploads/mutualaid-fama.pdf

6.6 Smoking and respiratory function

6.6.1 Introduction

Most patients in drug treatment smoke tobacco. Some will also have been smoking other drugs that can damage their lungs (such as crack cocaine, heroin and cannabis).

Smoking by people who use drugs causes extensive morbidity and leads to large numbers of premature deaths. This is mainly through the effects of tobacco smoking on the development of cardiovascular diseases and respiratory diseases (chronic obstructive pulmonary disease (COPD), lung cancer and poorly controlled asthma). The effects of lung disease on depression of lung function may also contribute to some deaths from opioid overdose.

Most people in treatment express the desire to quit smoking, however, only a minority may be offered adequate support to do so. Staff attitudes and training may be a factor in this, including the unfounded belief that discussion of smoking cessation needs to be delayed. Rather, engagement with support for smoking cessation has been associated with improved drug treatment outcomes, using the same kinds of psychosocial interventions as for treatment for other types of drug dependence (e.g. support for coping with cravings and prevention of relapse).

Those who are older and who smoke are at a heightened risk of COPD. As COPD is a risk factor for pneumonia, it is important that clinicians are alert to the symptoms of such infection and refer appropriately. Consideration should also be given to encouraging patients to take advice from their GPs on the need for vaccinations against pneumococcus and influenza especially as they get older. Local policies on use of influenza vaccination should be followed.

6.6.2 The role of drug treatment services in identifying and responding to smoking and respiratory problems in drug users

Drug treatment services need to:

- identify any history of smoking of tobacco and other drugs
- identify any indication of cardiovascular or respiratory disease (this may be simply through the history of symptoms and/or through simple observation or physical examination, but some services use simple lung function testing)
- provide information and advice on effects of smoking and the support available locally
- ascertain the attitude to engagement in smoking cessation support and promote or support engagement in local smoking cessation or provide smoking cessation support directly
- support attendance for more detailed physical assessment and investigation by the patient's GP (or subsequently by suitable specialist) if indicated
- support continued engagement with treatment services for respiratory problems from GP or specialist respiratory health services.

6.6.3 Taking a history for smoking and respiratory disease

Questions that can be useful for exploring potential respiratory disease include:

- recent and previous levels of smoking and current quit status (for tobacco and for other smoked drugs including heroin, crack cocaine and cannabis)
- current or recent history of cough, shortness of breath and symptoms of asthma, and any consequent impairment in activity such as walking
- previous respiratory diagnoses and any treatment for existing lung disease
- the desire, now or in the future, to quit tobacco smoking
- experience of previous quit attempts
- willingness to consider smoking cessation (including pharmacotherapy)
- current use of e-cigarettes.

6.6.4 Physical examination and investigations for smoking and respiratory disease

Physical signs that can be useful for exploring potential respiratory disease, and tests that are used most typically by the GP or respiratory team (but have been used in some drug treatment services):

- signs of breathlessness, cough, wheeze, and/or other signs of respiratory (or cardiovascular) disease
- pulse oximetry (SpO₂%) – a simple and useful test that can alert to otherwise unrecognised impaired lung function (this may be particularly of interest if using opioids and other respiratory depressants or with recent opioid overdose events)
- spirometry (including hand-held spirometry that may be more easily used in non-specialist clinics) – which can quantify impairment that may have been caused from tobacco or other drug use.

6.6.5 Appropriate interventions for respiratory problems

Clinicians can assist their patients to obtain appropriate respiratory care by:

- maintaining clear documentation in the patient record of patients' reported smoking and their reported respiratory health
- noting any observed deterioration in apparent respiratory health over time
- referring, if indicated, to the service user's GP for investigation and treatment (which may include full lung function tests and chest X-ray)
- supporting referral, usually by the GP, to the local specialist respiratory service/chest clinics – which may be required for patients with established respiratory disease if there are health concerns (such as evidence of low oxygen levels and/or recurrent exacerbations)
- referring urgently to the GP or to a local rapid access chest clinic any patients with respiratory disease with 'red flag' symptoms of chest malignancy (such as for patients who report haemoptysis and weight loss)

- referring urgently to an emergency department patients presenting with imminently dangerous conditions such as unstable or deteriorating asthma.

6.6.6 Support for smoking cessation

6.6.6.1 Staff competence

Staff need to be competent in providing or supporting smoking cessation interventions. Staff may feel they have not been appropriately trained to provide smoking cessation advice, may believe that it will interfere with the higher priority drug treatment, and some may be influenced by being tobacco smokers themselves. However, this needs to be addressed in all services to ensure staff are confident in addressing this issue, which essentially just involves a variation of their already established competencies.

6.6.6.2 Identification and motivational support for smoking cessation

Commissioners and planners of smoking cessation services and of specialist drug services need to consider with their providers what are the most appropriate pathways locally so that users of drug treatment service have adequate access to smoking cessation interventions.

The best outcomes for smoking cessation are seen from a combination of behavioural support and pharmacological interventions such as nicotine replacement therapies, and other drugs such as bupropion and varenicline (Champix). People who use drugs can respond to these same treatments as the general population although they may need more intensive or extensive options to achieve the same results.

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

All staff need to use a positive motivational style to assist a patient to evaluate their smoking and the options available. They also need to offer brief advice regarding the availability of smoking cessation support.

Given that different patients may wish to engage in help with smoking at different stages of their treatment journey, staff should continue to offer repeated brief advice for smoking cessation as treatment progresses. It is also important to be able to discuss options such as e-cigarettes that patients may already be using to reduce or stop their smoking.

While it may be helpful to have access to on-site smoking cessation services with both elements of psychosocial interventions and prescribing available, staff should be aware of the locally-developed pathways and approaches to support patient engagement in smoking cessation services, whether provided in primary care or elsewhere.

6.6.6.3 Harm reduction for tobacco smoking

Given the high rates of smoking and the low quit rates in people who use drugs, it may be reasonable to consider harm reduction approaches to smoking such as replacing some cigarettes with other sources of nicotine. This could be in the form of patches or gum for some of the day, for example, to alleviate the symptoms of tobacco withdrawal while a patient is in a residential or inpatient drug treatment facility.

Patients who have not engaged in smoking cessation or who have not managed to quit all tobacco smoking may already be using, or wish to use, e-cigarettes. They may wish to use such replacements for a short or long period to reduce their risks of harm. Clinicians need to be able to discuss this with patients by keeping up-to-date with the developing evidence base.

Several statements can be made on e-cigarettes:

- The continuing damage known to be caused by smoking tobacco can be stopped in those who use e-cigarettes (or other nicotine replacements) as long as they cease all smoking of tobacco.
- While there is no evidence to show there are likely to be additional long-term harms caused from heated nicotine vapour in e-cigarettes (and from the chemical agents used alongside the nicotine), there are no long-term studies to assure the safety of this.
- There is insufficient evidence to advise on the most reliable or consistent e-cigarette to use and the optimal dose of nicotine.
- It is not known how successful patients will be at staying smoke-free longer-term if using e-cigarettes in this way. However, nor is there any evidence of significant harm to date.

6.6.7 Resources and further reading

Action on Smoking and Health (2016) The stolen years: the mental health and smoking action report www.ash.org.uk/files/documents/ASH_1018.pdf

NICE (2013) Smoking: harm reduction. Public health guideline 45
www.nice.org.uk/guidance/ph45

NICE (2013) Smoking: acute, maternity and mental health services. Public health guideline 48
www.nice.org.uk/guidance/ph48

PHE (2015) Improving smoking cessation in drug and alcohol treatment
www.nta.nhs.uk/uploads/improving-smoking-cessation-in-drug-and-alcohol-treatment.pdf

Tobacco Advisory Group of the Royal College of Physicians (2015) Nicotine without smoke: Tobacco harm reduction
www.rcplondon.ac.uk/projects/outputs/nicotine-without-smoke-tobacco-harm-reduction-0

6.7 Oral health

People who have a history of substance use problems are more likely to have poorer oral and dental health generally. This has been linked to a variety of potential contributory factors:

- Excessive alcohol use has been implicated in the development of dental caries, tooth erosion and periodontal disease.
- Tobacco use is associated with increased severity and extent of periodontal diseases, tooth loss and poor wound-healing.
- Medical complications associated with substance use can have a negative impact on oral health including abscesses at injection sites, viral hepatitis, HIV, endocarditis and complications of anaesthesia.

- High rates of dental decay reported in heroin users may be due to xerostomia (dry mouth) from opiate use combined with negative impacts of high-sugar containing oral methadone.
- Dental and oral hygiene problems are common and can compound the problems.
- Lifestyle factors (alcohol and tobacco use, poor nutrition and oral personal hygiene) can also compound problems.
- People who use drugs are reported to visit the dentist less even though their treatment needs, both actual and perceived, are high.
- Opiate users may demonstrate low pain tolerance, which can require additional care from the dental team that the patient may not be confident about.
- Some people who use drugs have prior experience of dental teams being reluctant to treat them.
- Dental teams may be reluctant to offer appointments to people who use drugs if they have previous experience of them not keeping appointments or turning up late.
- Use of tobacco and alcohol is associated with increased risk of oral cancers.

Dentists are well placed to pick up signs of substance use and they have an opportunity to offer preventive advice to improve oral health as well as general health, including brief advice for smoking and alcohol.

At assessment, simple questions about dental and oral health problems, and current and past use of dental services, can help identify early positive health goals for the patient's care plan. Men and women with oral and dental health problems may be sensitive about the effects these have on their appearance, self-confidence and self-esteem.

Management of what can be a frequent source of pain can also be an important focus in achieving stability on an opioid substitute.

Provision of encouragement, help and advice to attend a suitable local dental service is also an opportunity to engage the patient in positive care for their health and wellbeing as part of a wider process of recovery. Liaison with the GP may also be needed in some cases.

Dental services should be competent in providing dental treatment and oral health promotion advice for people in drug treatment. They can also undertake identification and brief advice for hazardous or harmful alcohol use and for tobacco use, and can refer patients to smoking cessation and alcohol services.

Local dental policies may advocate the prescription of sugar-free preparations. Pharmacists can only dispense sugar-free methadone oral solution if specifically prescribed. However, some brands of sugar-free methadone solution may lead to unacceptable side effects in some patients due to intolerance of artificial sweeteners or side-effects secondary to a high sorbitol content, for instance nausea, stomach cramps and diarrhoea. Sugar-free medicines are generally recommended, as they do not contain sugars that can cause dental caries, but an association between methadone solutions and dental problems has not been demonstrated. All patients should have information on oral hygiene available to them, including ways to minimise any potential negative effects of their medication on their oral health (see [box 4](#)).

Enabling effective dental hygiene can depend on:

- supporting an individual's personal motivation (using basic motivational principles)
- ensuring provision of sound oral health advice
- supporting engagement with dental monitoring, advice and treatment.

It is important to be able to provide clear, consistent and sound advice on good dental hygiene for any patient who wants it.

Box 4: Advice for achieving and maintaining good oral hygiene

To achieve and maintain good oral hygiene:

- Brush your teeth last thing at night before bed AND at least one other time each day, normally taking around two minutes.
- Brush your gum line AND each tooth.
- Consider a small-headed, medium-texture toothbrush (replaced frequently).
- Interdental cleaning before brushing can improve your plaque control (use dental floss/tape, interdental/single-tufted brushes or kit recommended by your dentist).
- Avoid rinsing your mouth with lots of water after brushing (it washes away the fluoride). Just spit out the excess toothpaste.
- If you are using a fluoride mouth rinse, never use this just after brushing (you will simply be washing away the more concentrated fluoride from your toothpaste).
- Take advice from a dentist on the need for a fluoride varnish or high-concentration fluoride toothpaste. These are sometimes recommended for those at high risk of dental caries.
- Reduce the total amount of any foods or drinks with 'added sugar' you consume AND leave a couple of hours or more between any such products. This time gives saliva time to reduce some of the negative effects caused by the sugar. 'Added sugars' are sugars, syrups or honey added to foods and drinks by the manufacturer, cook or consumer.
- If you have evidence of problems with tooth wear you need dental advice. You should avoid frequent intake of acidic foods or drinks, keep acidic drinks to mealtimes and limit fruit drinks to no more than one a day. You should not brush immediately after eating or drinking acidic food or drinks as the acid makes the tooth temporarily vulnerable to added damage. You should not brush immediately after vomiting.
- If you are taking methadone solution you could consider:
 - using a straw to reduce direct contact of methadone solution with your teeth/gums
 - using water to wash down any remaining solution in your mouth
 - brushing your teeth after taking your methadone (however, the brushing should normally be delayed for at least half an hour or so if you have recently consumed any acidic foods or drinks).

6.8 References

ECDC and EMCDDA (2011) Prevention and control of infectious diseases among people who inject drugs. Stockholm: European Centre for Disease Prevention and Control and European Monitoring Centre for Drugs and Drug Addiction

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Chapter 7: Specific treatment situations and populations

7.1 General key points

Below are a few general key points that apply to working with any specific treatment situation and population. Key points specific to the situations and populations described in the rest of this chapter appear at the beginning of the relevant section.

- Assessment and care provided by a liaison team with competence in drug treatment, or otherwise through a system for multidisciplinary team and multi-agency working, is appropriate for many specific treatment situations and populations, which can include pregnant women, young people, older drug misusers, those with a dual diagnosis, drug misusers with acute and chronic pain, and drug misusers being admitted to or discharged from hospital.
- Commissioners and planners of treatment provision across commissioning boundaries need to take account of the benefits of maintaining suitable provision for liaison and multidisciplinary and multi-agency working for those with drug use problems and dependence.

7.2 Pain management

7.2.1 Key points

- Drug misusers in pain will have needs, similar to non-drug users, for pharmacological and other interventions to address pain.
- Drug services need competence in, and understanding of, the safe management of pain for such patients (underpinned by detailed assessment of the pain, of the dependence, and of any comorbid mental health problems).
- Drug treatment services need to have appropriate communication with health and social care professionals, the patient and their carers.

7.2.2 About pain

Most pain is self-limiting and does not need treatment.

The intensity of pain is normally determined by the degree of tissue injury and also cognitive and affective influences including current mood, past experience of pain and concerns about the cause of the pain.

When pain becomes chronic, emotional factors become predominant in determining intensity of pain – with anxiety, depression, post-traumatic stress disorder, previous emotional trauma

and other mental health diagnoses worsening the experience of pain and making it more difficult to treat.

7.2.3 The role of opioids in pain management

Opioids are effective drugs for the management of acute pain and for pain at the end of life but have little role in managing long-term pain. There are no good quality studies that demonstrate efficacy of opioids for long-term pain although it is recognised in practice that a small number of patients may benefit in the long term, normally only if opioid doses are low and the drugs used intermittently. The risk of harms increases if daily opioid load exceeds oral morphine equivalent greater than 120mg/24 hours and escalation above this dose has not been found to confer any additional benefit. If a patient using opioids is still in pain in such cases, the drugs are considered not to be working and should be tapered or stopped, even if no other treatment is available. Long-term harms reported for opioid therapy should also be discussed with the patient including opioid induced hyperalgesia (with worsening of pain).

There is growing concern about the rise of prescribed opioid use for chronic pain, both in the UK and internationally, not least because of the risk of dependence and given the very limited evidence for their effectiveness. Those addiction specialists assessing and managing complex cases involving chronic pain need to be fully aware of this evidence in their evaluation of such cases, in providing care and in giving advice to other professionals.

7.2.4 Pain management in secure settings

It is the right of every patient in custody to have access to evidence-based pain management that can be safely delivered. However, healthcare professionals working in secure settings face challenges in relation to diagnosis, management and measuring outcomes of treatment. Pain medications are properly a source of concern to professionals in this setting and to operational staff. The potential for misuse and diversion needs to influence clinical decisions both for the safety of the patient (in relation to bullying and coercion), and others in the patient's environment. The subjective nature of the report of pain may pose difficulties in distinguishing patients with a genuine clinical need for pain relief from those who are requesting analgesia for personal misuse or as a commodity for trade. When drugs known to be misused are clinically indicated for the treatment of pain, appropriate safeguards must be put in place.

The general principles for managing different types of pain in those with dependence are described below and apply equally for those in secure settings.

7.2.5 Misuse of prescribed analgesic medicines

Estimates from the US suggest that 8-12% of long-term prescribed opioid users meet criteria for a current or past opioid use disorder.

Risks for problematic use of prescribed opioids (including risk for dependence) include current comorbid mental health diagnoses and a current or past history of substance misuse (when it is possible opioids are used to attenuate unpleasant thoughts and experiences which are themselves known to worsen the perception of pain). Patients with these risk factors have also been found to be more likely to receive opioid prescriptions for pain, to be more likely to use problematic high doses and to be more likely to be co-prescribed other psychotropic and

centrally-acting drugs including benzodiazepines. This phenomenon has been described as 'adverse selection'.

While misuse of the recommended therapeutic doses of the gabapentinoids, gabapentin and pregabalin, has not been widely reported, their misuse has been noted for some years in those service users attending substance misuse treatment services, and within secure environment settings. It is possible that concerns about prescribing opioids to patients with a history of substance misuse have increased the likelihood of such patients being offered pregabalin, and this needs some care.

Significant misuse of prescription-only painkillers by those not prescribed them is apparent in national surveys.

Dependence on prescribed medicines, whether ongoing pain is present or not, requires individualised assessment and treatment planning and will usually draw on the expertise of primary care physicians, healthcare professionals working in drug treatment and recovery services, specialists in pain and mental health professionals.

7.2.6 Pain management in patients misusing or dependent on drugs

7.2.6.1 General considerations

Patients misusing or dependent on drugs will experience the same sources of pain as others. In addition, they may have previously self-medicated to attenuate their pain and psychological distress, and may also have poorer acceptance of non-pharmacological interventions for pain control.

A limited understanding of drug dependence by some clinicians, as well as associated stigma in healthcare teams, can be a barrier to optimal pain management. Reasonable concerns can include uncertainties regarding medication dosing when patients' illicit use cannot be verified, difficulty in distinguishing drug seeking behaviour from the clinical need for pain relief and concerns about the potential of diversion of medication used for pain.

Safe management of pain for such patients is underpinned by detailed assessment of the pain, of the dependence, and of any comorbid mental health problems, in the context of close communication between health and social care professionals, patients and their carers.

7.2.6.2 Management of acute pain

Acute pain is commonly related to obvious tissue injury such as surgery, fractures, burns or dental disease. Such pain can be mild or severe but usually resolves within days or weeks. Treatment of acute pain is usually successful and needs to be given for a short time while healing begins.

Good acute pain management for patients dependent on drugs is underpinned by empathic communication with, and reassurance of, the patient that their acute pain will be taken seriously and managed. Their anxiety also needs to be identified and managed.

The standard effective management of acute pain is offered as normal, using anti-inflammatory drugs, paracetamol, opioids and local anaesthetic procedures. A multimodal analgesia regimen should be used: one that involves considering combining analgesic drugs of different classes and local anaesthesia alongside general measures to minimise pain.

For moderate and severe acute pain management, opioid therapy is the mainstay of treatment and this applies equally for the opioid-dependent patient. It is important that when a proper clinical decision has been made about the need for opioid analgesia for acute pain in patients on maintenance OST, sub-optimal doses are avoided. In fact, higher than normal doses of opioids are typically needed, titrated to effect as for all patients. The frequent need for higher opioid doses is related to three factors:

- the maintenance dose itself will not provide the required analgesia due to established tolerance
- such patients commonly have developed an increased pain sensitivity (opioid hyperalgesia)
- some patients can also have a degree of resistance to the analgesic effects of the additional prescribed opioids.

While the same medications are used as for any acute pain problems, and suitably high doses should not be avoided, care is still required to manage risks of misuse and diversion. Deciding on the safest use of opioid analgesia should involve early corroboration of the patient's reports of illicit use and prescribed use. Prompt provision of appropriate opioid therapy is needed for opioid dependence, to avoid or to treat emerging withdrawals. In more complex cases, the analgesic regimens should normally be agreed between specialists in pain and in addiction.

As acute pain is likely to be short lived, there should be a clear plan for reducing the added medications as the acute pain subsides. To ensure this is continued and completed for such patients, the plan should be clearly communicated. When initiated by other clinicians, the plan should be communicated to the patient's GP and/or drug treatment service. Otherwise it should be discussed between the patient's GP and drug treatment service.

For patients who are currently on methadone or buprenorphine for dependence being treated for moderate or severe acute pain control with their additional analgesia being titrated against effect, the maintenance opioid dose should be divided into two or three daily doses. Note that patients on buprenorphine may require particularly high doses of opioid agonist initially, which will subsequently need to be tapered down. Alternatively, in certain circumstances, the OST regimen can be discontinued and restarted as the medication for acute pain is tapered.

When rapidly introducing high dose opioids for acute pain relief in patients on OST in a monitored setting, respiratory function should be monitored and naloxone needs to be prescribed on the drug chart and readily available.

Patients taking naltrexone will have no benefit from opioids prescribed for acute pain. If a patient on naltrexone is scheduled for elective surgery that is likely to be acutely painful, oral naltrexone may be discontinued 48-72 hours before the procedure. Patients presenting with unanticipated acute pain will need to be managed with non-opioid regimens including regional anaesthetic blockade.

For patients abstinent in recovery from opioid dependence, risk of subsequent relapse back to problem use could occur either from re-exposure to opioids or from under-treatment of pain. Treatment options should be discussed with the patient and the patient's decisions regarding opioid treatment should be respected. Effective non-opioid acute pain regimens should be used where possible.

7.2.6.3 Management of chronic pain

Chronic pain is usually defined as pain persisting after healing has occurred when acute injury is the inciting event, but chronic pain may also occur without obvious initial injury.

Examples of chronic pain include low back pain, pain related to arthritis and neuropathic pain (discussed in more detail below). Such pain can be experienced as mild or severe but distress and anxiety are often the biggest contributors to the perceived intensity of pain. Although chronic pain is usually not a sign of ongoing tissue damage, underlying disease processes need to be excluded. Chronic pain is often associated with low mood, poor sleep and physical disability.

Chronic pain is difficult to treat, with no intervention helping more than 20-30% of patients (including medication, CBT-based pain management programmes, meditation techniques and invasive procedures). For those patients who do respond, often reductions in pain intensity are modest and complete pain relief is not a realistic goal. It is important to explain to patients the limitations of treatments for chronic pain.

Chronic pain in the drug-dependent patient should be managed collaboratively between specialists in pain medicine, addiction specialists, the patient's drug team, the GP and the patient. The treatment goals and decisions about the package of care should be carefully discussed with the patient and this should be properly documented and communicated with all clinicians involved.

Three key components need to be assessed, identified and fully managed: the chronic pain, the dependence disorder, and any mental health diagnoses and emotional difficulties. The aim is to achieve a shared understanding that medications play only a partial role in pain management and are only part of a wider plan to support self-management of symptoms.

Support for patients with chronic pain aims to promote self-management and to improve function: physically, emotionally and socially. Comorbid active mental health problems alongside substance misuse disorders can be a barrier to successful pain management and attempts to address these issues should also be made. Physical rehabilitation, exercise and psychological treatments such as meditation strategies are normally essential parts of the wider pain management plan.

Opioids play little role in the management of long-term pain. Opioids prescribed for pain may actually be acting, in whole or in part, as maintenance treatment for the opioid dependence or, through the psychoactive effects, may be simply attenuating unpleasant thoughts and feelings associated with pain. In addition, current or past history of drug dependence is a risk factor for problematic use of prescribed opioids. The risks of misuse of prescribed opioids in such cases, and of diversion, need to be assessed, identified, monitored and managed. Regimens should be chosen and drugs dispensed that aim to help to achieve the treatment goals for the chronic pain and also reduce or minimise the risk of misuse and diversion. It is very important to have a shared understanding with the patient as to the realistic pain management goals of opioid therapy and how these will be assessed, and to have an agreed plan for opioid cessation in case treatment goals are not met, there is inappropriate non-compliance with the regimen or diversion is identified. The lead prescriber for each psychoactive drug prescribed should be identified, such as the addiction or pain specialist, along with clarity about the

goal(s) of their prescribing, to avoid subsequent changes in dose for inappropriate reasons (with risk otherwise of confused, inconsistent and unhelpful practice).

It can be very important in obtaining informed consent from the patient to be explicit about whether methadone is being prescribed primarily for the management of pain or the management of dependence. The primary purpose of prescribing may also affect eligibility for prescribing as different commissioners may fund the treatment of dependence and the treatment of pain. Whoever is recommended as the appropriate current prescriber of methadone (GP or pain specialist for pain, addiction specialist for dependence), effective multi-professional working is essential for complex cases in which the primary diagnosis requiring methadone could change (see for example, [section 7.2.7](#)).

When making medication choices for chronic pain, the initial medication potency used should not be determined by reported pain intensity (unlike the principle applied for the WHO ladder for cancer pain). Regardless of pain intensity, it is rational to start with non-opioid drugs, where these have some demonstrated efficacy for the condition being treated. Trials of both weak and strong opioid therapy may then be considered for some patients with well-defined pain diagnoses in whom symptoms have persisted despite the first line interventions. All drugs prescribed for pain should be subject to regular review to evaluate continued efficacy and periodic dose tapering is necessary to evaluate ongoing need for treatment. As medicines play only a small role in the pain management plan for chronic pain, they should be used in conjunction with non-pharmacological interventions such as advice regarding activity, physiotherapy and an explanation that pain may be resistant to medication and complete relief of symptoms is not usually a goal of therapy.

For patients on OST experiencing continuing pain, whether on methadone or buprenorphine, it is recommended that the daily dose should be divided as part of the wider pain management plan – taken 8 or 12 hourly. While chronic pain management with opioids is generally given using immediate-release medications, occasionally clinicians use low-dose sustained-release preparations with additional immediate-release preparations. In patients on OST considerable care is needed to be clear about the rationale for choice of any medication, for its frequency of use and for doses used, and for review of its success or otherwise in achieving the specific improvements aimed for.

7.2.7 Relief of emerging chronic pain after tapering down of methadone used as OST

Challenges arise when patients treated with methadone for dependence, experience (or re-experience) emerging pain during a tapering down of their methadone dose. Methadone used as an analgesic may have a role in some cases. The analgesic effect may be optimised by splitting the methadone dose and administering it 12-hourly. Where a 12-hourly methadone regimen appears to be effective as part of a broader pain management plan, there may then be justification for continuing that regimen. If the patient is assessed at that point to be taking the methadone to control their pain, and not due to their dependence, and so would otherwise be ready to be discharged from drug treatment services, there still needs to be a clear arrangement for ongoing opioid prescription for the management of the pain. Clarity about its purpose for pain is essential. Explicit and clear advice is likely to be needed for the local primary care team, alongside reassurance of rapid re-assessment, if there is evidence of

emerging misuse or addictive behaviour. In difficult diagnostic cases, in such circumstances, further assessment by pain specialists may also be needed.

7.2.8 Management of neuropathic pain

Neuropathic pain is chronic pain associated with injury to the peripheral or central nervous system. Types of neuropathic pain include lumbar radiculopathy following disc prolapse, nerve injury following spinal surgery, pain after infection such as shingles or HIV/AIDS, pain associated with diabetes, pain after amputation (phantom limb pain or stump pain) and pain associated with multiple sclerosis or stroke. Neuropathic pain is usually severe and intrusive. Medications may be used to treat neuropathic pain and are usually not very effective but do work for a small proportion of patients.

Gabapentin and pregabalin are drugs that act via voltage-gated calcium channels. They are discussed in more detail in [section 7.4](#). They are licensed for a number of indications including for treatment of neuropathic pain (and in the US for fibromyalgia).

Clinically meaningful pain relief, even for discrete diagnostic entities, is achieved in fewer than 20% of patients given gabapentin and pregabalin, and patients with poorly-defined disorders, such as fibromyalgia, fare even worse, with reductions in pain intensity being very modest: around 1-2 points on a 10-point scale. However, the small proportion of patients who do benefit can demonstrate significant improvements in quality of life.

In addition to their licensed use in neuropathic pain these gabapentinoids are frequently prescribed for non-neuropathic pains such as back pain and refractory pain syndromes with or without a clear organic cause.

The same general principles that apply to the management of chronic pain, apply equally to the management of neuropathic pain (see [section 7.2.6.3](#)).

7.2.9 Management of cancer pain and pain in palliative care

Many cancers are treatable but some will require management of pain due directly to the cancer, due to side-effects of treatment or for other non-cancer-related causes. Just over a quarter of all deaths are recorded as due to cancer. Most are preceded by a period of treatment, which may include pain management for some. A substantial number of people with a history of substance use problems may need effective management of their cancer pain either before successful remission or as part of palliative care. With an ageing cohort of individuals in receipt of OST, this may involve the need for such pain management alongside OST.

The World Health Organization describes palliative care as care that aims to improve the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual. Common clinical issues in palliative care include the management of pain, dyspnoea, nausea and vomiting, loss of appetite, constipation, anxiety, depression, delirium, insomnia and the provision of support for families and carers. The prescribed dose or type of opioid or its route of administration may need to be changed as, for example, when renal

function deteriorates or the oral route of administration is no longer an option. Multidisciplinary assessment and care management is essential.

A focus on the problem substance use itself may be an important element of optimising the care plan, so is an important element of assessment of those requiring palliative care. The full range of responses may be needed, from information and harm reduction advice, to active management and treatment of a comorbid substance use disorder or disorders. The usual approaches for safe prescribing, storage and monitoring of controlled drug use apply equally for these patients (including drug screening if appropriate).

Cancer pain is usually associated with an obvious source of tissue damage and may be acute or chronic. Pain can arise from the cancer itself or the cancer treatment (e.g. radiotherapy). Neuropathic pain can occur in relation to cancer diagnoses and treatments (see [section 7.2.8](#)). Because cancer pain treatment, particularly at the end of life, is often for a short duration, it is usually more successful than chronic pain treatment. Patients who recover from cancer or who survive a long time with cancer may have chronic pain that is more difficult to treat (see [section 7.2.6.3](#)). Patients with cancer may also experience acute or chronic pain unrelated to their cancer.

Patients with pain resulting from terminal illness should be managed by palliative care services with advice from specialists in addiction. Inequalities in access to such services for some groups has been reported as due to poor understanding of their needs, so substance misuse services may be able to facilitate good care by active communication and support. Helpful guidance on the treatment of patients with a substance use disorder who are also receiving palliative care is available from sources listed below.

The WHO analgesic ladder for the management of cancer pain suggests that medicines are used in an incremental fashion but with the starting potency according to the patient's current reported pain intensity:

- for mild pain non-opioid medication should be prescribed initially
- for moderate pain weak opioids should be prescribed initially
- for severe pain strong opioids should be prescribed initially.

Chronic pain poses additional challenges for the effective use of medicines and the WHO ladder does not apply.

Combinations of non-opioid analgesics and opioids should be titrated against response. It is important that palliative care teams are able to recognise and manage symptoms of opioid withdrawal. When using opioids for palliative care, fast acting preparations such as buccal fentanyl should be avoided and this also applies to those dependent on opioids.

Patients receiving OST will need to continue their prescription but it is helpful to split the daily dose of methadone or buprenorphine and administer doses 8-12 hourly in addition to the analgesic regimen, which will commonly involve immediate-acting opioids but can include a combination of slow-release and immediate-acting drugs. As noted for palliative care generally, for any patient receiving OST in need of treatment for cancer pain, clinical teams need to be aware of the risks of diversion and misuse of opioids by others in the patient's immediate environment. Risk-mitigating strategies should be in place including short

duration prescriptions (for example, two days) and storing opioids in locked boxes within the patient's home.

7.2.10 Resources and further reading

PHE and NHS England (2014) Advice for prescribers on the risk of the misuse of gabapentin and pregabalin

www.gov.uk/government/uploads/system/uploads/attachment_data/file/385791/PHE-NHS_England_pregabalin_and_gabapentin_advice_Dec_2014.pdf

Faculty of Pain medicine (2015) Opioids Aware: A resource for patients and healthcare professionals to support opioid prescribing for pain

www.fpm.ac.uk/faculty-of-pain-medicine/opioids-aware

Action on Addiction (2013) The management of pain in people with a past or current history of addiction

www.actiononaddiction.org.uk/Documents/The-Management-of-Pain-in-People-with-a-Past-or-Cu.aspx

Public Health England (2013) Managing persistent pain in secure settings

www.nta.nhs.uk/uploads/persistentpain.pdf

NHS England (2015) Pain management formulary for prisons

www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2015/12/Prsn-pain-mngmnt-formlry-pub.pdf

7.3 Dependence on prescribed and over-the-counter opioids

See also management of pain ([section 7.2](#)).

7.3.1 Key points

- There is only limited evidence to inform the management of dependence on over-the-counter and prescribed opioids.
- Careful specialist assessment is needed for such patients in order to develop a suitably informed care plan.

7.3.2 Introduction

Dependence can develop to prescribed opioids such as codeine, tramadol, dihydrocodeine and pethidine. Long-term use of excessive doses of codeine-containing over-the-counter (OTC) preparations can also lead to dependence and other health problems. This group of patients can present with relatively short histories of low potency opioid use and no comorbid health problems or may present with long histories of illicit drug use, comorbid health problem and continued use of higher potency opioids such as pethidine.

A wide range of indications of possible dependence on OTC or prescription opioids have been reported, such as long-term use of opioids for non-cancer pain and reluctance to explore alternatives, reported concerns by others, poor attendance for treatment review, repeated loss of medication, taking higher doses and requesting early 'repeats', trying

to obtain supply through multiple prescribers, appearing sedated at times, resisting drug screening and deteriorating social function. Comorbid substance use disorder and/or mental health problems, including previous profound emotional trauma, may increase risk.

Comprehensive assessment as described in [sections 2.2.2](#) and [2.5](#) is needed. For OTC opioid medications containing other drugs such as paracetamol or ibuprofen, the immediate risks may relate to those other drugs (such as a risk to the liver or of haemorrhage), and these may need explaining to the patient and urgent attention. Good communication with clinicians currently or recently involved with the patient's care can be essential to get a clear corroboration of use and to initiate ongoing communication for future management.

Those entering structured treatment for dependence on prescribed or OTC opioids have been found, on average, to stay in treatment for sustained periods (longer for those with additional illicit or polydrug use) so that following initial stabilisation they will have similar decisions to make regarding maintenance prescribing or early assisted withdrawal. A number do present with the realistic desire to stabilise and achieve abstinence quickly, while others will have treatment and prescribing needs that will last over months or years. A careful discussion is needed with the patient about their immediate and longer-term goals.

Overall, the evidence base to determine practice is weak. Most of the evidence for the use of buprenorphine and methadone in the management of opioid dependence relies on research into the treatment of heroin dependence. The ability to prescribe buprenorphine and methadone by instalments and to use supervised consumption are also important advantages in practice. However, patients solely dependent on prescribed or OTC opioids may respond differently than heroin dependent patients to such treatments, limiting the ability to provide definitive advice.

7.3.3 Management of dependence

With current knowledge, both for opioid-containing OTC medicines (such as codeine) and for prescribed opioids (such as dihydrocodeine or pethidine), the general principles of pharmacological management of opioid dependence should be taken into account alongside the need to offer a range of psychosocial and recovery support interventions (see [chapter 3](#)).

7.3.3.1 Choice of medication

Given the well-established advantages of buprenorphine or methadone for the management of heroin dependence, a period of substitution treatment with either should normally be recommended to the patient, whether the goal is to stabilise to initiate a period of detoxification or a period of maintenance. However, given the limits of the research base, clinicians do have to make decisions on a case-by-case basis. In some cases, patients may actually be provided with a prescription of the same medication they have taken excessively (over-the-counter or from other sources) particularly if the goal is for early detoxification. For some patients with substantial pain problems, buprenorphine may not be considered clinically suitable while methadone is considered by some such patients to be unacceptable (with fears for some of additional harm from the stigma associated with methadone use). In practice, particularly for lower potency opioids, different medications are sometimes used to substitute than are used for heroin dependence. This should normally only be agreed following suitable addiction specialist assessment.

Careful discussion is needed with the patient about the limits of the evidential basis of treatment and about its risks, and about the need for clear treatment goals, close monitoring and regular review.

Patients dependent on these drugs may sometimes present with relatively short durations of dependence, use of less potent opioids, younger ages and more recovery capital. In such cases, a comprehensive treatment and recovery care plan may be needed that reflects the opportunities for an early focus on recovery and aftercare support. However, some patients will have developed a severe and persistent opioid dependence. It is crucial to follow the basic principles of thorough assessment and individualised treatment and recovery care planning with the patient.

For the safer management of patients presenting as unstable or high risk, and for patients with a significant history of illicit drug use, buprenorphine or methadone substitution would normally be considered appropriate. Where a trial of continuation with a 'prescribed' opioid such as codeine or dihydrocodeine has been agreed, possible later transfer on to buprenorphine or methadone should still be reviewed subsequently (particularly where extended maintenance prescribing appears to be needed and/or where there are concerns about monitoring of the treatment, treatment safety and the patient's stability).

7.3.3.2 Medication doses

In determining initial opioid doses to provide for treatment, care is needed to quantify recent levels of opioid use and to clarify the doses of opioid consumed in different medications the patient has obtained. Titration on to buprenorphine and methadone should be initiated and titrated carefully according to response. Lower starting doses and smaller increments may be necessary in some cases compared to those used typically for heroin dependence. Substitution should normally be initiated in the community early in the week to facilitate rapid access to advice and to review of dose requirements in these early stages. Titration of dose against response is applied as for heroin dependence. Where the prescribed drug is the same as the drug on which the person became dependent, it can be difficult to judge the dose at which there is cessation of all illicit use. However, other evidence of stability should be taken in to account including corroboration by family or carer if appropriate. Close communication with the GP and any other prescribers such as pain specialists is essential at the outset especially if this may affect prescribing decisions.

Close supervision or inpatient assessment and stabilisation may be needed, particularly if stabilisation of a complex patient is needed (for example, a patient on fentanyl patches and other oral opioids).

7.3.4 Resources and further reading

Identification and treatment of prescription opioid dependent patients (Faculty of Pain Medicine 2014) www.rcoa.ac.uk/faculty-of-pain-medicine/opioids-aware/clinical-use-of-opioids/identification-and-treatment

7.4 Misuse of or dependence on gabapentinoids

Gabapentinoids are also discussed briefly in relation to the management of pain in [sections 7.2.5](#) and [7.2.8](#).

7.4.1 Key points

- There is only limited evidence to inform the management of misuse of or dependence on gabapentinoids.
- Prescribers need to be aware of the risk that some patients may wish to accumulate supplies with a view to taking excessive doses for a psychoactive effect.
- Patients presenting to services with possible dependence on pregabalin or gabapentin should be assessed for evidence of the features of dependence and for any relevant comorbid health problems (such as neuropathic pain or anxiety disorder).
- While it is advised both drugs can be discontinued over one week, a more gradual dose taper allows observation of emergent symptoms that may have been controlled by the drug, particularly at high doses.

7.4.2 Introduction

Pregabalin and gabapentin (gabapentinoids) are licensed in the US and UK for the treatment of epilepsy and neuropathic pain and in the US for fibromyalgia. In the UK, pregabalin is also licensed for the treatment of generalised anxiety disorder.

Evidence for misuse and dependence on supratherapeutic doses of gabapentinoids has been accumulating, particularly in people who misuse other drugs and in specific settings such as prisons. The doses misused are often many multiples of therapeutic ranges. The drugs have been reported to be able to produce euphoria and a sense of calm and relaxation. Some users have reported a stimulant effect. They have also been reported to enhance psychoactive effects of other drugs. In 2016, in the UK, it was recommended that pregabalin and gabapentin become controlled drugs because of the evidence of identified harms.

The drugs are structural analogues of the neurotransmitter GABA, and bind to the alpha-2-delta subunit of the voltage-gated calcium channels that affect GABA, producing GABA-mimetic properties.

Their mechanism for producing dependence is not yet well understood, possibly having direct or indirect effects on the dopaminergic 'reward' system.

Pregabalin's pharmacokinetics make it more dangerous than gabapentin in high doses. Both are predominantly excreted unchanged in the urine. Their CNS depressant effects may be additive with other CNS depressant drugs. It has been reported that morphine may increase bioavailability of gabapentin. Pregabalin appears to be more sought after for misuse than gabapentin, and this seems to relate to the differing pharmacokinetics, with pregabalin able to achieve higher doses in the body.

Separate guidance has been produced on the careful use of pregabalin and gabapentin, both in general and in patients with a liability to misuse and dependence, to support appropriate access to these drugs (with appropriate discussion with patients of their potential benefits and

risks and the monitoring of progress in the light of these considerations). Prescribers need to be aware of the risk that some patients may wish to accumulate supplies with a view to taking excessive doses for a psychoactive effect.

Reported symptoms and signs of withdrawal from gabapentinoids (including individual self-reports) include insomnia, headache, nausea, anxiety, diarrhoea, flu like symptoms, nervousness, depression, pain, fits, hyperhidrosis and dizziness. Rapid development and extinction of tolerance have been reported for pregabalin.

7.4.3 Assessment

Patients presenting to services with possible dependence on pregabalin or gabapentin should be assessed for evidence of psychological and physical features of dependence and for any withdrawal symptoms or signs that have been experienced and for any relevant comorbid health problems (such as neuropathic pain or anxiety disorder).

7.4.4 Management of dependence

There is currently insufficient research to provide any definitive advice on the management of gabapentinoid dependence. The summaries of product characteristics for gabapentin and pregabalin indicate that both drugs can be discontinued over one week, but a more gradual dose taper allows observation of emergent symptoms that may have been controlled by the drug particularly at high doses. It has been suggested that pregabalin daily dose should be reduced at a maximum rate of 50-100mg/week and that gabapentin daily dose should be reduced at a maximum rate of 300mg every four days.

There is currently insufficient evidence of benefit to recommend the use of any substitute or adjunctive medications in the management of withdrawal, although there are a small number of individual case reports of the use of benzodiazepines. Applying general principles on the psychosocial management of dependence is likely to be the treatment of choice for patients needing support.

7.4.5 Resources and further reading

PHE and NHS England (2014) Advice for prescribers on the risk of the misuse of gabapentin and pregabalin [www.gov.uk/government/uploads/system/uploads/attachment_data/file/385791/PHE-NHS England pregabalin and gabapentin advice Dec 2014.pdf](http://www.gov.uk/government/uploads/system/uploads/attachment_data/file/385791/PHE-NHS_England_pregabalin_and_gabapentin_advice_Dec_2014.pdf)

7.5 Hospitalisation

7.5.1 Key points

- For those dependent on opioids and in need of opioid substitution treatment (OST), provide reassurance, rapid assessment and suitable prescribing as soon as possible after admission, to facilitate their medical treatment as well as to manage the dependence.
- Hospital staff responsible for the assessment of an opioid-dependent patient should contact their local liaison or drug treatment service for advice and support as appropriate.
- Appropriate communication between key professionals in hospital and in the community, particularly around time of entry to hospital and around discharge, is vital to ensure safe,

effective and seamless care, including making appropriate plans for seamlessly and safely continuing OST prescribing in the community.

- Commissioners and planners of services can enhance safer and more effective care locally by developing the links between hospital services and local drug treatment services.

7.5.2 Overview

People who use drugs and alcohol may attend emergency departments or be admitted to general or mental health hospitals for treatment of conditions either directly related to, or coincidental to, their substance use. In this population, medical conditions may be masked, neglected or hidden for a number of complex reasons.

Patients may also present with the toxic effects of, or in withdrawal from, a range of drugs and alcohol they have used. They may have been using one or some combination of traditional or new psychoactive substances, which may be stimulants, depressants (such as benzodiazepines), psychedelic drugs with hallucinogenic effects and/or synthetic cannabinoid receptor agonists. Some such individuals, including new psychoactive substance users, will also present with injecting related problems, including from use of drugs like mephedrone or methamphetamine (see [section 7.7](#)).

Many 'traditional' drug dependent patients will present with problems associated with their heroin, crack or cocaine use, and with problems associated with injecting their drugs. Such patients now make up part of an ageing, high-risk, population who present at hospitals with an often complex picture of ill health related to current or historic substance use and with problems related to their ageing and to comorbid physical and mental conditions. Many also suffer from the effects of marginalisation, homelessness and poverty that may be inextricably linked to and heightened by their drug and alcohol use. Many homeless patients who use drugs continue to suffer from being discharged straight back onto the streets after brief hospital admissions, often without their underlying health complaints being fully addressed – which only decreases chances of successful recovery and increases the likelihood of readmission (Homeless Link 2014).

Admission to a hospital setting, whether planned or unplanned, provides an important opportunity for health professionals to detect and to address conditions previously undiagnosed, unresolved or neglected, including psychiatric disorders. People who inject drugs who seek care in an emergency department for soft tissue infections are at high risk for subsequent hospitalisation, amputations and death, so this presents a key opportunity for effective prevention of future harm and re-presentations (Binswanger et al 2008 and Takahashi et al 2003).

Common reasons for hospital visits related to drug use are:

- poisoning by illicit drugs and toxic states
- bacterial infections and abscesses
- bone, joint, respiratory and bloodstream infections
- thromboembolic disorders

- skin ulceration (including injecting related sores and open wounds)
- fevers
- problems with heart, lungs and liver
- injuries caused by being attacked or falling over (particularly among the homeless).

Unconscious bias or stereotyping of individuals who use drugs can inadvertently prejudice their assessment and management, not least when such patients may also present with complex problems. This has been found to affect their treatment outcomes, so it is important that all hospital clinicians, particularly those with limited familiarity caring for individuals with problems with substance use or dependence, do remain vigilant to the potential influence of such factors for their own such hospitalised patients.

Patients may withhold information for fear of being stigmatised, judged or inviting unwanted interference from outside services, such as the police or social services. Confidentiality issues should be addressed sensitively and clearly.

People who use drugs have the same entitlement as other patients to the services provided by the NHS, including access to adequate symptomatic and pain relief, and to proper discharge planning. It is the responsibility of all doctors and other clinicians to provide the appropriate care for both general health needs and for relevant drug related health problems, whether or not the patient is ready to stop using drugs.

Wherever possible, all hospitals should maintain contacts with local drug and alcohol services, as well as with emergency homeless shelters and support organisations, preferably through hospital-focused staff trained in substance misuse issues.

7.5.3 Admission

Admission to hospital represents an opportunity for diagnosis, intervention, treatment and care for patients who may have complex, unrecognised or untreated health problems.

An initial objective in hospital for a person who is found to have problems with drug use is often to rapidly stabilise any acute drug effects (or any current or potential acute withdrawals) so that the patient can be adequately assessed and investigated, and offered appropriate treatment for any non-drug-related presenting medical conditions (and for any further drug-related treatment needed).

Planned admissions, with adequate communication, provide a better opportunity for preparation for the admission and for any subsequent transfer of care on discharge. Emergency admissions and emergency department treatment present greater challenges. However, well thought-out protocols and guidance for how hospital staff can respond to people who may have problems from their use of drugs or alcohol, which address the full pathway from before admission to the point of discharge, will support better outcomes for the patient and clinicians, and can reduce the likelihood of re-presentation.

Effective care can be improved with suitable organisational planning by having:

- identified hospital medical and other clinical staff who are trained in the assessment and treatment needs of people who use drugs and who interface with local substance misuse treatment services

- identified support available from specialist hospital staff, such as senior nurses in the pain team, staff from HCV and HIV services, psychiatric unit staff or phlebotomists for difficult venous access
- a multidisciplinary approach to care that extends throughout a person's admission, treatment and discharge, and crucially when relevant, involving liaison with community services to ensure seamless care planning.

It is worth considering that, as more hospital, drug and mental health services engage trained volunteers and service users in the roles of peer support, advocacy and mentoring, such individuals can be a useful resource and support for the person entering or remaining in hospital, and when being discharged into the care of community substance misuse and mental health services.

7.5.4 Opioid-dependent patients

7.5.4.1 Assessment of opioid-dependent patients

The admitting clinician must ensure that an adequate assessment has been made before prescribing substitute opioids or other controlled drugs.

A full comprehensive assessment of dependence on heroin or other opioids requires specialist addiction knowledge and expertise. While hospitalisation can offer an excellent opportunity to engage a patient in starting specialist treatment of dependence, hospital doctors are strongly encouraged only to initiate OST as part of, or with clear advice and support from, a specialist drug treatment team (either through any liaison service available or by contacting the relevant community drug service). Appropriate senior advice should be sought. Hospitals should ensure they have the contact details of their local specialist drug services and of any local drug liaison team who may be able to provide advice. Areas have differing commissioning and service provider arrangements, so different levels of support may be available (and may be quite limited in some areas).

However, it is still vital for the hospital doctor to be able to treat opioid withdrawal states for all patients:

- Those confirmed as already in receipt of OST can be promptly and carefully initiated back onto OST, taking account of opioid tolerance confirmed to be present.
- Those not already on OST can have any acute opioid withdrawals treated in a timely fashion, consistent with safe prescribing. There should be attempts to seek specialist advice so that plans for further assessment or later transfer for ongoing drug treatment can be discussed.

Detailed guidance on assessment of drug dependence and on the use of opioid substitution treatment is provided in chapters 2 and 4. However, the following points provide a summary of the main considerations for the hospital setting. Aims of assessment by the hospital clinician(s) should include):

- obtaining all the information needed for diagnosis and treatment of the general health problem, whether an emergency or an elective admission

- obtaining information relevant to diagnosis and management of patients misusing or dependent on drugs, particularly heroin and other opiates, and any consequent health problems:
 - confirming that the patient is taking opioid and any other drugs and alcohol (history, examination, urine/drug analysis, discussion with opioid prescriber and dispensing pharmacist)
 - assessing the degree of dependence – for which confirming a history of opioid withdrawals (particularly by observing objective signs carefully and sympathetically to minimise any distress) can be very helpful to support a firm diagnosis – see table 2
 - determining the need for any opioid prescribing, whether for acute management of withdrawals or as ongoing opioid substitution treatment for dependence
 - identifying information regarding complications of drug use and of any current or previous injecting – including localised infections, abscesses, DVTs or damage to peripheral circulation or heart valves, as well as HIV, hepatitis B infection and vaccination, and hepatitis C status
 - identifying, especially for homeless people and those at potentially greater risk, any general nutrition problems, and hepatitis A vaccination and TB status
 - considering other comorbid conditions common in those with drug dependence – such as damage from alcohol and from smoking (typically looking for respiratory, cardiovascular and liver problems), and comorbid mental health problems
 - identifying any venous access problems, and potential urgent need for specialist phlebotomist support and/or use of equipment such as ultrasound imaging
 - identifying any dependent children and children who may be at risk, either from the impact of the drug dependence or from any prescribed opioids.

7.5.4.2 Confirming the current community opioid prescribing

Information concerning the prescription is needed as a matter of high priority for any patient currently engaged in community OST. For patients currently being prescribed methadone or buprenorphine for treatment of opiate dependence, good communication between hospital and community is essential for safe patient care. Patients will usually have a named keyworker and a named pharmacy. They will be receiving treatment from either their GP or specialist drug treatment services. Prescribing in these cases should be a relatively straightforward matter of continuing the usual dose while in hospital but only where it has been confirmed the patient has been taking it.

The hospital doctor should ascertain, by independent means, the likely dose of methadone or buprenorphine to which the patient is tolerant, by confirming:

- the daily dose prescribed
- when the last dose was dispensed
- whether recently the medication has been collected regularly
- the time the last dose was observed to be taken by supervised consumption.

Only when the medication has been confirmed to have been collected daily by supervised consumption, can you be completely assured of the patient's current tolerance. In such cases, one can prescribe the full daily dose in hospital, that has been provided in the community, as soon as it is next due.

Communicating with the community pharmacy is usually crucial to obtain assurance of the dose of medication to which the patient is currently tolerant. The pharmacist can also confirm the recent compliance of the patient with regularly picking up their prescribed instalments. In some cases, the drug service provides dispensing of the medication instead.

Communication with the patient's specialist prescriber, GP or the keyworker (or by consulting electronically the emergency care summary (ECS) in Scotland) can also assist in confirming what medication has been prescribed but the key information to identify is what has been dispensed and whether consumption has been supervised.

It is also important to liaise with the community prescribing service and with the dispensing service/pharmacy so that the community prescription can be cancelled as soon as a hospital prescription has been provided.

7.5.4.3 Initial dosing schedule for opioid dependent patients admitted to hospital

The initial objective of the drug treatment of an opioid dependent patient admitted to hospital should be to stabilise their opioid dose as quickly and safely as possible to avoid unnecessary distress and to stabilise the patient enough that they can be treated for any other medical conditions.

Opiate dependent patients generally harbour enormous anxieties around unplanned opiate withdrawals. This must be taken into account, especially with any prolonged waiting times in an emergency department for example, or in the early stages of admission before OST has been administered, as it may provoke a patient to leave before receiving treatment. While simple opioid withdrawal symptoms are not generally life threatening, associated anxiety and distress may become very significant for some, and particularly those who may have comorbid mental and physical health problems. It is important that rapid assessment and safe prescribing of OST is undertaken at the earliest opportunity by an appropriately trained member of hospital staff.

Hospitals need to ensure their staff understand the needs of people who use drugs in the hospital context. This includes the need to ensure that patients who are physically dependent on opioids receive suitable doses of OST to relieve the distressing symptoms of opiate withdrawal, the adequate treatment of acute pain (including the appropriate use of opioids as for any other patient), and the need to work flexibly with patients with complex mental and physical comorbidities and social problems. Failure to do so may result in continued use of illicit opiates on ward environments or premature discharge from hospital, with increased risks, untreated conditions and later re-hospitalisations.

For patients not on OST, or where there is uncertainty about recent compliance, it is appropriate to exercise particular care in initiating opioid substitution treatment.

On occasions patients may wish to take the opportunity of a hospital admission to reduce or detoxify fully. While this may occasionally be useful, if unplanned and just in response to

the admission, the patient is very likely to relapse on leaving hospital, which exposes the patient to a substantially increased risk of overdose. This should be explained to the patient to ensure they are able to give properly informed consent to their decision to detoxify in these circumstances.

Safety first:

- Only prescribe following an assessment, including where possible ascertaining independently when the last prescribed dose of OST was dispensed and, if possible, when it was consumed.
- Do not be pressured to initiate prescribing prematurely but do carefully consider how to manage the balance of risks if a patient is developing opioid withdrawals that make it difficult for them to engage in their required medical/surgical/obstetric treatment.
- Differentiate the multiple withdrawal syndromes that may develop in polydrug and alcohol misusers in order to prioritise treatment. Methadone may initially mask alcohol and benzodiazepine withdrawal symptoms.
- Exercise particular care in cases of respiratory disease, head injury and liver diseases.
- Be extremely careful when prescribing additional drugs such as sedatives. It may be necessary, in some cases, to contact the relevant pain control team for further advice on improving pain control (see [section 7.2](#)).

When it is concluded that it is appropriate to initiate opioid substitution in hospital to manage the risk of withdrawal, methadone may sometimes be preferred over buprenorphine, as the latter acts as a partial antagonist and may interfere with acute pain management. However, the choice of an appropriate substitute will depend on the circumstances of the individual case (especially, for example, if respiratory depression is a concern). Buprenorphine may be continued for a patient already prescribed it but the treatment may need to be altered if better pain management is needed (see [section 7.2](#)).

While induction should broadly follow the protocols described in chapter 4, the close supervision available in a hospital environment does allow for a modified protocol:

- Prescribe a small dose of methadone in divided doses (for example, four times a day) under conditions of supervised consumption and titrate against opiate withdrawal symptoms while monitoring for toxicity. Initial dose should be no more than 10mg four times a day.
- After initial induction (over three to four days) allow time for methadone levels to reach a steady state (and so minimise the risk of an excessive cumulative increase in blood levels in the early days of treatment), then reassess and give the medication as a supervised single daily dose.
- For individuals who have been clearly confirmed by their dispenser to be taking their daily dose regularly by supervised consumption, the prescribing service may well advise providing the full daily dose immediately, although initially this can still be provided in divided doses for added assurance.

- Signs of intoxication such as drowsiness, slurred speech or constricted pupils indicate a need to discontinue the drug or reduce dosage.
- The final total daily dose of OST needed for heroin dependence can range very widely between patients in the community, particularly for methadone. No final dose should normally be determined in advance. However, caution should be exercised about the risk of cumulative toxicity (especially mindful that discharge may occur quickly and unexpectedly), so progressive increases should be based on the observed degree of stabilisation and cessation of withdrawals, and on the avoidance of any intoxication.

Patients presenting out of hours in receipt of existing community OST may have been dispensed advanced supplies for weekends and bank holidays. This may be in their possession. Patients do not always disclose this information on admission. They may be concerned about inadequate substitution treatment being provided for them (and they may also have access to illicit opioids). Every effort should be made to reassure the patient that any withdrawal signs will be treated in hospital and that medication continuity will be maintained upon discharge. Attempts should be made to establish the whereabouts of patients' own supplies.

While evidence indicates that optimal doses for most people in the community lie between 60 and 120mg, some people will need more and some people will need less due to a range of individual factors such as size, gender, age, other health problems and metabolic clearance rates. Doses between 60mg and 120mg may exert clinical effects for 24 to 36 hours; low doses exert clinical effects for only a few hours.

Where there is evidence of acute opioid withdrawal but it is not possible to corroborate the patient's information about their prescribed opioid treatment (for example, outside of pharmacy hours or on bank holidays), the OST medications can be titrated up as recommended above, and subsequently the titration may be adjusted in light of findings from communication at the earliest opportunity with community services.

The hospital pharmacist can provide advice on important drug interactions for methadone and/or buprenorphine such as with rifampicin, antiretroviral therapies and with urine acidifiers and alkalisers. They will also advise on the co-prescribing of other sedative or depressant drugs with these medications. [Annexe A5](#) and the BNF provide a summary of all such interactions.

Several factors can alter methadone plasma levels, including gastric emptying, pregnancy, liver metabolism, and certain medications, all of which can increase the risk of overdose.

7.5.5 Other considerations

7.5.5.1 Ward management

If concerned about a patient's behaviour, assess whether small changes to their medication or treatment may resolve the problem, or if the close monitoring or suspension of certain visitors is warranted.

In addition, a risk assessment can be completed to determine the risks to patient, staff, public and the environment, following which the following could be considered:

- the ingestion of medication is observed

- freedom to wander the hospital is controlled
- visitors are limited
- regular urine samples are taken for analysis
- the patient's bed is placed close to the nursing station to facilitate observation.

(Peagram 2013)

7.5.5.2 Sleeplessness

Sleeplessness can present a management problem. It is a feature of opioid withdrawal and, therefore, as the titration of methadone progresses there will be a limited need for night sedation. This minimises over-reliance on sedative medication, which is itself dependence-forming.

Night sedation should not be considered in the first 2-3 days of stabilisation. The use of benzodiazepines should be actively discouraged unless there is evidence of concurrent benzodiazepine dependence. However, should the insomnia persist in exceptional circumstances and if z-drugs are not suitable, nitrazepam 5-10mg may be given at the discretion of the medical team. At the first appropriate opportunity, the medication should be discontinued.

7.5.5.3 Dealing with emergency overdose

In a hospital, suspected opioid overdose will be treated with standard resuscitation techniques and with the use of naloxone.

In dependent patients, it is worth being aware that using stepped doses of naloxone, as recommended (see [section 6.4.4](#)), titrated carefully against response, may limit the severity of rebound withdrawals that themselves can lead to a problem of marked agitation (and possible attempts to leave the hospital). The recommended approach may also avoid unnecessary cardiac stress (in a population of patients who are anyway at risk of premature cardiovascular disease).

In emergency departments and in other situations where the patient may leave the hospital suddenly because of the precipitated withdrawal that naloxone has created, attempts should be made to make clear to patients that they are at risk of re-emergence of life-threatening sedation when the naloxone wears off, typically in around 30-60 minutes. Engaging friends or family in this discussion is also important if the patient wishes to leave prematurely and the support from loved ones may go further towards reassuring the patient and preventing early discharge.

7.5.5.4 New psychoactive substances

Recent years have seen an alarming increase in acute admissions to emergency departments of patients in a confused and/or collapsed condition, following the use of new psychoactive substances (formerly called 'legal highs'). The numbers of such substances are many and increasing, with a wide variety of effects and toxicities. Patients frequently do not know what they have taken, descriptions on wraps may not be relied upon, and the toxicity of such drugs is often not well known. Medical treatment should be supportive. Following recovery, patients

should be encouraged to consider attending specialist substance misuse services for further advice and evaluation.

Clinical guidance on the treatment of NPS is available in the UK's recent publication, NEPTUNE 2015. See [section 7.7](#) on NPS in these guidelines.

7.5.5.5 Managing pain control in opioid dependent patients admitted to hospital

Deciding what drugs to administer in the hospital setting, and in what doses, requires clear, careful and sympathetic discussion with the opioid dependent patient, and may be assisted by obtaining advice of a specialist pain management team or an involved anaesthetist.

Pain management is described in detail in [section 7.2](#).

7.5.6 Discharge

7.5.6.1 Drug misusers not previously in treatment

Attendance at an emergency department or admission into hospital can present a window of opportunity to put people who use drugs in touch with other services to assist in their recovery.

On discharge the following information should be given as a minimum:

- general health promotion advice
- contacts for further help (such as needle and syringe programmes, drug treatment services or self-help groups)
- advice on reducing the risk of blood-borne virus infection and its consequences, including support for hepatitis B vaccination (this information is available from local drug treatment services)
- advice on preventing overdose.

Wherever suitable programmes have been established, naloxone and training in overdose should be given to any patient using opiates, including OST, and where possible to family or carers.

7.5.6.2 Patients prescribed substitute opioids prior to discharge

If the patient 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.

Ongoing treatment with methadone and buprenorphine should ideally only have been initiated following liaison with the community drug team and a documented plan for discharge and for safe prescribing should therefore be in place.

It is always preferable, if possible, that an appointment is made for assessment/re-assessment by the specialist services either while the patient is still in hospital or otherwise immediately on discharge.

At least 24 hours before discharge hospital staff should contact the local drug treatment service, or the patient's GP, regarding discharge date and agree how much methadone or

buprenorphine should be prescribed to the patient on discharge. This may be influenced by local treatment policies. Prior discussion with the previous community pharmacist, or any proposed new one, may facilitate determination of suitable options for safe dispensing.

On the day of discharge, confirm to the GP or drug treatment service:

- whether that day's dose has been administered at the hospital and, if so, how much
- the number of days' supply that the patient is taking home (minimising this usually to around one or two day's supply, depending on availability of an appointment/arrangement for further prescribing, as larger amounts increase the risk of overdose or being pressured to hand over or sell their supply)
- any other drugs that the patient is being prescribed.

If the patient's drug misuse is being treated by a GP and the GP cannot be contacted, contact the patient's community pharmacist who should be able to advise whether a community prescription is still current and to agree arrangements for continuation or to avoid double-scripting.

In some cases, if there has to be a brief delay before attendance at the first appointment at the local specialist drug treatment service, the GP may be willing to provide a brief bridging of a prescription for a few days (or a week or two).

Some patients are in hospital away from the area they need to attend for treatment and it may simply not be possible to arrange an immediate prescriber assessment from the local specialist service. In these cases, it is still always important to make suitable arrangements for safe prescribing and dispensing of the medication following initiation of this treatment in hospital.

For heroin dependent patients who may have been admitted for 24 hours or less, or just for a day or two (e.g. for immediate management of an acute abscess), the patient may have needed to be carefully titrated on to an opioid primarily to avoid/treat acute opioid withdrawal. But they may not be willing to engage in specialist treatment for their dependence (or it may just not have been possible to arrange this or any suitable alternative from local services before the patient leaves the hospital). This is a difficult situation when the focus needs to be on minimising risks. For a very brief admission, the patient can often be expected to have remained broadly tolerant to their previous opioid/heroin use, but should still be advised about ways to reduce harm and to reduce the risk of overdose when they are expected to return to illicit heroin or other opioid use following discharge (see [section 6.3](#)). There is no evidential or ethical basis to justify advising such patients to use the opportunity to detoxify themselves from all opioids after the discharge, tapering down any opioid medication given on discharge. This is important given the known high relapse rates and the known increased mortality risks from loss of tolerance with such relapse back to heroin. This may therefore require a realistic discussion with the patient about how they can best aim to reduce the harm from the anticipated return to illicit heroin or other opioid. For example, the patient could be advised to act cautiously, take small amounts to start, avoid injecting, use with others who could provide assistance, preferably have naloxone available, and avoid any other sedative use or alcohol. This remains an opportunity to provide information and advice about self-referring or being referred by the hospital to their local service.

Some high-risk patients will need assertive advocacy support for continuity of their supply of OST once it has been started in hospital, even in emergency, and they should not normally be discharged until this has been established. These patients include:

- a person who uses drugs presenting in opioid withdrawal in late pregnancy
- a patient with a serious concomitant physical or psychiatric illness where heroin/illicit opioid use is complicating the clinical problems.

Take care in prescribing take-home doses. Added care is needed with advice and arrangements for those with children at home. Generally, take-home doses should be avoided if an alternative arrangement is available although one or two days' supply may be necessary to ensure continuity of care, for example, at weekends. For longer periods, it is important to limit availability by ensuring daily or frequent pick-up (through instalment dispensing or by provision of multiple appropriately dated prescriptions for community supply). Liaison with the local pharmacist may assist in arrangements for suitable, safe dispensing.

7.5.7 Difficult venous access

For many people who have regularly injected drugs, access to peripheral veins for promptly needed blood-work and cannula insertions, can prove technically challenging for the clinician and worrisome for the patient. Clinicians may find surface veins generally inaccessible and multiple insertion attempts by different operators exposes the patient to an increased risk of complications and discomfort, while important laboratory test results can be delayed (Gregg and Murthi et al 2009). Such experiences may also lead to patients defaulting from follow-up blood-testing.

Some patients will report previous experience of substantial distressing problems with venepuncture. Phlebotomists or other clinicians who are experienced in venepuncture with people who inject drugs should be considered at the outset for such cases. Clinicians should discuss their intentions with the patient in cases where this could be a problem, and elicit their views and previous experience of such attempts. A plan should be agreed before proceeding.

Ultrasound-guided peripheral intravenous (UGPIV) access can be used as a quick and helpful tool for this patient group (being more successful, requiring less time, reducing the number of needle punctures, and improving patient satisfaction). It is a useful tool for any hospital and should be included in any protocols on caring for this patient group.

Among the many indications for bedside ultrasound, ultrasound-guided venous catheter placement is also well described and increasingly used.

7.6 Pregnancy and neonatal care

7.6.1 Key points

- Clinicians treating dependence in pregnant women should strike a balance between reducing the amount of prescribed drugs in order to reduce foetal withdrawal symptoms, and the risk of the patient returning to, or increasing, their misuse of illicit drugs.
- Midwifery and obstetric services should develop policies and good links with local drug specialists, GPs and social services.

7.6.2 Introduction

A large proportion of new presentations to treatment are women and many are in their child-bearing years. However, between 2009 and 2015 the number of opiate users in England presenting to treatment who were pregnant dropped from 5.6% of the overall percentage in treatment to 4.2% (PHE unpublished). Analysis of household surveys and other data sets indicate that large numbers of children in the UK are living with someone who uses drugs (Manning et al 2009).

Though pregnancy may act as a catalyst for change and present a ‘window of opportunity’ (Bell & Harvey-Dodds 2008), women who use drugs may not use general health services until late into pregnancy and this increases the health risks for both the mother and child.

Outcomes in opioid-dependent pregnant women are better, both in terms of the pregnancy and the outcomes for the neonate, for women who enter methadone treatment programmes during pregnancy and cease illicit drug use, than for those who do not. Women attending treatment services usually have better antenatal care and better general health than drug-using women not in treatment, even if they are still using illicit drugs. Therefore, services are advised to fast-track pregnant women into drug treatment to allow for the earliest engagement possible. Engagement of drug-misusing partners in treatment is also important in enabling pregnant women to achieve progress at the earliest possible stage.

There are some special considerations in relation to the treatment of pregnant women who misuse drugs in prison and these are covered in [section 5.4.4.2](#).

7.6.3 Unknown pregnancy, miscarriage and termination

Some women patients may be unaware they are pregnant because amenorrhoea is common in female opiate users and, if withdrawing, withdrawal symptoms can mimic signs of early pregnancy. All women who could be pregnant and who give a recent history of substance misuse should therefore be considered for encouragement to have a pregnancy test.

Sensitivity is needed, however, about encouraging this testing for all women as it will not be appropriate in all cases, such as for women who have been diagnosed as infertile, for some trans women who are not able to be pregnant, and for women who have indicated it is not possible because of recently having no relevant sexual activity. 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.

7.6.4 Management by a multidisciplinary team

NICE’s 2010 guideline recommends that agencies jointly develop care plans that contain information about opiate replacement therapy, that services are co-located and that women are offered information about the services provided by other agencies (NICE 2010). This type of joint approach to management has been found to improve outcomes of pregnancy (Mayet et al 2008).

The type of service in each area will depend on local circumstances, the number of pregnant drug users presenting for care, expertise of the obstetric and primary care services, and

availability of specialist or shared-care support. Midwifery services need competencies in assessing and managing drug-misusing pregnant women. WHO guidance published in 2013 recommends comprehensive assessment for this group and a programme of individualised care.

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

7.6.5 Management of antenatal care

The objectives of management are to achieve stability – pharmacological, social, medical and psychological. Engagement with and close monitoring in antenatal care and drug treatment are integral to achieving stability.

Good coordination between relevant parties is imperative. Risks and needs should be assessed as early as possible in the pregnancy, goals set and support networks planned. This assessment should be multidisciplinary. Agencies should consider convening case conferences around unborn children if there appears to be a significant risk of harm when they are born. This should reduce the need for emergency child protection proceedings at birth. Prospective parents should be informed about all meetings and invited to attend.

7.6.6 Maternal health problems

Health issues in pregnancy that need to be discussed with the woman and reviewed throughout the pregnancy include general nutrition, risks of anaemia, alcohol and nicotine consumption, oral hygiene and complications from chronic infection related to injection practice. These all contribute to the increased rate of obstetric complications and premature delivery found in drug-misusing women. It is also appropriate to consider socio-economic factors and domestic violence and abuse. Specific local protocols and referral procedures should be in place to encourage women's engagement with intimate partner violence services. Drug-misusing women are at high risk of antenatal and postnatal mental health problems.

7.6.7 Effects of drugs on the foetus and baby

It is important for clinicians to note that some of the effects of different drugs of misuse during pregnancy are broadly similar and are largely non-drug specific. Intra-uterine growth retardation and pre-term deliveries contribute to increased rates of low birth-weight and increased perinatal mortality rate. These outcomes are multifactorial and are also affected by factors associated with socio-economic deprivation, including smoking (Kaltenbach 1997, Winklbaaur et al 2008).

Higher rates of early pregnancy loss and third-trimester placental abruptions appear to be major complications of maternal cocaine use. Increased rates of stillbirth, neonatal death and sudden infant death syndrome are found in women who misuse cocaine. Women who misuse heroin have a higher rate of small-for-date babies and pre-term delivery, even when allowing for other confounding factors. There appears to be a correlation between methadone dose and severity of neonatal abstinence syndrome (NAS), but this is not always the case (Archie 1998, Ostrea, Chavez & Strauss 1976). There is also some evidence that methadone exposed fetuses have delayed visual development (McGlone et al 2014).

7.6.8 Substitute prescribing for pregnant women who use drugs

Substitute prescribing can occur at any time in pregnancy and carries a lower risk than continuing illicit use. Women whose babies were exposed to methadone and illicit drugs during pregnancy delivered earlier and had more severe neonatal withdrawal than those who were on methadone only (Jansson & Velez 2012). Substitute prescribing 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.

7.6.9 Prescribing opioids

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

If illicit opiate use continues, strenuous efforts should be made to stabilise the patient on a prescribed opioid, which may involve increasing its dose. 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.

The research evidence demonstrates no difference in adverse effects between methadone and buprenorphine with both having no adverse effects on the pregnancy or neonatal outcomes, with incidence of NAS similar to methadone exposure (Blandthorn, Forster & Love 2011, Jones et al 2010). However, there is some evidence that buprenorphine use results in NAS of lower severity. Therefore, in a pregnant woman who is informed of the risks it is reasonable to allow her to remain on methadone or buprenorphine. Transfer to buprenorphine during pregnancy is not advised because of the risk of precipitated withdrawal and the risk of inducing withdrawal in the foetus. If detoxification is unsuccessful and the patient's drug use becomes uncontrolled at any stage of pregnancy, reduction should be stopped or the opioid dose increased until stability is regained.

Regarding naltrexone in pregnancy, the manufacturer recommends that it should be used only if benefit outweighs risk.

7.6.10 Cocaine, other stimulants and cannabis

Women using cocaine, other stimulants (such as methamphetamine) or cannabis during their pregnancy should be advised to stop altogether, as there is no safe drug for substitute prescribing (WHO 2014). Psychological therapies, including family interventions, should be offered to this group of women.

7.6.11 Benzodiazepines

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 or buprenorphine should have her dose maintained during benzodiazepine reduction.

7.6.12 Tobacco

There is evidence that maternal smoking can increase susceptibility to sudden infant death syndrome in the new-born. Smoking cessation programmes in pregnancy reduce smoking and the incidence of low birth weight and pre-term delivery, and are therefore recommended for all pregnant women (Bhat et al 2015). There is some evidence that contingency management may be useful in reducing smoking in pregnancy.

7.6.13 Alcohol

Updated Department of Health alcohol advice (2016) says that “pregnant women should not drink alcohol at all”.

Pregnant women who drink alcohol at hazardous and harmful levels have high rates of comorbidity and social problems and while the neonates of very heavy drinkers are well known to be at risk from fetal alcohol syndrome, there may be a significant risk of related problems (such as described by fetal alcohol spectrum disorder) at lower levels of consumption. Pregnant women using alcohol should be offered brief and, if appropriate, extended interventions to reduce their alcohol use completely, or to very low levels.

There is evidence that mothers taking methadone during pregnancy also commonly drink excessive alcohol (McGlone et al 2014). Long-acting benzodiazepines, such as diazepam, should be used for alcohol detoxification if needed (WHO 2014). Drugs for alcohol relapse prevention have not been shown to be safe in pregnant women (WHO 2014).

7.6.14 Management of labour

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

7.6.15 Early neonatal care and withdrawals

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

Signs of withdrawal from opioids are vague and multiple, and tend to occur 24-72 hours after delivery. They include a spectrum of symptoms such as a high-pitched cry, rapid breathing, hungry but ineffective sucking, and excessive wakefulness. At the other end of

the spectrum, symptoms include hypertonicity and convulsions but these are not common. Neonatal withdrawal can be delayed for up to 7-10 days if the woman is taking methadone in conjunction with benzodiazepines. Maternal benzodiazepine use also causes more prolonged symptoms in the neonate, including respiratory problems and respiratory depression.

7.6.16 Postnatal management

Continuing support, which may need to include parenting advice and skills training, and mental health advice and interventions, should be provided if the ideal outcome of keeping mother and child together is to be achieved.

Breastfeeding should be encouraged, even if the mother continues to use drugs, except where she uses cocaine or crack cocaine, or a very high dose of benzodiazepines. Specialist advice should be sought if she is HIV positive. Hepatitis C is not a contraindication to breast feeding (HIS 2013). Methadone or buprenorphine treatment is not a contraindication to breastfeeding and breastfeeding may reduce the intensity and length of neonatal abstinence syndrome and has been shown to improve outcomes (Mayet et al 2008).

7.7 New psychoactive substances and club drugs

7.7.1 Key points

- It is important that drug services maintain a broad competence in the use of club drugs and new psychoactive substances (NPS).
- Drug services need to consider their competencies in working with relevant diverse cultures and in attracting those affected (e.g. younger people and some in the LGBT community).
- Regular updating of staff knowledge is required particularly concerning new acute or chronic harms.
- Closer working and joint training with acute and emergency departments and sexual health services, where individuals with such problems may present, can be appropriate for some drug services or staff.

7.7.2 Introduction

Terminology such as ‘new psychoactive substances’ (NPS) or ‘club drugs’, while definitionally problematic, does appear to have some use in highlighting, in the case of NPS, the level of uncertainty about their effects and harms, and in the case of club drugs, the importance of understanding the specific context and culture of the use of those drugs. All these drugs are, however, essentially simply variants of the established psychoactive drug types (stimulants, depressants, hallucinogens/psychedelics) or of other known drug types such as dissociative anaesthetics.

The term ‘new psychoactive substances’ is an imprecise but currently useful umbrella term that includes both a wide range, and a varied group, of drugs (predominately, though not exclusively, synthetic), which have stimulant, sedative or hallucinogenic/psychedelic psychoactive properties (or a combination of such effects). The NPS group may be divided further to include dissociative drugs. In addition, the synthetic cannabinoid receptor agonists are sometimes referred to as a separate group under this heading. They also include the new

synthetic opioids. Their defining feature is that NPS drugs were typically manufactured for the first time, or were brought back in to production, in an attempt to supply 'new' substances to the market that have similar effects to the long-established traditional drugs such as heroin, cocaine, cannabis and LSD. Producing 'legal' novel drugs, whose supply or possession was not currently controlled under legislation, was an important driver for their production.

'Club drugs', a different but related and also imprecise term, refers to that range of drugs currently or recently typically used at bars, nightclubs, concerts, and parties, or linked to such a lifestyle, and used typically by young persons and by young adults but also by some older adults. They currently include both traditional drugs and new psychoactive substances, such as cocaine, MDMA, ketamine, GHB/GBL or methamphetamine, in these contexts.

A legal definition of NPS is not a particularly helpful one for clinical purposes. For example, some drugs which only a few years ago were clearly NPS (and were then often referred to as 'legal highs'), such as mephedrone and GHB/GBL, would no longer fit a legal definition of NPS because their legal status has changed. In addition, many 'club drugs' are not used exclusively in the night-time economy so the term is potentially problematic. The drugs to which the term continues to apply might also be ones particularly vulnerable to changing patterns of use.

7.7.3 Extent of use and harm

The extent of use or levels of harm from use of NPS and club drugs is poorly recorded resulting in a need to rely, to some considerable extent, on informed anecdotes.

The numbers of NPS detected globally has risen year on year, with more than 500 being detected since 2008. More than 100 new drugs were detected across the EU in 2014. There has been a growth in online websites selling technically legal psychoactive drugs. This has also raised concerns about purchase through such sites of prescribed and counterfeit medications such as benzodiazepines. There is some evidence emerging through surveys of an increase in the number of people using NPS and club drugs.

There appears to be a diverse group of typical NPS users, who may be using different NPS from each other, and may be using them for different reasons. This includes some individuals among:

- students and 'clubbers', who are typically attracted to synthetic stimulant drugs
- the LGBT community, whose NPS use can be linked to lifestyle choices (including some MSM who are attracted to the sexually-enhancing effects of some of the drugs and may use them in the context of 'chemsex')
- 'psychonauts', individuals often attracted to the large number of new hallucinogens
- young professionals, previously attracted by the legality of some of the drugs and still attracted by the ability to avoid detection on routine drug screening
- prison populations, particularly attracted to potent synthetic cannabinoid receptor agonists and attracted by the ability to avoid detection on routine drug screening
- homeless populations and those with severe and enduring mental health problems, both of which groups may be attracted by cheap, potent and accessible psychoactive drugs

- users of established drugs, who may also be attracted by accessibility and potency
- vulnerable young people.

Some UK treatment data shows a modest increase in treatment presentations in adult services, particularly for mephedrone.

Drug-related death data indicates steady increases in deaths relating to NPS across the UK although they are still a relatively small proportion of total drug-related deaths. Better reporting may account for this but figures may still be a significant underestimate given the lack of routine toxicological testing or attribution of death to other co-ingested drugs.

7.7.4 Toxicity

There is now emerging data on the acute toxicity of some new NPS but there is very little evidence available regarding harms from chronic use. This is partly because most NPS have only been available for a few years and also that, with the exception of mephedrone, most NPS seem to rapidly appear then disappear from the drug market. More is understood about the harms of more established club drugs such as ketamine and MDMA. Assumptions about possible risks can be made from known harms of similar drugs (but these must remain speculative in the absence of established evidence and experience) and the risk of completely unknown risks and emerging harms must also be kept in mind.

7.7.5 Clinical management

It is crucial that frontline clinical staff feel competent and confident in discussing NPS and club drug use (including explaining the limits of current knowledge), and in treating NPS and club drug problems and dependence.

It is important that services maintain a broad competence regarding the use of club drugs and NPS, and consider their cultural competencies in working with users of these drugs (such as some young people and some in the LGBT community). Staff and services need to consider their ability to appeal to, and engage, non-typical service users who may require treatment and support for problem or dependent use of NPS and club drugs.

Asking about NPS and club drugs should be integrated into core assessment and, where feasible and appropriate, testing may be useful.

Information and advice on risk management and harm reduction (incorporating general principles such as the avoidance of mixtures of substances) should be provided when appropriate. Information about the known harms for specific NPS and club drugs should also be available. Suitable advice and support for reducing harm from injecting can also be relevant. General supportive and symptomatic advice on managing acute toxicity and withdrawal applies equally for NPS as for traditional drugs (and clubbers can be advised that advice and support may be available in some clubs if they feel unwell).

Treatment interventions for the management of dependence on NPS are essentially the same as for any other problem substances, using psychosocial interventions (and pharmacological support if appropriate). While some dedicated club drug services provide highly culturally-competent and particularly well-informed care, being able to provide assessment and treatment for NPS and club drug problems and dependence is the remit of all drug treatment services.

Keyworkers in drug services need to consider how to meet the needs of their patients with problems with NPS or club drugs if, for example, the available general groups are not sufficiently focused to cover relevant issues. In this case, one-to-one keyworking support may be needed. This may also be important in discussing issues around lifestyle and sexual practices. Those who have developed problems with drugs in the context of 'chemsex' need to be able to discuss these difficulties in an open and non-judgemental therapeutic context. Thorough assessment, goal setting and treatment planning, support for reducing harms and prioritising wider recovery goals apply equally for this group as for others.

Closer working and joint training with acute and emergency departments and sexual health professionals may be appropriate for some services or staff.

In addition to reinforcing general drug competencies and ensuring cultural and diversity competencies, more specific areas of new or updated learning may be needed for some staff. Examples of recent areas of developing knowledge include:

- ketamine-related urological damage
- management of GHB/GBL dependence and withdrawal
- the nature of injecting with NPS and the appropriate harm reduction advice
- assessment and management of persisting hallucinogen psychopathology
- emerging new harms such as synthetic cannabinoid related acute kidney injury and rhabdomyolysis
- new drug combinations being used (for example, GHB/GBL and methamphetamine) and the contexts of their use
- recovery support options that may be available specifically for NPS or club drug users.

As an example, for GHB/GBL, drug services need to be able to advise service users on:

- the risk with overdose of loss of consciousness and respiratory arrest, and the need to place affected individuals in the recovery position and call an ambulance
- the need to exercise care about the exact amount consumed, given that the toxic dose can be very close to the normal psychoactive dose
- the added risks of mixing GHB/GBL with other sedative drugs
- the risk of very serious withdrawals that can develop in dependent GHB/GBL users and how to manage this risk (see NEPTUNE guidance in [7.7.6](#) and [7.7.7](#)).

7.7.6 Available clinical guidance

There has been a paucity of clinical guidance relating to club drugs and NPS. Sources of advice for evidence-based practice include:

- For acute management of toxicity, TOXBASE – run by the National Poisons Information Service (NPIS) – is a well-used resource for acute medicine, the emergency room and other acute settings.
- Project NEPTUNE – an evidence-based review of available literature on NPS and club drugs – provides a useful summary of current knowledge and implications for treatment.

While NPS and club drugs present new challenges to drug treatment services, these drugs should be considered 'core business' rather than a more specialist area.

Many club drug and NPS users do not use heroin and will not be familiar, or necessarily comfortable, engaging in services seen as strongly focused on heroin. However, many services currently already offer pathways for primary stimulant and for primary cannabis dependent patients, and so this is more an issue of making suitable, and engaging entry paths to treatment and support, where such new service users can feel they will receive skilled, culturally-competent help.

7.7.7 Resources and further reading

TOXBASE clinical toxicology database (National Poisons Information Service)

www.toxbase.org

Novel Psychoactive Treatment: UK Network (NEPTUNE) clinical guidelines (2015)

<http://neptune-clinical-guidance.co.uk/wp-content/uploads/2015/03/NEPTUNE-Guidance-March-2015.pdf>

Club drug use among lesbian, gay, bisexual and trans (LGBT) people, also from NEPTUNE (2016) <http://neptune-clinical-guidance.co.uk/wp-content/uploads/2016/02/neptune-club-drug-use-among-lgbt-people.pdf>

7.8 Image and performance enhancing drugs

7.8.1 Key points

- People who inject image and performance enhancing drugs (IPEDs) are at risk of injection site injuries and other injecting-related infections and at risk from the side-effects of the drugs.
- Needle and syringe programmes with a high proportion of IPED injectors should provide specialist advice on the drugs, their side effects and alternatives, together with information and referral to sexual and mental health services and to specialist IPED services where available.
- While few individuals present to specialist drug treatment services, general principles of assessment and treatment can be applied.

7.8.2 Introduction

Image and performance enhancing drugs (IPEDs) is a term used to describe a range of drugs that are used to improve human attributes or abilities. They comprise a wide range of substances including anabolic agents, weight loss drugs, drugs that alter the appearance of the skin or hair, sexual enhancers, cognitive enhancers and even drugs that will alter social behaviour. Anabolic steroids and associated drugs (such as growth hormones, human chorionic gonadotrophin, and peptide hormones including the skin tanning agent melanotan II) are the IPEDs most relevant to clinical management of people who use drugs. These are all injectable and people who use these drugs commonly present to needle and syringe programmes (NSPs).

7.8.3 Characteristics of those who use IPEDs

While the vast majority of people who use IPEDs are male, female users of anabolic steroids in particular may experience more pronounced and enduring adverse consequences. IPED injectors attending NSPs are generally far younger than injectors of other substances. IPED use is now found in all socioeconomic groups, races and geographies.

7.8.4 Changes in practices and risk behaviour

IPEDs can include new untested substances (for example, as has occurred with some new peptide hormones), and there can be changing patterns of use and availability (for example, increasing use of growth hormone and higher doses of testosterone). In general, high-dose polypharmacy has increased, with associated increased risks and more prolonged periods at risk. Some people who use IPEDs also use cocaine and are at risk of mental health and cardiovascular problems. Some are also at risk from excessive consumption of alcohol, with risk to the liver when used in combination with oral anabolic steroids.

7.8.5 Harmful effects of IPEDs

Reported adverse events from use of IPEDs are diverse and can range from cosmetic and transient to life-threatening, and include cardiovascular, haematological, psychiatric and neurological effects (including depression and behavioural changes), and hormonal and metabolic effects. There may be an increased risk in long-term anabolic steroid users of cardiac dysfunction.

Changes in hormonal function due to prolonged exposure to anabolic steroids may be associated with uncomfortable physiological discontinuation effects that may be unrelated to any dependence potential and care is needed in attribution. However, there are features of dependence reported with anabolic steroids, and reports of the need for support for some long-term users to resist using. Reports of withdrawal symptoms from exposure to sustained high doses of anabolic steroids have included low mood (including suicidal behaviours), insomnia, tiredness, decreased sex drive, headache, and muscle and joint pains.

7.8.6 Adulteration and the illicit market

The vast majority of available anabolic steroids, growth hormones and melanotan products are illicitly manufactured. Incorrect recording of strength of medications and substitution with different drugs as well as mislabelling and contamination are all potential risks.

7.8.7 Injection injuries and infections

People who inject IPEDs are at risk of injection site injuries and localised infections but may be reluctant to engage in treatment.

Recent findings of an increase in rates of HIV have caused concern. The relevant transmission routes remain unclear for this population.

7.8.8 Guidance on IPED needle and syringe provision

In 2014, NICE recommended that NSPs meet the specific needs of IPED injectors regarding both opening times and venues, for example, outreach and detached work in gyms, and that

the equipment, information and advice be provided by appropriately-trained staff. NSPs with a high proportion of IPED injectors should provide specialist advice on the drugs, their side effects and alternatives, together with information and referral to sexual and mental health services and to specialist IPED services where available. Research to identify effective and cost-effective ways of delivering needle and syringe programmes to IPED injectors was also recommended.

7.8.9 Treatment

There is very little published research evidence on which to base specific recommendations for the treatment of those with problems stopping IPED use, and few patients present to specialist drug treatment services.

In general, detailed comprehensive assessment should be carried out, including of substance use as well as of any previous symptomatic (physical and/or psychological) problems in cutting down or stopping use. Such comprehensive assessment should include assessment of any pre-morbid or comorbid problems such as body image difficulties and assessment of any perpetuating factors. Endocrine specialist advice may be needed for severe or complex cases.

It appears that for most of those looking for help with IPEDs, basic motivational support and planning of sustained cessation of use in the context of personalised evaluation of need is the main approach reported.

In addition to harm reduction advice and support for appropriate needle and syringe and paraphernalia packs, brief interventions to address risk and to reflect on goals may be sufficient.

For those with more severe problems in stopping and avoiding relapse, following detailed individualised comprehensive assessment and explanation of some limitations in the evidence base, basic psychosocial interventions used for other dependence disorders may be offered.

If any symptoms develop following cessation of use of IPEDs that are suggestive of possible hormonal imbalance, endocrinology assessment may be needed.

Various pharmacotherapies have been reported to be used for specific symptoms following cessation of use (such as for insomnia, headaches or low mood) but there is no established evidence base upon which to provide recommendations.

7.8.10 Resources and further reading

Needle and syringe programmes. Public health guideline 52 (NICE 2014)

www.nice.org.uk/guidance/ph52

Providing effective services for people who use image and performance enhancing drugs (PHE 2015) www.nta.nhs.uk/uploads/providing-effective-services-for-people-who-use-image-and-performance-enhancing-drugs.pdf

7.9 Coexisting problems with mental health and substance use

The quality of the experience of care for those with coexisting problems with mental health and with substance use is significantly affected by management and organisation of services and the local system and pathways of care, which is the responsibility of the commissioners of care as well as providers.

7.9.1 Key points

- Common mental health problems are typical in drug misuse treatment populations. Interventions for these may need to be provided in drug misuse services.
- Those with severe mental health problems should have high-quality, patient-focused care integrated with mental health services.
- Complex and comorbid mental health and other problems need to be assessed and may need to be addressed alongside or ahead of the drug misuse problem.

7.9.2 Introduction

Individuals with coexisting mental health and substance use problems (also referred to as coexisting mental health and addiction, dual diagnosis or comorbidity) often have complex assessment and treatment needs and so a range of opportunities for intervening positively. A number of interacting dimensions need to be considered (including type of mental health problem, type and amount of substance use, type of substance use disorder or substance use problem, severity of disorders, presence of physical comorbidity and often relevant complex social issues), and all these elements can change over time.

Those with coexisting mental health and substance use problems have poorer prognoses, greater levels of unmet need, higher rates of relapse, increased hospitalisation, housing instability, poorer levels of social functioning such as poverty, greater risk of being either a victim and/or perpetrator of violence, greater involvement with criminality and marginalisation, less compliance with medication and treatment, greater service utilisation, higher costs to services, high rates of suicide in drug dependent patients, high rates of history of drug misuse in those psychiatric patients who subsequently commit suicide or homicide and severe and multiple disadvantage (substance misuse, homelessness and criminal justice involvement).

Among individuals in need of treatment for dependent or problem use of drugs and alcohol, there are known to be high rates of mental health problems. In drug and alcohol treatment services such problems – chiefly depression, anxiety and significant personality difficulties and disorders – may negatively impact upon their presentation and pose challenges to their engagement in treatment.

It is important that individuals are not turned away from either drug and alcohol treatment services or mental health services due to their coexisting illness but rather that such services should aim to be perceived by service users and their carers as supportive with ‘no wrong door’ through which to enter services (whether based on levels of alcohol and/or drug dependence or on presence or absence of specific diagnoses of mental illness), even if subsequently this sometimes leads to referral for alternative pathways of care. Individuals should receive appropriate assessment of their need and risk and should be supported to receive relevant and evidence-based treatments. This may include referral to other providers when appropriate but this ‘no wrong door’ approach is important not least because such patients face greater risks and threats to their wellbeing and recovery than those without such coexisting problems.

7.9.3 Prevalence

Many large epidemiological surveys demonstrate the high prevalence of comorbidity in those attending mental health services and drug and alcohol treatment services.

Typically, nearly half of community mental health patients have reported problem drug use or harmful alcohol use in the previous year (although rates can vary widely in different services and settings).

In drug and alcohol treatment services, over three quarters of patients have been found to have had a psychiatric disorder in the past year (mostly depression, anxiety and personality disorders). Recent problems with suicidal thoughts are commonly reported in those admitted to drug treatment services, as are recent psychiatric hospital admissions. A large minority of those attending drug and alcohol services are reported to have 'personality disorder'.

Typically, almost 30% of the drug treatment population and over 50% of those in treatment for alcohol problems actually experience 'multiple' morbidities (co-occurrence of a 'number' of psychiatric disorders or substance use problems) (Weaver et al 2002).

There is also a very high prevalence of comorbidities among prison populations – with coexisting problems with substance use and mental health being seen as the norm rather than the exception among most offenders. A history of drug dependence is a significant risk factor in prison suicides.

7.9.4 Framework for services

There are established principles for commissioners and providers of health and social care within any local area, which may have a range of different providers of substance misuse and mental health services to be able to meet the identified needs of those with coexisting substance misuse and mental health disorders. Local areas, including both mental health and drug treatment service commissioners, as well as voluntary, independent and statutory providers need to:

- ensure there is effective strategic collaboration between commissioners and providers of mental health and substance misuse services to provide adequate treatment experience and to support optimal outcomes for individuals with coexisting substance and mental health issues
- ensure there are adequate mechanisms, that are integral within all services, for identification of such individuals at whichever mental health or substance misuse service is initially involved
- ensure assessment information is used to inform adequate care planning and is not used inappropriately to exclude individuals from the assessing service or support for other care
- ensure assessment of individuals with comorbidity does lead to receipt of the appropriate treatment and care for both the mental health and substance misuse problems, either directly within the assessing service or through active support for provision of more specialised treatment and support elsewhere
- support people with comorbid problems with access to person-centred care to assist them to be better able to better manage their lives

- ensure that services are suitably tailored (suitably flexible and well-coordinated) to address the known complexity of need associated with comorbidity
- ensure there are good communication systems with other services (which may be part of agreed joint working protocols)
- ensure all relevant services deliver timely, compassionate and clinically appropriate responses to individuals in crisis, including individuals intoxicated or in acute withdrawals (not excluding suicidal or psychotic patients where intoxication or withdrawal is considered the cause) whether in emergency, mental health or drug treatment services.

Positive outcomes can be underpinned by:

- shared local strategies and co-commissioning, with outcomes jointly owned by substance misuse and mental health commissioners, and supported at a senior level within the health and social care system
- the involvement of service users, providers and clinicians in developing a local strategy or joint working protocols
- the involvement of all stakeholders, including the police and those responding strategically to the duty to 'safeguard' children and adults, in developing effective responses to mental health crisis care where drugs and alcohol are involved
- an appropriate level of clinical expertise to oversee and ensure quality of service provision for this group in both sets of services
- a workforce in mental health and substance misuse services who are competent to identify, assess and deliver evidence-based interventions (within their service remit), and who can work collaboratively across agencies to deliver care centred on the needs of individuals.

It is important to recognise that those affected by coexisting mental health and substance use problems (who are in need of effective and collaborative planning, delivery and accountability of their services), are not limited only to those with psychosis but include many others, not least those with mild-to-moderate mental ill health, those with early traumatic experiences or recent trauma, and those with personality disorders.

7.9.5 Treatment delivery models

Given the high prevalence of comorbid problems in all drug and alcohol services and all mental health services, suitable interventions are needed for substance problem(s) in all mental health services, and for mental health problems in all substance misuse services, with competent staff available to deliver such interventions.

Clinical competencies will be distributed differently in different systems of care, both within providers (e.g. the balance of psychiatric clinical skills and counselling skills); and in the balance and accessibility of different types of providers (e.g. availability of counselling services for common mental health problems or for substance misuse problems and accessibility of specialist psychiatric treatment). Geography can play a crucial role in configurations of provision, including the possibility of any co-location of drug treatment and mental health care and the feasibility of one-stop shop provision. Such factors may affect what choices are

available to service users and need to be taken into account by those planning the provision of services to best meet local need.

Where feasible, care for comorbidity may be best provided in one service (integrated model). Undoubtedly, provision for those in need of information and advice and in need of basic motivational skills can be feasible in almost all treatment services. More specific interventions may also be provided in some services with suitably skilled workers, particularly for patients who are unable or unwilling to engage with more than one service. However, in other and more complex cases of comorbidity, where there is need for additional specialist interventions, such provision may only be practical as additional treatment from a specialist substance misuse or mental health treatment service, when the emphasis should still be on adequate collaboration, good communication and ensuring patients do not fall between gaps (parallel model).

In all cases, services need to adopt a 'no wrong door' approach for initial assessment and support. Access to provision, however delivered, should be made as seamless as possible and carefully supported to limit dropout between services.

Sequential models of treatment prioritise the treatment of one disorder over another until the successful stabilisation of the other. Given the recognised reciprocal relationship between mental health and substance use disorders, this approach is not normally recommended given untreated disorders can potentially limit the effectiveness of treatment for the other comorbidity but initial timing can sometimes be affected by the current severity and stability of one or other disorder.

Where any mental health symptoms are assessed as due to intoxication or withdrawal, apparent comorbidity may only present temporarily and careful consideration and further assessment of such possible comorbidity may be needed prior to any referral to adult mental health services, when this does not present as an acute mental health crisis. Equally, where those in need of treatment of adult mental health disorder have not been found to have dependent use of substances but rather need education and advice, or are using substances secondary to untreated mental disorder, referral for involvement of substance misuse treatment services may simply complicate care. In such cases, clear analysis of the diagnosis and treatment need is essential to underpin suitable advice to the patient, with suitable review of this assessment over time.

Where a decision to pursue sequential provision of treatment could simply lead to a service user's exclusion from both sets of services, particular care is needed to communicate between agencies, to discuss core diagnostic assessments and to consider carefully the rationale for the treatment plan proposed and any modifications needed, which should also include consideration of the service user's preferences. A good understanding of the local eligibility criteria typically used, alongside good communication with primary care and between secondary care services, can be vital to avoid individuals in distress slipping through the gaps.

7.9.6 Crisis interventions

Management of mental health crises can be important for those seen in drug treatment services. Rates of suicide are raised in substance-dependent populations and some substances cause time-limited psychosis either in intoxication or withdrawal. Substance misuse services need to have skills in appropriate assessment, immediate support and

onward referral of individuals in such a crisis. This will include contacting the appropriate emergency services and the mainstream acute health services commissioned for such acute care, whilst responding appropriately to the immediate risks as per local policies. Most acute crises in those with drug and alcohol misuse disorders are either physical health or mental health crises. However, most substance misuse services are commissioned and designed primarily for the planned management of dependence and are not staffed to provide acute crisis services. This can create confusion among some professionals and this should be carefully explained where appropriate so that individuals are not inappropriately excluded from the commissioned acute crisis care services locally.

7.9.7 Assessment and treatment

All services need staff with core engagement skills, including a focus on building and maintaining the therapeutic relationship (including trust and collaboration), underpinned by a motivational approach (non-judgemental, promoting autonomy with self-determined goals and values).

Services should also be aware of the risks of interaction between psychiatric medication and illicit drugs (and alcohol). They should further be aware of the abuse potential of some psychiatric medications.

Substance use can be both a cause and consequence of mental health disorders. It is often impossible to determine which came first and whether this is still relevant. Some will have mental health symptoms that simply improve with abstinence from particular or all substances. Others may need active psychiatric management even despite ongoing alcohol and or drug use. There can be an ongoing interaction between substance use and mental health symptoms, where each can affect vulnerability to developing the other or influence its clinical course and outcome. Clinicians need to continue to assess the situation in response to this complexity but core skills of person-centred, reflective care, with a focus on good therapeutic alliance, and motivational and psychoeducational working, and collaborative care planning and risk management, commonly underpins effective care in such cases.

Components in the standard treatment of co-occurring mental health and substance use disorders include:

- good case management, effective communication and assertive outreach for service users
- a focus on building and maintaining the therapeutic relationship (i.e. trust and collaboration), underpinned by a motivational approach (non-judgemental, promoting autonomy and self-determined goals and values)
- a focus on retention in treatment, supported by a motivational approach and other behavioural interventions such as contingency management
- treatments that develop recovery capital (e.g. meet meaningful life goals/values, create a sense of worth and purpose) in addition to focusing on symptom reduction
- where indicated, simultaneously addressing mental health and substance use symptoms and stepping up intensity of treatment as required
- multifaceted treatment, with combinations of evidenced-based psychological therapies (e.g. motivational interviewing, contingency management, cognitive-behavioural therapy) and pharmacological therapy, are likely to result in the greatest efficacy.

7.9.8 Within mental health services – assessment for, and responses to, substance use and substance use disorders

Mental health workers need to be supported by their commissioners and their managers need to understand:

- the pathways of substance use care that have been commissioned, and are available, locally
- the entry and referral criteria for the different kinds and levels of services
- how to advocate appropriately for any patients who may appear to be falling between gaps of care provision.

7.9.8.1 Assessment

Those carrying out initial and ongoing assessment within mental health services, including keyworkers/care coordinators, should be competent to:

- ask patients about their substance use and about any evidence of problem or dependent use
- either provide, or arrange, in-house information, advice and support for managing their substance use or substance use problems, or provide and actively support appropriate local referral for such problems identified
- recognise, and deal appropriately with substance use 'crises', whether acute mental or acute physical health crises, which in the latter case may include acute overdose, severe withdrawals or other acute harms related to drug use such as deep vein thrombosis, when typical responses include providing basic life support and/or referring for urgent medical assessment, or arranging transfer to an emergency department or calling emergency services.

7.9.8.2 Information, education and support for drug use or problem use

Mental health patients using psychoactive drugs may be assessed as having dependent use (and so likely to benefit from provision of specialist drug treatment interventions). However, 'dependent' use may not be clearly present with some patients, or they may indicate that they have chosen to continue using 'recreationally' for what they see as positive reasons (without any self-perceived loss of control, for example). The latter use may still create challenges for the stability of a patient's mental health although the patient may at the time not see this as their priority. Such patients may be assisted by their mental health professional in making healthier choices through the provision of information, education and advice that uses their core psycho-educational and/or motivational styles.

For those with coexisting alcohol and drug misuse issues and for their families/carers, information about, and support to engage in, alcohol and drug recovery support services should be available within, and provided by, all mental health services (including information and advice about harm reduction and needle and syringe services, drug and alcohol treatment services, 12-step groups such as AA/NA/CA, SMART Recovery groups, peer support and recovery cafes, service user and other mutual aid groups, family and carer groups, and other resources available locally).

Often, self-referral to substance misuse services will be available to such service users but active communication by involved mental health professionals may still be beneficial, particularly communication with any primary or secondary care prescribing services.

7.9.8.3 Severe mental illness and substance use disorders

Individuals with severe mental health problems should be supported to have access to as fully integrated care as possible within mental health services. This care should support all treatment goals, whether the treatments are formally 'integrated' or provided through a 'parallel' model of delivery.

For those with severe mental illness, mental health services will usually lead the coordination of the overall care plan developed with the patient. However, they will often work in partnerships with drug and alcohol treatment services for the delivery of specialised substance misuse treatment interventions, when needed. It may be possible to link this treatment with attendance at the mental health service or this may involve attendance at appointments with the drug service or at substance misuse community groups.

Patients with mental health problems of sufficient severity and risk may be required to be provided with special monitoring arrangements for their care planning and coordination (and for their risk management) within mental health services, such as through the care programme approach (CPA). Such arrangements should normally be led within mental health services (although local policies may differ). Whatever the local arrangement, the purpose is to ensure that patients' care is planned and coordinated by individuals with the competencies to do so within sufficiently resourced provision. Such patients may well also have a substance misuse treatment and recovery care plan with their drug service keyworker but there should be adequate coordination so that this fits within, or can be reflected by, an overarching plan of care with the mental health care coordinator.

On exceptional occasions, a patient with a severe mental illness may only be willing to attend the drug treatment service, in which case creative interventions for management of the mental health disorder (especially for patients at high risk) may be appropriate. This might include active in-reach by a mental health worker to the drug service or prescribing for the mental health problem by the drug service (dependent on local arrangements and psychiatric prescriber competencies being available within that service). Active communication with the responsible mental health service and primary care, particularly in managing any medication monitoring protocols or emerging serious risks, would also be important.

7.9.9 Within drug treatment services – assessment for, and responses to, mental illness

Drug treatment workers need to be supported by their commissioners and their managers to understand:

- the pathways of mental health care that have been commissioned, and are available, locally
- the entry and referral criteria for the different kinds and levels of services
- how to advocate appropriately for any patients who may appear to be falling between gaps of care provision.

Those carrying out initial and ongoing assessment within substance misuse services, including keyworkers, should be competent to:

- ask patients about their mental health and, where relevant, use routine screening tools to identify symptoms and diagnoses
- either provide, or arrange, in-house support for mental health difficulties or provide and actively support appropriate local referral for the problem(s) identified
- recognise, and deal appropriately with a mental health 'crisis', including suicidality and psychosis (which could include referring for urgent psychiatric assessment, arranging transfer to an emergency department or calling emergency services in line with local risk management policies).

Before recommending specific mental health treatments of specific mental health problems, suitable skilled assessment is essential. Skilled diagnosis and determination of mental health treatment need may be available in-house within some services but for others further assessment by the patient's primary care team or by psychiatric assessment services will be required. Where this assessment does take place within drug treatment services, it is essential that there is adequate governance, including supervision, of any mental health treatments provided in-house.

A number of evidence-based treatments are available for the wide range of conditions. Guidelines, such as from NICE, provide advice on the use of interventions including psychological approaches for disorders including depression, anxiety disorder, post-traumatic stress disorder, eating disorders, obsessive compulsive disorder, borderline personality disorder and antisocial personality disorder.

Many patients who meet the diagnostic criteria for mild to moderate mental illness (including cases of depression and anxiety), and many patients who have evidence of personality disorder, present with a need for treatment for substance misuse disorders. Their drug treatment should usually be met without referring to secondary care mental health services unless the conditions are particularly severe or complex to manage. Depending on the severity or complexity of their mental health disorder, in line with agreed protocols between substance misuse and mental health services/commissioners locally, these patients could have their mental health treatment needs met in primary care services (GP or psychological therapy services), substance misuse treatment services, mental health services, or a combination.

Patients who have both mild, common mental health problems and mild substance misuse problems may not meet the access criteria locally either for the mental health or the substance misuse service, despite the combination of problems requiring assistance. They may benefit from brief interventions for substance misuse or from primary care or IAPT involvement around their mental health. Clear pathways for assessment of such patients and for provision to meet their care needs should be explicit. They should be agreed between commissioners and local providers to ensure adequate provision when such patients do present, and to avoid patients simply being identified as not meeting any service's criteria.

A summary of the evidence regarding the management of specific mental health problems/ disorders alongside coexisting substance use disorders is provided under the heading *Coexisting substance misuse with mental health issues* in [section 3.7.3.2](#).

7.9.10 Resources and further reading

National Institute for Health and Care Excellence (2016) Coexisting severe mental illness and substance misuse: community health and social care services
www.nice.org.uk/guidance/ng58

7.10 Young people

7.10.1 Key points

- Specialist drug treatment and competencies for young people are different to those for adults.
- The treatment services that address young people's substance use problems need to sit within the wider framework and standards for young people that support both engagement and access of children and young people to services and appropriate responses to young people and their parents.

7.10.2 Introduction

Most young people do not use illicit drugs or have significant problems with alcohol. While a minority of under-18s will experiment with or use illegal drugs occasionally (often in conjunction with alcohol), most illicit drug use is short-term cannabis use. Alcohol use in young people is generally of experimentation or episodic bingeing. Few under-18s use drugs regularly or dependently, or to an extent where drugs and alcohol have a harmful impact on their lives. Some do experience harm. This is more often related to intoxication and/or excessive consumption, or for example, new psychoactive substances (NPS), which carry risks because of toxicity and the use of combined, untested ingredients. At the time of writing, misuse of over-the-counter (OTC) or prescription drugs did not seem to be a substantial issue for young people in the UK. Dependence (especially opiate or stimulant dependence) and drug injecting are uncommon. Substance misuse may be damaging to the developing brain, and interfere more indirectly with development, and exacerbate problems for those who are more vulnerable. There is an association between early substance use problems and crime and antisocial behaviour, an indirect impact on suicide and accidents, and impacts on mental health and general functioning.

7.10.3 Services – general and specialist

Specialist drug treatment for young people is different to that for adults (relating to factors such as age and maturity, responsibility, safeguarding duties, the legal framework, developmental needs and the patterns of substance use problems). For some, drug and alcohol use is essentially experimental though this can cause difficulties related to intoxication and idiosyncratic reactions. Brief interventions may be appropriate for this group to prevent escalation.

For those with substantial levels of use or problem use, it is more likely that drug misuse compounds other problems such as family breakdown, anti-social behaviour, educational issues and mental health concerns – that is, drug use is more of a symptom than a cause of the vulnerability. Evidence indicates that young people with other problems, such as young offenders, young people with mental health problems, those experiencing child sexual exploitation and those excluded from school, are more likely to misuse drugs and alcohol. Consideration needs to be given to gender differences, with young girls and women more likely to have mental health problems and be vulnerable in specific ways, such as exposure to sexual exploitation and abuse (RCPsych 2012).

Treatment services for young people that address substance use problems need to sit within the wider framework and standards for young people, which support both engagement and access of children and young people to services and appropriate responses to young people and their parents.

Implementing the treatment process within such a framework involves comprehensive assessment, active engagement, collaborative teamwork across local health, social care, family services, education and employment services, utilisation of the broad range of evidence-based interventions for substance use/misuse and for comorbid conditions, and active follow up. Coordinated, well-led interventions should mobilise resources of local communities, including safeguarding, education, training, mental health and resilience building.

Most young people attending specialist services in the UK identify cannabis and alcohol problems. New cases of heroin or opioid dependence have become even less common in the last few years. There is growing concern about the increase in availability of NPS, and of trends in stimulant and polydrug use, that may pose additional risks for young people.

All staff working with young people need to be competent to assess and manage responses to the developmental needs of young people and to be able to identify relevant risks such as educational delay. They need to understand the legal framework for working with children and young people, safeguarding issues, and the issues relating to responsibility and capacity to consent to interventions.

7.10.4 Clinical governance

While the principles of clinical or quality governance apply equally for all treatment services (see [annexe A2](#)), there are some related issues in delivery of substance misuse treatment for those under 18 that are different and require different actions and need to be incorporated within governance arrangements. These include:

- All professionals involved in treating young people should be able to assess capacity of the young person to give consent for the appropriate interventions.
- All decisions should be made in the best interests of the child; they should receive confidential care but information must be shared to protect a young person from abuse or neglect. Effective information sharing guidance and working practices should be set.
- All professionals or staff working with young people and their parents/families must be competent to understand the developmental needs of children and young people, and understand parental responsibility and their effective involvement.

- All should be aware of the use of frameworks for assessing children and young people's needs, the work of Local Safeguarding Children Boards and Child Protection Committees, and policies, procedures and organisations that work to protect children and promote their welfare.
- Professionals should be competent to deliver the intervention(s) and work with other agencies and professionals in the best interests of the child/young person.
- An awareness of considerations in prescribing for under-18s, including drug licensing considerations.
- An understanding of the different legal, statutory and policy framework for young people and families.
- All professionals must be aware of the current relevant guidance on safeguarding children.

7.10.5 Research evidence on treatment effectiveness for young people

The evidence on young people's substance misuse interventions is not extensive, with few randomised controlled trials and minimal research from the UK. Consensus guidance on standards has been developed by the Royal College of Psychiatrists (2012) and elements of the evidence base have been summarised in NICE guidance documents (2007a, 2007b, 2007c, 2007d, 2007e, 2010, 2011a), with the majority of these relating more to adolescents and adults.

Responses to drug and alcohol use/misuse and dependence are based on universal and targeted prevention, on brief interventions in some cases, and on other specialist treatment interventions, whose nature depends on severity of the presentation and comorbidities that may be accompanying the substance use problem.

Specific substance misuse treatment should include psychosocial interventions delivered generally within a holistic package of care that addresses a range of the young person's identified needs.

Much of the evidence for pharmacological treatments such as detoxification and stabilisation of opioids is derived from the adult evidence base. There is less evidence on the pharmacological responses to dependence specifically in young people. The majority of young people will not demonstrate signs of physical withdrawal to their drug use and most will not require pharmacological treatments. However, some will require prescribing interventions such as opioid substitution treatment and need prompt, safe access within a supported package of health and social care.

Evidence on pharmacological interventions in young people is incorporated in various summary documents, including from the British Association of Psychopharmacologists (Lingford-Hughes et al 2012), NICE (2011a), Royal College of Psychiatrists (2012) and Department of Health (Gilvarry & Britton 2009a).

7.10.6 Screening and assessment

The screening and assessment process and the definition of 'problematic' use are different for young people. What is problematic can depend crucially on the age of the child, the

child protection context, the nature of parental involvement and responsibility, and on developmental issues.

All services dealing with children and adolescents need clear screening processes for identifying use of drugs and alcohol, and referral procedures in place for when needed. This is particularly important for those vulnerable young people who are more at risk: those with behavioural or mental health problems whose family members are using substances, those excluded from school, for looked after children and in homeless groups. Screening should be used within any common agreed assessment framework for young people locally. A number of appropriate and validated tools that can help in assessment are described in the RCPsych practice standards (2012).

For all young people aged under 18, screening can simply be sensitive, brief questioning about substance misuse (how often, what was used and in what context) or it may be a more specific tool.

If there are any substance use concerns (a positive screen), the generally recommended response tends to be somewhat different depending on age and circumstances. In general, those aged under 15 (NICE 2011a) should be offered a comprehensive assessment of health, education and social needs, substances, family, physical/mental health and other complexities; while those over 15 years should be offered a brief assessment, with advice and extended brief interventions (NICE 2007a). In some exceptional cases, with dependence apparent that may need prescribing, comprehensive assessment for prescribing will be needed too.

Essentially, this assessment and any interventions provided should be age appropriate, taking into account safeguarding issues, the competence of the child and the context.

Comprehensive substance misuse assessment should be coordinated, comprehensive, timely and collaborative, with young people fully involved, and with – wherever appropriate and possible – involvement of parents. It should address substance use and behaviour, developmental needs, physical and mental health, risks and safeguarding, family functioning, educational attainment and any difficulties, vulnerabilities, resilience, community resources and risks.

7.10.7 Psychosocial interventions and care planning

The evidence base on the effectiveness of substance misuse-specific treatment for young people is limited. However, there is a consensus that the delivery model should be one of assertive outreach in partnership with multiple agencies, with multiple interventions, that address the full range of identified needs, along with any drug and alcohol treatment interventions needed.

Integrated care planning should address the full range of needs, be effectively coordinated with all agencies and family, support involvement of parents, be regularly updated and monitored and where appropriate have coordinated transition arrangements to adult services. This transition should not simply be a transfer of care to an adult service, but a coordinated transition over time with clear engagement.

There is guidance on the provision of information and advice to children and young people about alcohol and drugs, about their effects and their risks (including the risks of overdose, and the risks to physical and mental health). While young people and those at risk of harm are entitled to information and advice, and this is encouraged within health provision for young people, there is little specific evidence that providing such information is effective in altering behaviour.

Within specialist services, young people should receive testing and advice regarding blood-borne viruses, with provision of hepatitis vaccination, and other health related advice including smoking cessation. If needle and syringe provision is required, a careful assessment of age and capacity, with frequent review, is advised to prevent escalation of risk.

Generally, psychosocial interventions should, as for adults, involve motivational and engagement techniques, including building a therapeutic alliance, to work collaboratively with the young person and their family. The range of specific psychosocial interventions that are used in adults may be relevant in some young people. Individual cognitive behavioural therapy (CBT) should be available for those with certain comorbidities and good social support in line with the established evidence base (NICE 2011a).

Family therapy techniques can be used to engage families and facilitate communication and behaviour change. For those with significant comorbidities and/or limited social support, services should offer multicomponent programmes (such as multidimensional family therapy, brief strategic family therapy, functional family therapy or multisystemic therapy) (NICE 2011b).

These interventions will normally require coordination with other children's agencies. The involvement of a young person's parents is considered good practice. This needs to be actively considered in terms of parental responsibility and consent of the young person.

7.10.8 Pharmacological interventions

The pharmacological management of substance use should be only one component of addressing substance related needs, tailored to a holistic assessment of the child or young person's needs, delivered alongside relevant psychological therapies and mental health intervention and delivered in the context of a clear clinical governance framework. Where medication is used, prescribing protocols and best practice guidance are followed. Prescribing should be closely monitored and regularly reviewed by competent staff with involvement of family and parents as appropriate.

Age-appropriate pharmacological interventions for substance misuse need to involve specialist services such as paediatricians, young people's clinicians, primary care, CAMHS staff and addiction psychiatrists (Gilvarry & Britton 2009).

Particular care is required in settings such as secure estates, residential settings, acute or mental health hospitals, to ensure that treatments are available for the management of withdrawal if required, for example, alcohol and opiates. Care is required both on discharge from these settings, because of overdose risks; and in transition to adult services.

An important issue is the trend to polydrug use. Clinicians will need to carefully assess level of any dependence on each drug, particularly if alcohol and other drugs such as opiates are used together.

7.10.9 Alcohol dependence

The recommended medication for assisted withdrawal for alcohol dependence is a long acting benzodiazepine, either chlordiazepoxide or diazepam. The overall dose of the drug will vary and depend on the severity of the dependence on clinical assessment, the context of detoxification (e.g. hospital based or community) and the available monitoring over the withdrawal period. Those requiring medically assisted withdrawal, aged 10-17 years, should be offered inpatient care (NICE 2015). For older adolescents, the same principles apply as for assisted withdrawal in adults, though drug regimens and doses will differ (NICE 2015).

After a careful review of the risks and benefits, specialists may consider offering acamprosate or oral naltrexone in combination with a psychological intervention to young people over 16 who have not benefited from, or engaged in, a multicomponent treatment programme (NICE 2015).

7.10.10 Benzodiazepine dependence

Benzodiazepine dependence is unusual in young people, the problem characterised more commonly by bingeing on variable doses of benzodiazepines with illicit supplies (sometimes it is unclear as to the quality and amount consumed). If dependence is present requiring assisted withdrawal, diazepam is the choice of drug to use. The daily dose rarely needs to be above 30mg for initial induction and stabilisation, and usually requires a much smaller dose. It will depend on factors such as age and physique, and duration of use and the severity of withdrawals. A time-limited withdrawal should be planned. There is no evidence for maintenance or prolonged slow reduction in young people.

7.10.11 Stimulant dependence

There is no evidence for substitution pharmacological treatments to manage reduction and abstinence from stimulants. Stimulants are very varied, and include cocaine, amphetamines, stimulant NPS of different types, and combinations of these. Varying quality and purity is quite normal and the true chemical nature of some of the stimulants taken may well be unclear or unknown. Some individuals may present with problems of intoxication or with acute psychosis. Others may present with depression (often following cessation of use). Any physical health problems need to be addressed, with emergency assessment and treatment if needed. Other temporary states may need reassurance or may need symptomatic treatment (such as for agitation or psychosis) and care is needed to support individuals who may be at risk of self-harm. It is important to ensure any psychotic state is diagnosed adequately and has resolved with full recovery within days or so of cessation of use.

7.10.12 Cannabis dependence

Cannabis remains the most frequently used illicit drug by young people. Cannabinoid effects may also now be achieved through use of highly-potent synthetic cannabinoid receptor agonists (SCRAs). Cannabis dependence can occur in around 10% of users of cannabis. Withdrawals can also occur in some and these can contribute to sleep problems, agitation and risk of self-harm. These effects may need to be managed on cessation of use. Cannabis use can also exacerbate depression and it may cause an acute short-lived toxic psychosis, which resolves on cessation of use (but with possible need for antipsychotic medication,

if severe). Chronic cannabis use may be associated with persistent paranoid symptoms. Therefore, any prolonged, complicated psychotic state may need careful follow-up with mental health teams, for instance early intervention psychosis teams.

7.10.13 Nicotine dependence

Young people who screen positive for tobacco use in any service should receive advice and, if dependent, should be offered referral to smoking cessation services. Nicotine replacement therapies (NRT) have a strong evidence base in adults and appear to be safe in adolescents. It is important that those who are dependent on tobacco smoking in a particular setting, such as secure estates, should have NRT available, both on assessment and in the first days of entry to such settings, to support any withdrawal.

7.10.14 Opioid dependence

The main drugs used in the management of opioid dependence in young people are similar to those in adults, chiefly methadone and buprenorphine. Both drugs can be used to support assisted withdrawal over a number of weeks or months. They can also be used for longer-term stabilisation and for periods of maintenance and review.

The setting for induction and dose titration can either be in the community or through day care. This will depend on age of the child/young person, the severity of dependence and other issues such as the impacts of any mental health problems, other drugs used and family/social support. All such medication should be dispensed under supervision.

As for adults, comprehensive assessment of dependence by competent teams, including toxicology, is essential. Care must be taken regarding initial tolerance as this is not always so clear in young people. Induction and titration of dose is a similar process to adults but care must be taken on initial daily dose and initial increases, commonly starting on a smaller dose (such as under 30mg of methadone daily or less), taking account of the age and physique of the child/young person, but also mindful of the reported tolerance and evidence of intoxication or continued withdrawals following medication. Care is essential but giving too little methadone too slowly could also lead to additional use of illicit heroin, for example, with added risks. Very careful explanation to the young person, with assurance of frequent review to adapt treatment as needed, can address these issues.

For those dependent on prescription opioids, such as tramadol, or over-the-counter opioids, there is little evidence to guide medication choice. Clinical practice includes use either of substitution with buprenorphine or use of the original prescribed drug in reducing doses. Clinical consensus suggests that stabilisation on a long-acting substitute medication such as buprenorphine may be most useful, when acceptable, to allow time to assess all other needs, to fully engage the young person and their family, and to develop and implement a care plan. However, this may be decided on a case-by-case basis, while monitoring to ensure stabilisation (with avoidance of any 'highs' and of withdrawals).

The length of stabilisation period and duration of the detoxification will depend on the clinical risks, the severity of the dependence, other drug or alcohol use/dependence, social functioning, mental health problems, family context and offending behaviour.

Lofexidine can be used for young people where tolerance and dependence is unclear, and an appropriate decision is made regarding a supported detoxification (NICE 2007b).

Naltrexone relapse prevention pharmacotherapy for opioid dependence may be required for older adolescents (16+ years old), when it is important to ensure good supervision, support from family members and engagement in psychosocial support (NICE 2007c).

7.10.15 Management of comorbid disorders

Substance use, persistent use and dependence can all cause mental health problems, exacerbate existing problems and/or interfere with treatment of such problems.

It is important that all young people with significant drug and alcohol problems receive a comprehensive assessment of their mental health, including for issues of self-harm, autistic spectrum disorders, hyperactivity disorders, emerging personality issues, and any evidence of learning difficulties.

The mainstay of the treatment for comorbidity is addressing the range of a young person's identified personal, family, health and social care needs within which the substance use is occurring and maintaining carefully coordinated care. The treatments for comorbid mental disorders will vary but are mainly psychological, for example, CBT for depression. However, some young people may also need pharmacological treatments such as for ADHD or major psychotic disorders. Mental health treatment will often involve paediatrics and child and adolescent psychiatric services and there needs to be active communication and coordination with those providing, mainly psychological, interventions in young people's substance misuse services.

7.11 Older people

7.11.1 Key points

- An increasing number of service users in drug treatment are maintained on opioid substitution treatment into their 50s and beyond, have complex comorbidities and are prescribed multiple medicines.
- Seamless and supportive care for these patients is helped by a named clinician developing good relationships and communications with the patient's pharmacist and primary care team, and with, as appropriate, mental health or other specialist health and social care services.

7.11.2 Introduction

The importance of preventing and treating drug use problems in older people is becoming more pressing because the UK has a growing and ageing population.

Two distinct, but sometimes overlapping, groups of older people with problem drug use have been described and these have some clinical utility in considering the range of need. Older people with a long history of substance use that persists into later life – including long-term users of heroin, crack cocaine, tobacco or alcohol – can be described as the 'early onset users' to differentiate them from a sometimes quite distinct population of 'late onset users' of substances. The early users may well already have suffered significant complications of

their drug or alcohol use, which could have implications for their life expectancy and need for treatment (such as a need for hepatitis C treatment). Many long-term older drug users, especially heroin users, may have had long histories that include negative experiences with services such as childcare services, the criminal justice system and the healthcare system, which has damaged their trust in services. Those described as 'late onset users' may have begun using substances regularly only later in life, sometimes following stressful life events or lifestyle changes that typically occur later in life (such as retirement, marital breakdown, social isolation, increasing morbidity or bereavement). The latter group tends to be a larger but less visible population of older drug users typically using prescription or over-the-counter medicines (such as benzodiazepines and opioid analgesics), or problematic amounts of alcohol.

While stigmatising approaches are not consistent with established principles of good medical practice, some doctors and other healthcare staff may sometimes have treated drug users, seeking treatment for physical or mental health problems, with suspicion or with an attitude that they simply have a self-inflicted disorder. Such attitudes can influence the expectations or trust of older users of substances. Even within specialist addiction services, some people who use drugs may have received sub-optimal treatments or been excluded from services for somewhat tenuous reasons, with changes in the professional approach over time or simply with changes in treating staff.

Tobacco and alcohol use cause the greatest degree of harm at a population level in the older age group and these issues will need to be addressed in those attending for other drug treatment.

Drug treatment services now have increasing numbers of service users who are being maintained on opioid substitution treatment into their 50s and beyond. Nearly half of those in drug treatment services for opiate problems are now 40 and over. The number in this older age group starting treatment has risen in recent years despite a clear trend for the number overall starting treatment to be falling. This reflects a downward trend in incidence of heroin dependence alongside an ageing cohort of those already dependent for many years. The number aged 40 or over accessing treatment for alcohol problems has also risen in recent years. The average age of drug-related deaths (which are mainly related to opioids) has also increased over the last decade (with a greater proportion occurring in adults in their 30s and 40s). Continued injecting drug use remains a key factor in overdose deaths.

Prescriptions in the over-65s often include multiple medications, with plenty of scope for interactions and adverse effects. Those aged over 65 are particularly vulnerable to the effects of drugs and alcohol due to a fall in their ratio of body fat to water, reduced capacity to metabolise drugs, the potential presence of coexisting medical disorders and greater likelihood of drug-drug interactions.

Comorbidity can be a key factor, with increased risk with age of suffering from chronic pain, insomnia, bereavement, loneliness and mood disorders. In addition, impaired memory, immobility, incontinence, sensory impairment and iatrogenic problems can develop. These physiological and other health changes mean that older people, especially some over 65, can be at greater risk of harm when using even small amounts of alcohol, medications or other substances. Falls, in particular, can have serious consequences in later life. When prescribing any psychotropic drugs for this age group it is usually prudent to 'start low and go slow'.

Health practitioners need awareness of substance use in older people to identify and address problems and to understand that they may present with physical or mental health problems in the first instance. A GP may be alerted to a substance use disorder in an older person by their presentation with a disorder which might be linked to substance use, by demands for prescriptions for particular medicines or by contact with a concerned family member.

Older patients can achieve equivalent or better results than younger adults when they enter treatment for substance misuse. It is important that they have access to effective healthcare services where they will be catered for with dignity and sensitivity.

Table 5: Special health needs of older people with substance use problems

Complications related to a long history of drug and alcohol use	<ul style="list-style-type: none"> • hepatic damage due to hepatitis B or C infection or excess alcohol use (or a combination) • HIV infection • chronic airways disease from smoking tobacco or from inhaling drugs or TB • increased cardiovascular disease risk due to alcohol, smoking and lifestyle • venous damage (IV access can be difficult) and/or arterial damage • past cardiac valve destruction • poor dental health • family breakdown/relationship problems • mobility problems consequent on groin injecting • traumatic injuries due to falls, accidents or assaults • ongoing risk of overdose • impaired immunity • increased risk of cancer • chronic pain • impaired mental health (with increased risk of self-harm and suicide).
Polypharmacy	<ul style="list-style-type: none"> • increased risk of falls, sedation, cognitive impairment and road traffic accidents with polypharmacy, when prescribing sedating medicines such as benzodiazepines, hypnotics, antipsychotics, antihistamines, anticholinergics or other opioids • risk of drug-drug interactions which may increase or decrease methadone levels and to a lesser extent buprenorphine • risk of QTc prolongation when methadone is co-prescribed with a range of medications including antipsychotics, tricyclic antidepressants, citalopram, and erythromycin.

Normal ageing process	<ul style="list-style-type: none"> • increased sensitivity to alcohol or drugs or prescription medications • age-related disorders common in the elderly population, including chronic pain, hypertension, diabetes, cognitive impairment and chronic airways disease • loneliness, boredom and mental health problems for some who become isolated with age • alcohol or drug withdrawal syndromes may be more severe and prolonged • housing or financial problems can develop with dwindling resources or increased care costs.
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7.11.3 Specific considerations for providing drug treatment for older people

The following points are intended to assist professionals, working in health and social care settings, on the management of substance misuse in older people:

- Drug treatment services should ensure their services for older people are accessible and private, and have easy-to-read and prominently-displayed information leaflets. It should be possible to carry out assessments and treatment sessions within the service user's home when required.
- The needs of family members or carers should be recognised and addressed.
- Additional time may be required for comprehensive history-taking, providing or arranging physical examination and investigations, and obtaining collateral history.
- Additional to drug treatment interventions, age-appropriate general health screening and monitoring is needed for older people who use drugs.
- Medications which may cause dependence or increase the risk of falls or confusion should be used with caution. Particular care should be taken to avoid or minimise the long-term use of benzodiazepines, hypnotics, opioids and anticholinergics in older people. Any decision to continue these medications should be kept under active review.
- Some older people may have become infected with hepatitis C while using drugs for a limited period in early adult life. The possibility of chronic hepatitis C infection should be considered in any adult with unexplained abnormal liver function tests.
- Older people can benefit from treatment in individual and group settings. They may be less likely to drop out of treatment than younger people.
- There is no established superiority of dedicated substance misuse services for older people, although service user preferences can be taken in to account.
- Drug treatment services should have a lower threshold for arranging inpatient detoxification for older people.
- An integrated model of service delivery involving substance misuse, mental health, primary care and social care services, coordinated by a named individual, is likely to deliver best outcomes for the complex healthcare and social needs of older people who use drugs.

7.11.4 Older patients on long-term OST

A small but significant minority of older people who use drugs have been in receipt of opioid substitution treatment (OST) at regular intervals throughout their lives, or may have been in OST treatment continuously for many years. Some may show no obvious desire to come off their treatment, believing they have ‘finally achieved stability’ with their current treatment option, or they may have developed a safe and supportive long-term relationship with their prescriber that they do not wish to see end.

However, there may be more complex reasons behind an older person’s decision to stay longer in treatment, and therefore discussions around promoting change should be approached with sensitivity and understanding, as part of an individualised, service user-focused process. Previous, repeated difficult or unsuccessful attempts at becoming abstinent may leave a patient feeling that they are now too old (or too ill, too tired, or too afraid) to undertake such a degree of change. And an experience of repeated bereavements, imprisonment and family breakups may mean they do not feel they have the practical or emotional support required to create the kind of sustained change abstinence would require.

A few of these older patients may have learned techniques that have allowed them to ‘fade into the background’ of treatment services to avoid any unwanted or enforced changes to their lives, their treatment or their hard-won stability. Others may have experienced trauma, anxiety or animosity engaging with numerous treatment services and staff over many years. As such, they may show little, if any, willingness to engage proactively with their treatment providers.

These possibilities warrant particular consideration and awareness from the keyworker and clinician. Patients with a lifetime history of drug misuse and dependence can still hold great insights into their own behaviour, their own needs and the role and expectations of the drug treatment being offered, and listening to their experiences can provide the clinician or keyworker with important feedback on how best to proceed.

Older people receiving long-term OST can, and should, be regularly reviewed by their prescribing service as well as their GP, not least as attendance for physical health reviews become more regular and important. Mobility or accessibility problems are a very real consideration for such older patients expected to attend frequent appointments. Services need to find suitable solutions when pain, mobility or anxiety is a problem (see [section 2.7](#)).

As physical ill health problems become more prominent for many in this age group, it is important that clinicians are aware of possible damaged or absent relationships with, or confidence in, other healthcare providers and their expectations of and fears about engaging in treatments.

Developing good relationships and good communications with the patient’s pharmacist and primary care practice team are crucial to ensure seamless and supportive care, especially as comorbid health problems and polypharmacy become more prevalent.

It is important that older patients established on long-term prescribing for drug dependence, particularly with more uncommon treatments or on higher than average doses, where there is no current evidence of instability or deterioration in problems with dependence, should not be faced with arbitrary withdrawal of such treatments simply due to change of prescriber or change of service provider. Decisions about such prescribing should be based on careful,

individualised assessment and should take account of all relevant factors including historical assessments of need and responses to treatment; and should also take account of and respect the older person's right to equitable care (including adequate involvement in decisions that affect them and consideration of use of second opinion where there is disagreement about continuing a previous long-term prescribing arrangement). Such patients should, of course, never have their treatment withdrawn in an arbitrary fashion and any review should take account of whether their current treatment or an alternative is meeting or will better meet their needs.

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Annexes

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Declarations of interests

Members of the working group lodged written declarations of interests with the secretariat, and made oral declarations to the working group during discussion of related topics.

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Service user and carer representatives were supported and advised by national groups of user and carer representatives respectively.

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Secretariat was provided by Public Health England:

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Daniel Burn (to November 2015)
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A1.5 Reviews and synopses

A series of evidence reviews and topic synopses was commissioned by Public Health England to advise the working group. In addition to some obtained from members of the working group, these were provided by:

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A1.6 Other contributors

Other experts presented evidence and topic summaries directly to the working group, or sat on working groups developing sections of the guidelines:

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Professor John Dillon, University of Dundee, on the blood-borne infections subgroup

Alex Fleming, Department for Work and Pensions, on The Dame Carol Black review into the impact on employment outcomes of drug or alcohol addiction

Professor Sharon Hutchinson, Glasgow Caledonian University, on the blood-borne infections subgroup

Professor Stephen Pilling PhD, UCL, on the governance of psychosocial interventions

A2: Governance

A2.1 Quality governance

A2.1.1 Introduction

Quality governance is a term used to describe a structure and related processes to assure delivery of high-quality, safe and effective services. Quality governance components include lines of responsibility and accountability, quality improvement activities, policies that manage risk and procedures to identify and remedy poor performance. Some health and social care organisations and individuals are directly and statutorily accountable for elements of quality governance but all have a general responsibility to engage in activities that improve service user safety, service effectiveness and the service user experience.

Quality governance is a term widely used by the NHS and voluntary sector provider services and by commissioners. It has largely replaced the term 'clinical governance' that was used in the 2007 Clinical Guidelines, although depending on the setting it may be known as clinical and care governance or some variation.

A2.1.2 Background

There have been some influential inquiries affecting the current approach to quality governance, including the Francis Inquiry and the inquiry into Winterbourne View.

The Francis report on Mid Staffordshire NHS Foundation Trust found: "The first priority for any organisation charged with responsibility for performance management of a healthcare provider should be ensuring that fundamental patient safety and quality standards are being met. Such an organisation must require convincing evidence to be available before accepting that such standards are being complied with."

A key action from the Winterbourne View report states: "We expect directors, management and leaders of organisations providing NHS or local authority-funded services to ensure that systems and processes are in place to provide assurance that essential requirements are being met and that they have governance systems in place to ensure they deliver high quality and appropriate care."

A2.1.3 Areas of quality governance needing focus in substance misuse services

The following components of quality governance only include some of those relevant to the provision of clinical services to people who use drugs.

A2.1.4 Clinical effectiveness

Clinicians should use evidence-based interventions such as those supported by NICE, SIGN or in other authoritative guidance. They should also monitor their implementation and effectiveness through clinical audit or other quality improvement methodology. Protocols and linked training may be useful to ensure consistent provision and to support sharing of good practice. For all clinicians, monitoring and learning from research is essential. For some clinicians, there are opportunities to participate in research with their own teams or patients to help improve knowledge. Others will lead on developing their own research to establish new evidence for the field.

A2.1.5 Staff competencies

Clinicians need to have appropriate competencies for their clinical roles and receive training to achieve those competencies. They need to have appropriate certification, such as specialist registration, and take account of any professional revalidation. Non-clinical skills such as leadership and management development are also important. Clinicians benefit from individual or peer supervision, personal development plans, mentoring or other forms of professional support. Volunteers and peer mentors may also have relevant qualifications for their roles.

Clinicians have an obligation to update their knowledge and skills base according to emerging evidence and developments in professional practice. Appraisal is mandatory for all clinicians working in the NHS and is good practice in other settings.

It is particularly important for non-professional staff who may not have recourse to professional bodies to be supported and supervised to carry out their roles effectively.

The professional regulatory bodies (such as the Health and Care Professions Council, the General Medical Council, the General Pharmaceutical Council and the Nursing and Midwifery Council) are responsible for setting the standards of behaviour, competence and education of regulated healthcare professionals. They also have responsibility for registering professionals who meet those standards, and taking action where the standards are not met. For other clinical and care staff, national occupational standards (including DANOS) set out the competencies and qualifications required.

A2.1.6 Reporting of serious incidents and other near misses

Commissioners and their senior clinical advisors, as well as senior clinicians involved in delivery of the local healthcare system, should take a leading role in reviewing serious incidents (SIs) and significant adverse events, including (but not limited to) alcohol and drug deaths. This is likely to involve convening and leading a review of deaths, adverse events, systems and processes as appropriate. A review is designed to ensure that learning takes place following an event, that a structure is in place to support improvements and to monitor their impact. Providers need established processes to monitor and learn from incidents of a range of severity. Mechanisms for monitoring the effectiveness of safeguarding care and procedures are a more recent development.

A2.1.7 Risk management

Incident reporting, investigation and review, risk assessment, risk management and control and infection control normally constitute a duty of both an individual clinician and the organisation in which they work. Staff at risk of infection from patients should be appropriately immunised.

A2.1.8 Information governance

Clinicians need to keep patient records (electronic or paper); ensure appropriate information sharing, confidentiality and data protection; collect and analyse data; and make effective use of information and data. Service providers need to ensure appropriate policies and procedures are in place to support these professional and organisational objectives.

Information sharing can be of great value to the direct care of individual patients and may also contribute indirectly to the delivery and effectiveness of the drug treatment system. Information sharing protocols should be consistent with guidance from the local Senior Information Risk Owner (SIRO) and/or Caldicott Guardian (Caldicott Guardians are senior staff in the NHS and social services appointed to protect patient information) and any national guidance, and acknowledge that patient consent to disclosure is key in most situations where identifiable information is shared. SIROs are appointed at executive level to ensure information security policy and procedure is effectively implemented. Clinicians must be satisfied that local information sharing is consistent with guidance from their professional and regulatory bodies.

A2.1.9 Service users

Clinicians must take account of the needs and views of service users (and their carers) in planning the delivery of care. Feedback is a key element of effective quality governance. Services developed to meet the needs of service users are safer, more effective and deliver positive treatment outcomes. Good service user involvement can support effective quality governance by contributing to enhanced care and better service design, particularly if this is linked to quality improvement and related capacity and capability planning.

A2.1.10 Resources and further reading

How CQC regulates specialist substance misuse services provider handbook (CQC 2015)
www.cqc.org.uk/sites/default/files/substance_misuse_handbook_20150720.pdf

The role of addiction specialist doctors in recovery orientated treatment systems: a resource for commissioners, providers and clinicians (PHE, RCGP and RCPsych 2014)
www.nta.nhs.uk/uploads/the-role-of-addiction-specialist-doctors.pdf

Delivering quality care for drug and alcohol users: the roles and competencies of doctors – a guide for commissioners, providers and clinicians (RCPsych and RCGP 2012)
www.rcpsych.ac.uk/files/pdfversion/CR173.pdf

The contribution of clinical psychologists to recovery-orientated drug and alcohol treatment systems (British Psychological Society 2012) www.nta.nhs.uk/uploads/contributionofclinicalpsychologiststorecoveryorientateddrugandalcoholtreatment2012-022013.pdf

Alcohol and other drug use: the roles and capabilities of social workers (Galvani S 2015)
<http://www2.mmu.ac.uk/media/mmuacuk/content/documents/hpsc/research/Alcohol-and-other-drug-use-report.pdf>

The role of nurses in alcohol and drug treatment services: a resource for commissioners, providers and clinicians (PHE and RCN 2017) www.gov.uk/government/publications/role-of-nurses-in-alcohol-and-drug-treatment-services

Clinical and care governance framework (Scottish Government)
www.gov.scot/Resource/0049/00491266.pdf

Learning from adverse events through reporting and review (Healthcare Improvement Scotland) www.healthcareimprovementscotland.org/his/idoc.ashx?docid=3e877507-c77e-4bef-9566-852329abe425&version=-1

Health (Tobacco, Nicotine etc & Care) (Scotland) Act 2016, Part 2 Duty of Candour Procedure
www.legislation.gov.uk/asp/2016/14/part/2

NHS Scotland Information Security Policy Framework
www.informationgovernance.scot.nhs.uk/wp-content/uploads/2016/03/IS-Policy-Framework.pdf

A2.2 Confidentiality and safeguarding

A2.2.1 Confidentiality and information sharing

Clinicians must be satisfied that local guidelines and decisions concerning information sharing are consistent with the relevant legislation, guidance from GMC, NMC and other professional bodies, and with guidance from the local Caldicott Guardian.

Patient consent to disclosure should be sought in most situations where identifiable information is shared and information will be shared on a 'need to know' basis only. However, there may be incidents where information is shared without the consent and/or knowledge of the individual involved. Whenever a clinical relationship is entered into, the boundaries of this confidentiality must be discussed with the patient so that they understand what it means and how and when information is likely to be shared.

Information sharing can be of great value to the direct care of individual patients and may also contribute indirectly to the more effective delivery of the drug treatment system. Many patients, will, following appropriate discussion, be willing to consent to share appropriate personal information with relevant others on a need-to-know basis. It is important to maintain public confidence in the confidential nature of personal health information, while at the same time optimising use of such information. Therefore, identifiable information about patients must not be given to others unless the patient consents or where such disclosure without consent can be justified (for example, where it is important to share the information that is needed to address an imminent threat to the safety of another person, including a child in the patient's care).

Given the significant physical and psychiatric morbidity associated with drug use and complex pharmacological interactions between medications used to treat drug dependence and other medications, regular communication and relevant information sharing should normally always

take place with a patient's GP. In exceptional circumstances, treatment may continue despite a patient having withheld consent for sharing of information with their GP. To try to overcome this barrier, discussions will usually be held to address the underlying problem that lead to the withholding of consent. However, information sharing should always take place if the patient is to be in receipt of a prescription from the treatment service because of risks of potential drug interactions and because of the serious risks of, and for, a patient who may obtain duplicate supplies of medicines from two services. Similar principles apply for sharing suitable information with other relevant involved healthcare professionals (particularly other potential prescribers).

Local protocols on information sharing arrangements between the criminal justice system and health and social care providers of drug treatment can be useful. Such protocols describe and facilitate suitable information sharing arrangements that are consistent with legal and ethical obligations, and avoid unnecessary barriers or delays.

A2.2.2 Protecting children and adults

Across the four countries of the UK, the protection of children and vulnerable adults sits within different legislative and implementation frameworks. However, similar basic principles apply. The following sections will address some of these basic principles. It does not aim to replace relevant national and local guidance and training.

A2.2.2.1 Protecting and safeguarding children

Clearly, not all parents or carers with drug problems cause harm to their children, but, for some, substance misuse can significantly reduce their capacity to provide appropriate practical and emotional care.

The health or development of children of substance misusing parents or carers may be impaired to such an extent that the children suffer, or are likely to suffer, significant and long-term harm. Although the nature and the extent of the impact on a child will depend on a range of factors, evidence suggests that these children are more likely to experience serious neglect, emotional difficulties and lower educational attainment. Some of the children may also become more vulnerable to developing drug or alcohol problems themselves.

Additionally, some young people, as a result of parental or familial substance misuse, may take on inappropriate and unidentified caring roles, and do not receive appropriate support as young carers.

Individual clinicians, treatment services and those with accountability for protecting and safeguarding children locally, have a responsibility to patients' children for their wellbeing and to establish and maintain the suitable framework to minimise their risk of harm. This statutory and professional duty overrides a service's or individual clinician's responsibility to the patient. Clinicians need to take systematic steps to ensure that they assess risk to children, such as making sure that suitably detailed knowledge of a patient's children, and risks to them, are ascertained as a regular part of assessments.

If a clinician suspects a child may be at risk they must take steps, if necessary immediately, to deal with that risk. At the core of many child protection investigations is the failure to share important information between relevant agencies. Addressing this may require referral to involve others such as social services, usually in accordance with local relevant frameworks

and protocols. This should be done with the patient's knowledge, if possible, but not necessarily with their consent. The safety, welfare and wellbeing of a child are paramount when making decisions to share information with, or about, them. Parents have a right to express their views and to have them taken into account when decisions are made about what should happen to their children. In general, information will normally be shared with the knowledge and consent of the parent but where the child is at risk of significant harm, information may need to be shared without consent. The intention to share without consent, and the reasons for this, should be notified to the parent(s) unless it is believed this poses a risk to the child.

A2.2.2.2 Protecting and safeguarding adults

A substantial number of adults in need of treatment for drug misuse or dependence will be at risk of harm from self-neglect, from exploitation or from various forms of abuse and neglect by others. And, by virtue of their drug misuse alone or because of other problems, they may need help to protect themselves and to manage these risks.

Professionals, services and other agencies have a duty to identify individuals at risk, and to act alone and together to try to reduce current risk and harm and to protect such individuals from future harm.

Different statutory and policy frameworks exist in England, Wales, Northern Ireland and Scotland. And different local frameworks, policies and training are in place in different parts of the UK. These guidelines do not attempt to replicate these and readers need to check local guidance and arrangements relevant to their own practice.

However, it is important for clinicians to act on the responsibility expected of them for adult protection and safeguarding. This includes participating in adequate engagement and communications with affected individuals and with other professionals and agencies, when appropriate. Had clinicians and other professionals been more engaged and proactive in the past, and communicated more effectively, it is clear that vulnerable adults could have been protected rather than suffering serious harm.

Adults at risk may not ask for, or feel able to ask for, the help they need. Careful consideration needs to be given to the possibility that adults with problems with drug misuse and dependence may be at risk. This is a first step to identifying people who are currently at risk and who may need actions to safeguard them, and allows discussion with them about the possibility of, and options for, actions to minimise their risks.

It is important to consider whether an adult at risk has the capacity to make decisions about safeguarding themselves. Lack of capacity may affect the actions that can be taken and will be covered by local policies, guidance and training on capacity.

In many cases, however, adults attending for treatment of drug misuse and dependence will retain legal capacity for decisions they wish to make in relation to safeguarding. This does not limit the duty on clinicians to support the patient in minimising their risks. But the clinicians and the other professionals in their team, must work closely in what can be difficult circumstances to support the patient's own decision making, while keeping plans and assessment of risks under review. This can involve exploring carefully the patient's

circumstances, discussing the options open to the patient and making clear any additional support available, with a view to helping them make themselves safer.

Working to support adult service users at risk will commonly involve multidisciplinary and multi-agency working and resources. Joint working is an important aspect of the minimum standards of care expected of health and social care professionals when safeguarding at-risk and vulnerable adults.

Professionals should be proactive and positive in engaging affected individuals and encouraging them to allow reasonable sharing of relevant personal and sensitive information with other agencies in their own interests.

However, properly supporting individuals with capacity to make their own decisions, even ones that may involve risk or harm, does pose challenges. For example, an at-risk or vulnerable adult may be suffering psychological or financial abuse but refuse disclosure to agencies that could help. Clinicians continue to have a duty not to break confidentiality unless established exceptional grounds for doing so are met (such as certain cases of potential serious or imminent violence taking place).

In some parts of the UK, there is a new statutory duty on clinicians to share clinical confidential information on named individuals for purposes such as oversight of implementation of safeguarding. There is a clear public interest in having oversight of the systems for safeguarding. However, this new statutory duty for clinicians to disclose does not apply to managing the day-to-day clinical care and safeguarding of patients and does not provide a duty to disclose confidential information in such circumstances. It is essential that clinicians take an enabling and supportive approach to adults at risk, and work with colleagues to optimise the options available to those affected, empowering and supporting their patients to make their own safeguarding decisions. Clinicians should not assume, incorrectly, any authority that could undermine the patient's confidence in the duty of care and confidence expected of clinicians and of healthcare services.

A2.3 Non-medical prescribing

The term 'non-medical prescribing' refers to the prescribing of medication by health professionals other than doctors and dentists. In the context of alcohol and drug treatment, non-medical prescribing only generally applies to nurses and pharmacists. It is part of a range of NHS reforms designed to improve patients' access to medicines, develop workforce capability, use skills more effectively and ensure provision of more accessible and effective patient care.

There are two distinct forms of non-medical prescribing:

Independent prescribing is carried out by clinicians who are responsible and accountable for assessing patients with undiagnosed or diagnosed conditions and for deciding the clinical management required, including prescribing. Independent prescribers can prescribe licensed or unlicensed medicines within their clinical competence.

Supplementary prescribing is a voluntary partnership between an independent prescriber (usually a doctor) and a supplementary prescriber (nurse, midwife or pharmacist) to implement an agreed patient-specific clinical management plan (CMP) with the patient's agreement. The independent prescriber makes the initial diagnosis then both

prescribers prepare and agree the individualised CMP. Non-medical prescribers (NMPs) can then prescribe within the parameters set out in the CMP.

NMPs as supplementary prescribers have joint responsibility with the independent prescriber for the content of the CMP, but the NMP is still solely responsible for the decision to prescribe within the scope of a clinical management plan.

A2.3.1 Non-medical prescribing in clinical practice

Legislative change in 2012 means that NMPs can now assess, diagnose and independently prescribe for the treatment of drug misuse and dependence. As a result, supplementary prescribing has limited utility. Since 2012, non-medical prescribers can independently prescribe controlled drugs for the treatment of dependence, with the exception of diamorphine, cocaine and dipipanone.

Non-medical prescribing is now integrated into treatment systems across the UK and has enabled service providers to deliver more flexible services. Independent NMPs have the same responsibilities and accountabilities as medical prescribers so these clinical guidelines and other prescribing guidance is equally applicable to all prescribers, regardless of professional discipline.

However, an important consideration is that medical and non-medical prescribing roles are complementary, and not fully interchangeable, and care needs to be taken to ensure NMP is delivered safely and effectively within treatment systems. As with all prescribers, NMPs must only prescribe within their scope of competence. It is essential that the skill mix of multidisciplinary teams caring for people with alcohol and drug problems has the required competence to manage an increasingly complex treatment population. The NMP must have access to a suitable medical practitioner for advice (normally an addiction psychiatrist or GP with special interest in drug misuse), recognise the limits of their competence and refer patients whose clinical needs fall outside these limits to an appropriate colleague.

A2.3.2 Resources and further reading

Non-medical prescribing in the management of substance misuse (Public Health England 2014) www.nta.nhs.uk/uploads/nmp-in-the-management-of-substance-misuse.pdf

Non-medical prescribing in Wales: A guide for implementation (Welsh Assembly Government 2011) www.wales.nhs.uk/sitesplus/documents/861/Non%20medical%20prescribing%20guidance%202011.pdf

Non medical prescribing in Scotland (Scottish Government, web) www.gov.scot/Topics/Health/NHS-Workforce/Pharmacists/Non-Medical-Prescribing

Prescribing by non-medical healthcare professionals (Department of Health, Northern Ireland, web) www.health-ni.gov.uk/articles/pharmaceutical-non-medical-prescribing

A3: Marketing authorisations

Drug manufacturers seeking permission to bring newly developed medicinal products and devices into the UK market must gain regulatory approval through the Medicines and Healthcare products Regulatory Agency (MHRA), an executive agency of the Department of Health, and in accordance with the Human Medicines Regulations 2012. Unless exempt, all medicines must gain a marketing authorisation (previously called a product license) before sale or supply in the UK. Some medicines used in the UK are licensed by the European Medicines Agency rather than the MHRA. A marketing authorisation lasts for five years and covers all the main activities associated with the marketing of a medicinal product.

A3.1 'Off-label' or 'unlicensed' prescribing

The Medicines Act 1968 and its regulations provide exemptions that enable appropriate practitioners to use, or advise the use of, licensed medicines outside the recommendations for the licence, or to override the warnings and precautions given in the licence. Independent or supplementary prescribers usually prescribe these medicines based on previous professional experience, published studies or newly presented findings. This is called 'off-label' prescribing.

A medicine used outside of the terms of its license, or that has no recognised license for use in the UK, is known as 'unlicensed'. Unlicensed medicines can be prescribed if the appropriate practitioner concludes "for medical reasons, that it is necessary to do so to meet the specific needs of the patient" (GMC 2013).

NHS bodies, independent or supplementary prescribers, dispensers and those administering medicines must take precautions to ensure that the use of 'off label' or 'unlicensed' medications is managed properly. There should be local governance arrangements in place to provide guidance and to monitor the use of 'unlicensed' and 'off-label' medicines.

According to MHRA guidance, there are several factors to consider before 'off-label' or 'unlicensed' prescribing:

- If a UK-licensed product can meet the clinical need, even off-label, it should be used instead of an unlicensed product.
- Responsibility for deciding whether an individual patient has 'special needs' which a licensed product cannot meet should be a matter for the prescriber responsible for the patient's care. Examples of special needs include an intolerance or allergy to an ingredient, or an inability to ingest solid oral dosage forms.
- The requirement for a special need relates to the special clinical needs of the individual patient. It does not include reasons of cost, convenience or operational needs.

- Anyone supplying an unlicensed medicinal product, where an equivalent licensed medicinal product is available, must be satisfied as to the existence of a special need for the unlicensed medicinal product. Documentary evidence of this special need should be obtained by manufacturers, importers or distributors and made available on request. This evidence may take the form of a prescriber's letter, however, as an alternative, a fully-documented audit trail through the supply chain confirming special need may be acceptable.

A3.2 Young people

Many medicines that are given to children and young people are not licensed for the particular indication, the age of the child or for the route of administration. In these cases, the informed use of unlicensed medicines or of licensed medicines for unlicensed applications ('off-label' use) is often necessary if young people are to have access to the most effective medicines.

Children are different from adults: their bodies metabolise medicines differently and young children respond differently than older children. Detailed care and attention therefore needs to be taken when making prescribing decisions for children and young people, taking into account their age, weight and developmental stage. When making the clinical decision to prescribe these drugs, the risks and benefits of the treatment must be considered and fully documented (Gilvarry and Britton 2009).

Information must be given to the young person and their parents on the nature of the drug to be used, the likely effect, the timing of this effect and the safety and licensing of the medication. It would be useful if this information was available in leaflet form as well as discussed verbally. Any difficulties in literacy skills need to be acknowledged. This information is important for several reasons:

- young people need to feel their dosage adjustments are for their own comfort and safety, rather than any punishment system
- it ensures informed consent can be given
- it facilitates understanding of treatment given including likely outcomes.

Above all, health professionals, health service managers, parents and carers who prescribe, dispense, or have responsibility for administering medicines have a duty to ensure children and young people are "able to receive medicines that are safe, effective, appropriate for their condition, palatable and available with minimal clinical risk" (RCPCH 2013).

A3.3 References

General Medical Council (2013) Good practice in prescribing and managing medicines and devices. Available at: www.gmc-uk.org/static/documents/content/Prescribing_guidance.pdf

Medicines and Healthcare products Regulatory Agency (2014) The supply of unlicensed medicinal products ("specials"): MHRA Guidance Note 14. Available at: www.gov.uk/government/uploads/system/uploads/attachment_data/file/373505/The_supply_of_unlicensed_medicinal_products_specials.pdf

Gilvarry E and Britton J (2009) Guidance for the pharmacological management of substance misuse among young people in secure environments. Available at: www.nta.nhs.uk/uploads/guidance_for_the_pharmacological_management_of_substance_misuse_among_young_people_in_secure_environments1009.pdf

Royal College of Paediatrics and Child Health (2013) The use of unlicensed medicines or licensed medicines for unlicensed applications in paediatric practice. Available at: www.rcpch.ac.uk/system/files/protected/page/The%20use%20of%20unlicensed%20medicines%20or%20licensed%20medicines.pdf

Table 6: Marketing authorisations for medicines used in the treatment of drug dependence in adults

Pharmacological group	Drug/Preparation	Marketing authorisation status for the treatment of drug dependence in adults
Opioid agonists and antagonists	Methadone oral solution 1mg in 1ml Methadone oral solution 1mg in 1ml sugar-free	Authorised
	Methadone oral concentrate (blue) 10mg in 1ml Methadone oral concentrate (brown) 20mg in 1ml Methadose diluent	Authorised (NB The final strength of the methadone solution to be dispensed to the patient must be specified on the prescription) Use with diluent.
	Methadone injection 25mg in 1ml – ampoules of 2ml Methadone injection 50mg in 1ml – ampoules of 1ml	Authorised
	Methadone tablet (oral)	Not authorised
	Naltrexone (oral)	Authorised as adjunct for relapse prevention. Not all brands are licensed for drug dependence
	Naltrexone (depot)	Not authorised
	Buprenorphine (sublingual)	Authorised
	Buprenorphine-naloxone (sublingual)	Authorised
	Dihydrocodeine (any route) Codeine (any route) Morphine (any route)	Not authorised

Pharmacological group	Drug/Preparation	Marketing authorisation status for the treatment of drug dependence in adults
	Diamorphine (heroin) (any route)	Not authorised. Diamorphine for the treatment of drug dependence can only be prescribed under a Home Office licence issued pursuant to the Misuse of Drugs (Supply to Addicts) Regulations 1997
Benzodiazepines	Diazepam (oral)	Authorised for benzodiazepine and alcohol withdrawal
	Chlordiazepoxide (oral)	Authorised for alcohol withdrawal
Amphetamines	Dexamfetamine (any route)	Not authorised
Alpha-adrenergic agonists	Lofexidine (oral)	Authorised for management of opioid withdrawal
Cigarette smoking	Bupropion (oral)	Authorised as adjunct to smoking cessation in combination with motivational support
	Nicotine (patches, gum, lozenges, nasal spray, inhalator)	Authorised as adjunct to smoking cessation
	Nicotine (e-cigarettes)	At the time of writing just one electronic cigarette has a marketing authorisation as an adjunct to smoking cessation. Others seem likely to follow
	Varenicline (Champix)	Authorised as adjunct to smoking cessation

Table 7: Marketing authorisations for medicines used in the treatment of drug dependence in young people

Pharmacological group	Drug / Preparation	Marketing authorisation status for the treatment of drug dependence in under 18s
Opioid agonists and antagonists	Methadone oral solution 1mg in 1ml Methadone oral solution 1mg in 1ml sugar-free	Not authorised for children. 'Children' in this context is generally recognised to mean those aged 13 and younger, however, manufacturers note the lack of evidence for adolescents.
	Naltrexone (oral)	Not authorised as adjunct for relapse prevention in under 18s. Not all brands are licensed for drug dependence
	Buprenorphine (sublingual)	Authorised for those aged 15 plus with opioid dependence
	Buprenorphine-naloxone (sublingual)	Authorised for those aged 15 plus with opioid dependence
	Dihydrocodeine (any route) Codeine (any route) Morphine (any route)	Not authorised for the treatment of dependence and not recommended
Alpha-adrenergic agonists	Lofexidine (oral)	Not authorised for management of opioid withdrawal in under 18s
Cigarette smoking	Bupropion (oral)	Not recommended in those under 18 years
	Nicotine (patches, gum, lozenges, nasal spray, inhalator)	All products are authorised for adults and children over 12 except for Nicotinell lozenges which are licenced for under 18s on the advice of a doctor
	Nicotine (e-cigarettes)	At the time of writing no electronic cigarette has a marketing authorisation for under 18s
	Varenicline (Champix)	Not authorised for under 18s

A4: Writing prescriptions

NB: This annexe covers the requirements for writing prescriptions for Schedule 2 and 3 controlled drugs for the treatment of drug dependence for dispensing by a community pharmacist.

A4.1 General considerations

Writing prescriptions for controlled drugs (CDs) is complicated as it is necessary to consider:

- the safety of the patient and others, for example, dependants, partners and the wider community
- communication between the prescriber and the dispensing pharmacist
- the legal requirements of the Misuse of Drugs legislation and NHS legislation, and the legal and good practice requirements implemented as a result of the Shipman inquiry
- additional requirements when prescribing relating to instalment prescriptions.

A4.2 Patient safety

Patients must be advised:

- of the requirements of safe storage of methadone, buprenorphine and other prescribed medicines:
 - all medications must be stored safely and kept out of reach and out of sight of children and vulnerable individuals
 - empty methadone containers should be rinsed thoroughly and disposed of safely
- of the risks of overdose and death if an opioid-naïve person takes opioids
- of the availability of take-home naloxone
- that children (under 18) of patients prescribed controlled drugs must not be authorised to collect their parents' (or others') medication from the pharmacy.

The person collecting the medicine from the dispensing pharmacy will be required to sign the back of the prescription form when collecting Schedule 2 (for example, methadone) or Schedule 3 (for example, buprenorphine) controlled drugs. Legislation states that the pharmacist must ascertain whether the person collecting is the patient, patient's representative or healthcare professional. In the case of Schedule 2 prescriptions (for example, methadone), the person may, if not already known to the pharmacist, be asked to present some form of identification. If the person collecting the Schedule 2 controlled drug

is a healthcare professional acting in their professional capacity on behalf of the patient, the pharmacist must ask for identification and obtain evidence of the name, address and professional registration number of the healthcare professional.

Note that the requirements for signing the prescription and identification on collection apply to instalment prescriptions only on the first occasion that the patient presents. However, it is at the discretion of the pharmacist who, in special circumstances, may supply without these requirements being met.

Patients should normally collect the controlled drug in person. If they are unable to collect prescriptions in person, they may authorise a representative to collect it. In such circumstances, the pharmacist is advised to obtain a letter from the patient that authorises the named representative to collect the medicine on their behalf on that day. The pharmacist will retain the letter. Such authorisation is also recommended, for example, when a patient is in custody, to authorise a named police officer to collect an instalment from the pharmacy. The decision on whether to supply is at the discretion of the supplying pharmacist and is based on their professional judgement. Authorisation letters help to prevent misunderstandings or deceit. The record of supply in the controlled drugs register should record details of the patient's representative.

A4.3 Legal and good practice requirements

Do not leave blank prescription forms unattended. When not in use, keep in a suitable place. NHS Protect has produced guidance on the security of prescription forms:

www.nhsbsa.nhs.uk/Documents/SecurityManagement/Security_of_Prescription_forms_Updated_August_2015.pdf

Practitioner Services have produced similar advice for NHS Scotland:

www.psd.scot.nhs.uk/professionals/pharmacy/documents/security_of_prescription_form_guidance-final_July2012_000.pdf

The Northern Ireland Medicines Governance website has comparable advice at:

www.medicinesgovernance.hscni.net/primary-care/gp-practice/prescription-security/

A pharmacist is not allowed to dispense a controlled drug unless all the information required by law is given on the prescription. The pharmacist can make some changes (see A3.4) but cannot agree other changes requested by the prescriber by telephone or letter. If an incomplete prescription is returned by the pharmacist then the prescriber signing the prescription must make the necessary alteration(s). In an emergency, the Home Office has stated that it would be acceptable for another doctor or health professional, who is allowed to prescribe CDs under the legislative rules and is based at the same working address, to amend a controlled drug prescription, provided that he or she signs and dates the whole prescription, not just the amendment, and therefore accepts responsibility for the prescription in its entirety. A prescription must satisfy the following criteria:

- It must be indelible. It can be computer generated.
- It must be signed by the prescriber with their usual handwritten signature – the dispensing pharmacist must be acquainted with the prescriber's signature and believe it to be genuine, or take reasonable steps to satisfy themselves that it is genuine.

- It needs to include the date on which it was issued (a computer-generated date or rubber stamp is acceptable). Controlled drug prescriptions are valid for 28 days after the appropriate start date on the prescription. The appropriate date is either the issue date or any other date indicated on the prescription (by the prescriber) as the treatment start date before which the drugs should not be supplied, whichever is the later. There are specific circumstances, normally at holiday periods, where the pharmacy may be closed on the treatment start date. If the issue date is before the treatment start date and the appropriate Home Office wording is included regarding pharmacy closed days (see table 8), the pharmacist can exercise professional judgement on the appropriate supply date to ensure there is no disruption to treatment.
- It must specify the prescriber's address, which must be in the UK (does not include the Channel Islands or the Isle of Man).

The prescriber's name should be legible – it may be pre-printed on the prescription or added in block capitals. It is good practice to include the prescriber's registration number and the profession of the person signing the prescription.

Non-medical prescribers must include the type of non-medical prescriber (IP or SP) and PIN or professional registration number.

Following legislation changes in 2012 Pharmacist Independent Prescribers (PIP) and Nurse Independent prescribers (NIP) can prescribe, administer and give directions for the administration of Schedule 2, 3, 4 and 5 controlled drugs. Other non-medical prescribers also have rights for prescribing CDs. There may be some restrictions depending on the type of prescriber and whether they are independent or supplementary prescribers. Check the Home Office website for the current status.

Carbon copied or faxed prescriptions are not acceptable for Schedule 2 and 3 controlled drugs. The prescription must always state the following:

- The name and address of the patient. An email address or PO Box is not acceptable. 'No fixed abode' (or NFA) is acceptable as an address for homeless people.
- In the case of a preparation, the form and where appropriate the strength of the preparation.
- The total quantity of the preparation, or the number of dose units, in both words and figures (for liquid methadone preparations, the total quantity must be stated as a volume in millilitres, not a weight in milligrams).
- The daily dose, or dose of each amount to be taken, and the frequency (note that simply 'as directed' is not acceptable (although 'one as directed' can be acceptable – see table 8).
- In addition to the daily dose, when prescribing in instalments, the prescription must specify the total amount of each instalment to be supplied AND the interval(s) between instalments.

Other points:

- England and Wales – use the special instalment prescription forms if more than one pick-up is required. In England, Schedule 2 CDs, buprenorphine and buprenorphine-naloxone, and diazepam can be supplied by instalments on blue FP10MDA-S and FP10MDA-

SS forms. In Wales, Schedule 2, 3, 4 and 5 CDs can be supplied by instalments on the green form WP10MDA. For private prescriptions specially designed forms include, in England, the pink form FP10PCD and, in Wales, the green private WP1-PCD and WP10PCDSS forms. In Scotland, orange GP10, blue HBP and pink HBP(A) forms (and their equivalents for non-medical prescribers), and the beige private PPCD form, can be used for prescribing instalments. In Northern Ireland, HS21 forms may be used by GPs for instalment dispensing (and their equivalents for non-medical prescribers). A complete description of forms and validity for prescribing in the UK is available at: <http://psnc.org.uk/dispensing-supply/receiving-a-prescription/is-this-prescription-form-valid/>

- The prescription must specify an instruction to allow medication to be collected on days to cover when the pharmacy is closed. See table 8 for specific Home Office approved wording, which can be added to prescriptions to enable such advance supplies for unplanned pharmacy closures. If the prescription is stating the need to provide in advance for a Sunday, for example, the amount to supply in advance must be stated (as for any other planned instalment supply).
- The pharmacist must only supply the prescription on the date on which it is due. If the patient does not collect an instalment when it is due, that supply is no longer valid – the patient cannot collect that instalment on another day. Part instalments may be collected provided the approved Home Office wording is included on the prescription (see table 8).
- Additional wording can be added to the prescription to allow the pharmacist to supply part of an instalment; for example, if the patient is required to collect more than one day's supply at a time and misses the specified day for collection, the patient will be able to collect the remaining balance of the instalment provided additional wording authorising this is included on the prescription. This wording must be as approved by the Home Office. Examples of Home Office approved wording are given in table 8.
- Only medical practitioners who hold a special licence issued by the Home Secretary (or, in Scotland, the Scottish Government as detailed in CEL (2012) 35) may prescribe, administer or supply diamorphine, dipipanone or cocaine in the treatment of drug addiction. Currently, non-medical prescribers are not considered to be 'medical practitioners' for this purpose and so may not prescribe these drugs or obtain a special licence.
- In most circumstances, when prescribing substitute opioid medicines, no more than one week's total supply should be dispensed at one time, except for holidays and special arrangements.
- Prescribers should restrict prescriptions for Schedule 2, 3 and 4 controlled drugs to amounts of no more than is sufficient to meet the patient's clinical needs for up to 30 days, except in exceptional circumstances. FP10MDA forms are limited to two weeks' supply.
- It is good practice to write a start date on the prescription which is clear and unambiguous. Prescriptions for Schedule 2, 3 and 4 controlled drugs are valid for 28 days from the date of signing if no start date is specified. A start date, even if more than 28 days after the date of signing issue, will ensure the prescription is still valid. The pharmacist will not be able to supply the prescription before the start date or date of signing/issue.

- Where a start date is not included, in the case of instalment prescriptions, the first instalment must be dispensed within 28 days of the date of signing, with the remainder instalments dispensed in accordance with the instructions. Although legally valid for 28 days, the pharmacist should confirm with the prescriber that the prescription remains clinically valid if there is an extended time between the date of signing and the date the prescription is presented for dispensing.
- Alterations are best avoided but if any are made they should be clear and unambiguous. NHS Protect recommends that alterations should be signed and dated by the prescriber.
- The name of the dispensing pharmacy (chosen by the patient) may be added to the prescription. However, the patient will still retain the right of choice to take their prescription elsewhere. It is good practice for a pharmacy to confirm before supply any prescription brought in that carries a different pharmacy's name.
- The name and address of the dispensing pharmacy should be written in the patient's notes.

A4.4 Minor amendments

Where the prescriber's intentions are clear, pharmacists are permitted to make minor technical amendments to CD prescriptions for Schedule 2 or 3 drugs. The error must be a minor spelling or typographical error or the omission of either words or figures in the total quantity (but not both).

The pharmacist making the amendment must amend the prescription in ink such that the change is attributable to them.

A4.5 Additional country-specific rules

A4.5.1 England

- Do not write instalment prescriptions for durations of longer than 14 days on FP10MDA forms.
- Instalment prescriptions (FP10MDA) can only be used for the treatment of addiction using Schedule 2 controlled drugs (for example, methadone), buprenorphine (Schedule 3), buprenorphine-naloxone (Schedule 3) and diazepam (Schedule 4). Single supplies of water for injections can also be prescribed where appropriate, for example, when diamorphine dry powder injection is prescribed to be dispensed in instalments.
- The FP10MDA instalment prescription forms cannot be used for other Schedule 3, 4 or 5 controlled drugs; for example, dihydrocodeine 30mg tablets (Schedule 5) or temazepam (Schedule 3) cannot be prescribed in instalments using this form.
- FP10MDA forms are available as either pads of 10 ten prescriptions (pre-printed with prescriber details and service address) or as FP10MDA SS (single sheet). FP10MDA SS are intended for computer generated prescribing available as boxes of 500 forms – although they can also be used for occasional handwritten prescribing however full prescriber details, service address and cost centre codes need to be added.

- Hospital FP10HMDA forms are pads of 50 forms pre-printed with prescriber details and service address overwritten with the words 'hospital prescriber'. Hospital prescribers (only) can also prescribe single supplies of any other medicine prescribable on FP10 using FP10MDA SS forms.
- Green FP10NC forms can only be used to order a single supply (not instalments).
- Patients should be warned that, in the case of Schedule 2 CDs, they will usually be asked to show identification to the dispensing pharmacist when collecting their medications.
- Pharmacists in England can only dispense Welsh instalment prescriptions for Schedule 2 controlled drugs, buprenorphine, buprenorphine-naloxone and diazepam and therefore cannot dispense instalment prescriptions for other Schedule 3, 4 and 5 controlled drugs.
- Legislation change from 1st July 2015 allows Schedule 2 and 3 controlled drugs to be prescribed and dispensed using the Electronic Prescription Service (EPS R2) release 2. EPS release 2 prescriptions for Schedule 2 and 3 controlled drugs will need to satisfy the usual prescription writing requirements including the need to express the total quantity in words and figures. The date when pharmacy teams will start to receive such prescriptions has yet to be confirmed.
- English, Scottish and Welsh prescriptions dispensed in an English pharmacy are subject to prescription charges according to English rules.

A4.5.2 Wales

- Do not write prescriptions for durations of longer than 14 days on the WP10(MDA) or WP10HP(AD) forms.
- Instalment prescriptions WP10(MDA) and WP10HP(AD) can be used to order any Schedule 2, 3, 4 and 5 controlled drug in instalments.
- Pharmacists in England can only dispense Welsh instalment prescriptions for Schedule 2 controlled drugs, buprenorphine, buprenorphine-naloxone and diazepam and therefore cannot dispense instalment prescriptions for other Schedule 3, 4 and 5 controlled drugs.
- WP10 forms can only be used to order a single supply.
- Patients should be warned that, in the case of Schedule 2 CDs, they will usually be asked to show identification to the dispensing pharmacist when collecting their medication.

A4.5.3 Scotland

- There is no 14-day instalment restriction (as separate instalment prescriptions are not used). Prescriptions for Schedule 2, 3 and 4 CDs will be valid for 28 days from the date signed by the prescriber or from the date specified by the prescriber. The 30 days' supply stated in the guidance is good practice.
- Forms GP10 and HBP, and their non-medical prescriber equivalents, can be used to prescribe any medicine (including non-schedule prescription only medicines) to be dispensed in instalments.
- Form HBP(A) is issued in Scotland by drug dependence clinics and can be used to order any medicine used in the treatment of addiction.

- It is good practice to include the patient's identifier on the prescription; in Scotland this is the Community Health Index (CHI) number.
- In Scotland, the additional form PC70 is used by community pharmacies to record individual supplies of a controlled drug when dispensed in instalments and is required to allow recording of date and quantity supplied.

A4.5.4 Northern Ireland

- In the community, form HS21 is used by prescribers in Northern Ireland treating people who use drugs.
- SP forms are used by specialist drug treatment services.
- SP and HS21 forms can be used to prescribe methadone solution 1mg in 1ml, methadone tablets (methadone hydrochloride 5mg) or sublingual buprenorphine (including buprenorphine-naloxone) for instalment dispensing, subject to Department of Health (DOH) guidelines (www.health-ni.gov.uk/publications/safer-management-controlled-drugs-guide-strengthened-governance-arrangements-northern).

A4.6 Other considerations

For liquid preparations, for example, methadone oral solution 1mg in 1ml, it is essential that the patient is able to accurately measure their daily dose. It is recommended that all take-home doses should be supplied as measured doses in individual containers with child-resistant lids (to enable accurate daily dosing, promote compliance and safety, and reduce the risks of unauthorised ingestion).

From April 2013, a new payment structure was agreed for all prescriptions in England (FP10MDA or FP10) where oral liquid methadone is prescribed. An additional fee per dose where the pharmacist has packaged each dose separately is paid. Under Schedule 4, paragraph 8 (11), of the NHS (Pharmaceutical and Local Pharmaceutical Services) Regulation 2013, pharmacists are required to consider and decide the most appropriate method of packaging oral liquid methadone. They are also required to package in accordance with that decision. Where a prescriber has specified that each dose of the medicine should be packaged separately, the pharmacist must exercise their professional judgement having regard to the prescriber's views. Where, in their professional judgement, it is appropriate to deviate from the prescription, they should discuss this with the patient and prescriber and record the outcome of the discussion, as appropriate.

If local policies support pharmacists crushing buprenorphine tablets (an unlicensed use of the medicine) then the local policy and lines of accountability should be clearly indicated in the policy or protocol. Pharmacists may need to take out additional insurance to cover this procedure (the National Pharmacy Association will indemnify members provided they comply with the NPA model protocol). Procedures describing the crushing of doses must be evidence based, and fully supported by any local group that monitors shared care, the prescriber, and clinical governance leads. Informed patient consent must be obtained. A risk assessment must be made to minimise or remove any risks to the operator or patient from crushing (potential risks include danger to staff from inhaling the powder, and danger to the patient

from crushing the tablets so finely that they create a sludge that sticks to the buccal mucosa). Patients should be offered a drink of water before taking their dose.

Colour-free or higher-strength methadone oral solution is not recommended for routine use due to the possible increased potential for misuse and increased safety concerns.

Local dental policies may advocate always prescribing sugar-free preparations. Pharmacists can only supply sugar-free methadone oral solution if specifically prescribed. However, some brands of sugar-free methadone solution may lead to unacceptable side effects in some patients due to intolerance of artificial sweeteners or side-effects secondary to a high sorbitol content, for instance nausea, stomach cramps and diarrhoea.

Patients should still be advised to rinse their mouth with water, and preferably brush their teeth after consuming the sugar-free methadone, to minimise adverse effects on their teeth (however, the brushing should normally be delayed for half an hour or so if the patient has recently consumed acidic food or drink). More detailed advice for patients on oral hygiene is provided in [section 6.7 \(box 4\)](#).

A4.7 Examples of what to write on a prescription

See table 8.

(M) indicates mandatory requirements for a controlled drug prescription

(R) indicates things that are not legally required but are strongly recommended to help prevent missed doses and errors, and ensure the patient receives optimum care

(HO) indicates Home Office approved wording

Table 8: Examples of prescription writing

What you want to prescribe (M) Mandatory CD requirement (R) Not legally required but strongly recommended (HO) Home Office approved wording	Examples of what to write on the prescription (notes in italics)	
Drug (M)	Methadone	Buprenorphine <i>NB The Temgesic brand is licensed for analgesia, not substitute opioid prescribing. The patient information leaflet supplied will not give the appropriate information on substitute prescribing.</i>
Form (M)	Oral solution	Tablets <i>The word 'tablets' must still be included even if implicit in the name of the drug.</i>
Strength (M) (where appropriate)	1mg in 1ml <i>When prescribing 10mg/ml or 20mg/ml preparations, the final strength to be dispensed to the patient must be specified on the prescription.</i>	400 micrograms, 2mg, 8mg or a combination <i>Can be included as part of total quantity – see below. NB Subutex or Suboxone brands are not available as 200 microgram tablets. This strength should not be prescribed in the treatment of opioid addiction as the patient information leaflet will not give appropriate information.</i>
Sugar free	SF	n/a
Dose (M)	60mg daily <i>(60ml daily is also acceptable for liquids as the strength must be included on the prescription)</i>	12mg daily (as one 8mg tablet plus two 2mg tablets) <i>Only the controlled drug component of the combined preparation needs to be specified.</i>
For how long (R)	<i>'to be taken as directed' is not acceptable 'one as directed' is acceptable for solid dose formulations</i> See section A4.5 on country specific rules	

What you want to prescribe (M) Mandatory CD requirement (R) Not legally required but strongly recommended (HO) Home Office approved wording	Examples of what to write on the prescription (notes in italics)	
<p>Total quantity of <u>dose units</u> in WORDS and FIGURES (M)</p> <p>If either words or figures (but not both) are missing the pharmacist can add the missing item as a minor technical amendment</p>	<p>840ml eight hundred and forty ml (or millilitres) <i>(milligrams or mg is NOT acceptable)</i></p> <p><i>For all liquid controlled drug formulations the total quantity should be expressed as millilitres</i></p>	<p><i>If there are different strength tablets, the quantities for each strength must be listed in words and figures, either as:</i></p> <p>1. 'numbers of tablets' e.g: 7 (seven) x 8mg tabs 14 (fourteen) x 2mg tabs</p> <p><i>or as:</i></p> <p>2. 'milligrams' e.g. 56 (fifty-six) mg as 8mg tablets 28 (twenty-eight) mg as 2mg tablets</p> <p><i>For clarity, the name of the drug should also appear each time for each different strength so that there can be no ambiguity. If there is only one strength of tablets specified, the total can be provided simply in numbers of tablets or milligrams e.g. as:</i> 112 (one hundred and twelve) mg, <i>or</i> 14 (fourteen) tablets</p>
<p>Supply by daily instalments</p> <p>Use of HO wording outlined below</p>	<p>Supply daily in instalments</p> <p>Please dispense instalments due on pharmacy closed days on a prior suitable day</p>	<p>Supply daily in instalments</p> <p>Please dispense instalments due on pharmacy closed days on a prior suitable day</p>
<p>Date (M)</p>	<p>Date</p>	<p>Date</p>

What you want to prescribe (M) Mandatory CD requirement (R) Not legally required but strongly recommended (HO) Home Office approved wording	Examples of what to write on the prescription (notes in italics)	
Start date (R) Where a prescription is provided and intended to start after the date entered in the required date box next to the signature, that alternative start date should be stated clearly on the body of the prescription	Start date <i>The start date can be after the date provided in the required date box on the prescription but not before</i> <i>All CD prescriptions are valid for 28 days after the start date on the prescription. The date in the required date box is considered the start date unless another later treatment start date is clearly indicated by the prescriber on the prescription (as the date from which it is intended the drugs can be supplied)</i>	Start date <i>Can be stated on the body of the prescription. The start date can be after the date provided in the required date box on the prescription but not before</i>
Pharmacy details (R)	Pharmacy name and address <i>Good practice to add the dispensing pharmacy details, chosen by the patient, onto the prescription and to record in patient records. This minimises diversion of prescriptions and allows for an accurate record to be available in the event of an emergency pharmacy closure.</i>	
Where consumption is required to be supervised (R) (HO) <i>(Local arrangements for payment and for training are commonly needed for this prescribing arrangement to be available from selected pharmacies)</i>	Supervise consumption on collection days <i>The frequency of supervised consumption may also be added if necessary</i>	

What you want to prescribe (M) Mandatory CD requirement (R) Not legally required but strongly recommended (HO) Home Office approved wording	Examples of what to write on the prescription (notes in italics)	
Where buprenorphine tablets are required to be crushed <i>(Local policy/ agreement must be in place)</i>		Please crush <i>Note: Buprenorphine-naloxone as a combination product should not be crushed</i>
To cover pickups due on bank holidays, public holidays or other irregular or emergency pharmacy closures (R) (HO)	Please dispense instalments due on pharmacy closed days on a prior suitable day <i>For the regular closure of a pharmacy such as on Sundays, the prescriber's intention should be made clear by stating the total amount of the advance instalment supply.</i>	
To cover pick up to be less frequently than daily, state days or dates for collection and total amount of the individual instalment (M) Amounts to be dispensed can, alternatively, be specified for individual dates By using this HO approved wording, if a patient misses an instalment pick up, they can still collect the remainder of their instalment due another day without having to wait until the next specified collection day	Collect on Mondays Wednesdays and Fridays <i>For 60ml daily, this would be 120ml on Mondays and Wednesdays and 180ml on Fridays</i> <i>For 60ml daily, this would state:</i> 19.07.16 120ml 21.07.16 120ml 23.07.16 180ml If an instalment's collection day has been missed, please still dispense the amount due for any remaining day(s) of that instalment (HO)	Collect on Tuesday each week <i>For 12mg daily this would be 84mg (7 x 8mg tabs plus 14 x 2mg tabs) on Tuesdays</i> <i>For 12mg daily, this would state:</i> 20.07.16 84mg (7 x 8mg tabs plus 14 x 2mg tabs) 27.07.16 84mg (7 x 8mg tabs plus 14 x 2mg tabs) If an instalment's collection day has been missed, please still dispense the amount due for any remaining day(s) of that instalment (HO)

What you want to prescribe (M) Mandatory CD requirement (R) Not legally required but strongly recommended (HO) Home Office approved wording	Examples of what to write on the prescription (notes in italics)	
<p>It is recommended good practice for pharmacists to supply multiple doses in separate containers</p> <p>To reinforce this practice additional HO wording can be added to the prescription</p>	<p>Dispense daily doses in separate containers (HO)</p>	<p><i>Not needed as the tablets are easily counted.</i></p>
<p>To allow collection of part instalments following a missed pick up (HO)</p>	<p>If an instalment's collection day has been missed, please still dispense the amount due for any remaining day(s) of that instalment</p>	
<p>To ensure the patient is not supplied with their dose without consultation with prescribing service or prescriber if they have missed collection for three or more days (HO)</p> <p>Local arrangements that require earlier consultation arrangements may be in place</p>	<p>Consult the prescriber if three or more consecutive days of a prescription have been missed</p> <p><i>This does not invalidate the prescription but the prescriber or the prescribing service should be consulted for advice. The service may wish to assess the patient before agreeing whether the prescription can continue.</i></p>	

A4.7.1 Prescription text samples

Example 1: Daily dispensing supervised for seven days (methadone)

Methadone Oral Solution 1mg in 1ml
Dose: 100ml daily. Supervised
Total quantity: 700ml (seven hundred ml)
Supply 100ml daily
Please dispense instalments due on pharmacy closed days on a prior suitable day.

Example 2: Three times a week dispensing, supervised on day of collection (methadone)

Methadone Oral Solution 1mg in 1ml
Dose: 100mls daily. Dispense 3 times weekly. Supervised on day of collection.
Total quantity: 700ml (seven hundred ml)
Supply: 200ml on Mon, 200ml on Wed and 300ml on Fri.
Please dispense instalments due on pharmacy closed days on a prior suitable day.
If an instalment's collection day has been missed, please dispense the amount due for any remaining day(s) of that instalment.

Example 3: Daily dispensing supervised for seven days (buprenorphine-naloxone)

Buprenorphine-naloxone tabs 8mg and buprenorphine-naloxone tabs 2mg
Dose: 12mg daily. Supervised.
Total quantity:
Buprenorphine-naloxone tabs 8mg x 7 (seven) and
Buprenorphine-naloxone tabs 2mg x 14 (fourteen)
Supply 1 x buprenorphine-naloxone 8mg tab and 2 x buprenorphine-naloxone 2mg tab daily
Please dispense instalments due on pharmacy closed days on a prior suitable day.

Example 4: Three times a week dispensing, supervised on day of collection (buprenorphine-naloxone)

Buprenorphine-naloxone tabs 8mg and buprenorphine-naloxone tabs 2mg
Dose: 12mg daily. Dispense 3 times weekly on Mon, Wed and Fri
Supervised on day of collection
Total quantity:
Supply buprenorphine-naloxone tabs 8mg x 7 (seven)
Supply buprenorphine-naloxone tabs 2mg x14 (fourteen)
Supply: 24mg (2 x 8mg and 4 x 2mg tabs) on Mon, 24mg (2 x 8mg and 4 x 2mg tabs) on Wed and 36mg (3 x 8mg and 6 x 2mg tabs) on Fri.
Please dispense instalments due on pharmacy closed days on a prior suitable day.
If an instalment's collection day has been missed, please dispense the amount due for any remaining day(s) of that instalment.

Example 5: Five times a week dispensing, supervised on day of collection (methadone)

Methadone Oral Solution 1mg in 1ml
 Dose: 100ml daily. Dispense 5 times weekly. Supervised on day of collection
 Total quantity: 700ml (seven hundred ml)
 Supply: 100ml on Mon, 100ml on Tues, 100ml on Weds, 100ml on Thurs and 300ml on Fri
 Please dispense instalments due on pharmacy closed days on a prior suitable day
 If an instalment's collection day has been missed, please dispense the amount due for any remaining day(s) of that instalment

Example 6: Five times a week dispensing, supervised on day of collection (buprenorphine-naloxone)

Buprenorphine-naloxone tabs 8mg and buprenorphine-naloxone tabs 2mg
 Dose: 12mg daily. Dispense 5 times weekly on Mon, Tues, Weds, Thurs and Fri
 Supervised on day of collection
 Total quantity:
 Supply buprenorphine-naloxone tabs 8mg x 7 (seven)
 Supply buprenorphine-naloxone tabs 2mg x 14 (fourteen)
 Supply:
 12mg (1 x 8mg and 2 x 2mg tabs) on Mon
 12mg (1 x 8mg and 2 x 2mg tabs) on Tues
 12mg (1 x 8mg and 2 x 2mg tabs) on Weds
 12mg (1 x 8mg and 2 x 2mg tabs) on Thurs
 36mg (3 x 8mg and 6 x 2mg tabs) on Fri
 Please dispense instalments due on pharmacy closed days on a prior suitable day
 If an instalment's collection day has been missed, please dispense the amount due for any remaining day(s) of that instalment

A4.8 Private prescriptions

Standardised private prescription forms must now be used for the private prescribing of all Schedule 2 and 3 CDs dispensed in community pharmacies or in dispensing practices. There is no scope to use headed notepaper or other prescription forms.

- In England – forms FP10(PCD).
- In Scotland – forms PPCD(1).
- In Wales – forms WP10PCD and WP10PCD SS.
- In Northern Ireland – forms PCD1.

In England private prescriptions for Schedule 2 and 3 CDs must include the prescriber's six-figure identification number unique for private prescribing. Forms and prescriber identification numbers are obtained from the local primary care organisation. Current NHS prescribers receive a separate private prescriber number in addition to their NHS prescriber number.

In Scotland, private prescribers of Schedule 2 and 3 controlled drugs must register with their local health board before being able to order prescription pads. Private prescribers will be allocated a prescriber code. Valid NHS prescriber codes will be used where available. New private prescriber codes will be issued where necessary.

In Wales, unique prescriber identification codes will be issued for all private prescribers of Schedule 2 and 3 CDs. The number is issued by the relevant NHS agency (the primary care organisation) for the purpose of that person's private prescribing. This number is not the person's professional registration number.

In Northern Ireland, private prescribing of opioid substitution treatment would be considered unusual. In the unlikely event that PCD1 forms are required for this purpose, discuss with a member of pharmacy team at the local office of the Health and Social Care Board, who will advise on the process.

Private prescribers may also issue prescriptions for instalment dispensing but may not prescribe repeat prescriptions for Schedule 2 and 3 controlled drugs. Private repeat prescriptions for Schedule 4 and 5 CDs are allowed.

Private prescribing of CDs is monitored electronically for prescribing patterns and shared within the local intelligence networks.

A4.9 Resources and further reading

A4.9.1 Sources of prescription writing requirements

Pharmaceutical Services Negotiating Committee www.psnc.org.uk

Royal Pharmaceutical Society. Controlled Drugs Quick Reference Guide
www.rpharms.com/support-resources-a-z/controlled-drugs-quick-reference-guide.asp

Royal Pharmaceutical Society. Medicines Ethics and Practice. The Professional Guide for Pharmacists, Edition 39. July 2015.

A4.9.2 Further information

Home Office. Circular 027/2015: Approved Mandatory Requisition Form and Home Office Approved Wording www.gov.uk/government/publications/circular-0272015-approved-mandatory-requisition-form-and-home-office-approved-wording

NHS Business Services Authority, 1st April 2013, Oral Liquid Methadone Fee Arrangements
www.nhsbsa.nhs.uk/3905.aspx

Controlled Drugs Accountable Officers' Network Scotland
www.knowledge.scot.nhs.uk/accountableofficers.aspx

A5: Interactions

A5.1 Medicinal interactions

Two or more drugs taken at the same time (whether prescribable, obtained over the counter, herbal, or illicit) may exert their effects independently or may interact. The interaction may be potentiation or antagonism of one drug by another, or occasionally some other effect.

Alcohol and nicotine can also interact with other drugs.

Patients at increased risk from drug interactions include the elderly and those with impaired renal or liver function.

Drug interactions may be pharmacodynamic or pharmacokinetic and an explanation of these terms is included in an appendix of the British National Formulary. Refer to this appendix for an up-to-date list of drug interactions. Drugs are organised in the appendix by approved name and by pharmacological classification. Interactions with alcohol are also listed.

The sections in the BNF of most relevance to the drug treatment field are:

- alcohol
- anabolic steroids
- anaesthetics, general (such as ketamine)
- analgesics, opioid analgesics
- antidepressants, SSRI
- antidepressants, tricyclic (and tricyclic related)
- antihistamines
- antipsychotics
- antivirals (as individual drug names)
- bupropion
- anxiolytics and hypnotics
- cannabis extract
- disulfiram
- interferons
- lofexidine

- nalmeferene
- sympathomimetics (such as dexamfetamine).

In addition to the BNF, manufacturers' summaries of product characteristics (SPCs) should be consulted for prescribing information. Detailed information on interactions is contained in Stockley's Drug Interactions Pocket Companion. See Resources and further reading.

A5.1.1 Opioid interactions

Compared to most other street drugs, there is more data on the potential interactions between opioids and medicines because opioids are so widely used therapeutically. Factors which may pre-dispose opioids to interact may include the following:

- All of them are central nervous system depressants and so will have at least additive effects with medicines (and other illicit drugs) that have this property.
- Methadone and buprenorphine are both metabolised by the cytochrome P450 enzymes CYP3A4, CYP2D6 and, for methadone probably CYP3A4, so may undergo the same interactions.
- Inhibition or induction of cytochrome P450 will have a consequential increase or decrease in the amount of methadone or buprenorphine in the blood and tissues.
- In particular, CYP3A4 enzyme inducers e.g. antiretrovirals can cause a decrease in methadone or buprenorphine levels and, although not directly life threatening, can cause symptoms of withdrawal and increase the risk of relapse and overdose.
- The enzyme CYP2D6 is occasionally important in interactions. For example, it is responsible for the metabolism of oxycodone, and for the transformation of codeine and tramadol into active metabolite. Methadone inhibits CYP2D6.
- Buprenorphine is also an enzyme inhibitor with action on CYP2D6 and CYP3A4 so if it is combined with other medicines metabolised by CYP2D6 or CYP3A4 then plasma concentrations of these other medicines may be affected.
- Methadone can increase zidovudine concentrations by reducing glucuronidation in the liver.

A5.2 Interactions with illicit drugs

Interactions between illicit drugs and conventional medicines have not been systematically studied in humans. Most data has been derived from case reports and small-scale laboratory research and so should be interpreted cautiously. In addition, there are the added complications that many illicit drugs are often 'cut' (diluted) with unknown compounds, some of which may have pharmacological actions that also may interact adversely with the illicit drug or any other drug taken.

People who use drugs may be taking counterfeit or fake drugs, for example, anabolic steroid users and benzodiazepine users who buy drugs over the internet (that may not contain what it says on the label).

Many people who use drugs are polydrug users of both illicit drugs and medicines, including prescribed and over-the-counter medicines for comorbid conditions. Medicines may be prescribed in primary care or by hospital specialists as well as by drug treatment specialists. Illicit drugs, including new psychoactive substances, may already contain combinations of compounds.

People may not report all drugs they use – such as cannabis, benzodiazepines, alcohol, over-the-counter drugs and nicotine.

The potential for all these different drugs to interact should not be overlooked.

For example, QTc prolongation is associated with some cardiac drugs, some antibacterials, over-the-counter antihistamines for hay fever (e.g. loratidine), and cocaine and other stimulants. There is a risk of additive effects, particularly with prescribed methadone and especially at higher doses.

NICE's 2015 guidance on medicines optimisation recommends a comprehensive medicines reconciliation at every structured medication review to identify potential risks of drugs used and prevent adverse drug events (NICE 2015). This should include effective communication systems for medicines reconciliation when service users move from one care setting to another (e.g. prison release).

A5.3 Resources and further reading

British National Formulary www.bnf.org

The electronic Medicines Compendium (eMC) www.medicines.org.uk/emc contains approved and regulated prescribing information for licensed medicines, including summaries of product characteristics (SPCs) that identify drug interactions.

Medscape drug interaction checker www.medscape.com/druginfo/druginterchecker

www.hiv-druginteractions.org: Liverpool HIV Pharmacology Group providing drug-drug interactions in HIV+ patients.

Stockley's Drug Interactions Pocket Companion 2016. Claire L Preston (ed). Pharmaceutical Press.

Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes. NICE guideline 5, 2015 www.nice.org.uk/guidance/ng5

Table 9: Important interactions with methadone and buprenorphine

Interaction type	Which medicines or other substances?	How?	Effect?
CNS depressants and opioids including buprenorphine	<ul style="list-style-type: none"> • other opioids • hypnotics, anxiolytics, sedatives • benzodiazepines • many tricyclic antidepressants and MAOIs • many antipsychotics • older antihistamines • clonidine • anaesthetics • barbiturates • alcohol <p>For methadone:</p> <ul style="list-style-type: none"> • lofexidine 	<ul style="list-style-type: none"> • increased CNS depression 	<ul style="list-style-type: none"> • additive effect – potentiation of respiratory depression, hypotension
Medicines which increase methadone or buprenorphine levels	<ul style="list-style-type: none"> • cimetidine • ciprofloxacin • antimicrobials including: <ul style="list-style-type: none"> – macrolides: erythromycin, clarithromycin, telithromycin – azoles: ketoconazole, itraconazole, fluconazole, voriconazole • antidepressants: fluvoxamine and possibly other SSRIs • some cardiovascular agents: amiodarone • some anti HIV agents <p>For buprenorphine:</p> <ul style="list-style-type: none"> • other CYP3A4 inhibitors e.g. gestodene, protease inhibitors indinavir, saquinavir, nelfinavir, ritananovir, boceprvir <p>For methadone:</p> <ul style="list-style-type: none"> • disulfiram • grapefruit juice • delavirdine • quinidine • verapamil • dihydroergotamine 	<ul style="list-style-type: none"> • increased blood levels of methadone or buprenorphine by inhibition of the enzyme CYP3A4, CYP2D6 or reduced protein binding 	<ul style="list-style-type: none"> • dose of methadone or buprenorphine may need to be decreased to prevent toxicity or overdose AND may need to be increased when the enzyme inhibitor is stopped to prevent withdrawal symptoms (sedation, confusion, respiratory depression)

Interaction type	Which medicines or other substances?	How?	Effect?
Medicines which decrease methadone or buprenorphine levels	<ul style="list-style-type: none"> • anticonvulsants e.g. barbiturates, carbamazepine, phenytoin, primidone, fosphenytoin • rifampicin • rifabutine • spironolactone • St. John's Wort <p>For methadone:</p> <ul style="list-style-type: none"> • smoking (CYP1A2) • fucidic acid (not topical) • dexamethasone • antiretrovirals: abacavir, amprenavir, lopinavir, efavirenz, nevirapine, nelfinavir, ritanovir 	<ul style="list-style-type: none"> • decreased blood levels of methadone or buprenorphine by induction of enzyme CYP3A4 or increased urinary excretion 	<ul style="list-style-type: none"> • dose of methadone or buprenorphine may need to be increased to prevent withdrawal symptoms AND decreased when the enzyme inducer is stopped to prevent overdose
Buprenorphine and other opioid agonists	<ul style="list-style-type: none"> • methadone • diamorphine • other full agonists e.g. fentanyl 	<ul style="list-style-type: none"> • buprenorphine is a partial agonist and displaces other opioids from receptor sites 	<ul style="list-style-type: none"> • can precipitate withdrawal symptoms – advise waiting until opioid is excreted (confirmed by presence of withdrawal symptoms) before taking buprenorphine

Interaction type	Which medicines or other substances?	How?	Effect?
Opioid agonists or partial agonists with opioid antagonists	<ul style="list-style-type: none"> • naltrexone (active orally) • naloxone (active intra-nasally and parenterally) 	<ul style="list-style-type: none"> • naltrexone and naloxone are full antagonists and displace other opioids (including buprenorphine, pentazocine) from receptor sites 	<ul style="list-style-type: none"> • will precipitate withdrawal symptoms if taken when agonist or partial agonists have recently been taken
Methadone plus medicines affecting QTc interval	<ul style="list-style-type: none"> • antidepressants: tricyclics, SSRIs including sertindole, citalopram/escitalopram, fluoxetine • antipsychotic medicines including haloperidol • antimicrobials: <ul style="list-style-type: none"> – pentamidine – macrolides: erythromycin, clarithromycin, azithromycin – quinolones e.g. moxifloxacin, sparfloxacin – azoles: fluconazole, itraconazole, ketoconazole, voriconazole • antiemetics: domperidone, droperidol, ondansetron • antiarrhythmics/cardiovascular drugs: digoxin, dronedarone, sotalol, quinidine, amiodarone, flecanide, procainamide, dofetilide disopyramide • some antimalarials • some cancer treatments • some HIV protease inhibitors e.g. atazanavir • cocaine and stimulants including atomoxetine, dexamfetamine, methylphenidate • terodiline • antihistamines including: terfenadine, astemizole, loratidine • possibly lithium and lofexidine 	<ul style="list-style-type: none"> • prolongation of QTc interval can cause torsades de pointes 	<ul style="list-style-type: none"> • life threatening ventricular arrhythmias • use cautiously with methadone

Interaction type	Which medicines or other substances?	How?	Effect?
Methadone plus medicines affecting cardiac conduction or which may affect electrolyte imbalance	<ul style="list-style-type: none"> • cytotoxics • rifampicin • atomoxetine • protease inhibitor crizotinib • antimalarials 	<ul style="list-style-type: none"> • precipitated ventricular arrhythmias 	<ul style="list-style-type: none"> • risk of cardiac events • avoid concomitant use
Medicines affecting urine pH	<ul style="list-style-type: none"> • vitamin C • ammonium chloride • sodium bicarbonate (antacids) 	<ul style="list-style-type: none"> • affect excretion of methadone: <ul style="list-style-type: none"> – increased excretion in acidic urine (ammonium chloride) – decreased excretion in alkaline urine (sodium bicarbonate) 	<ul style="list-style-type: none"> • increased excretion may cause withdrawal • decreased excretion may cause toxicity

Table 10: Other clinically important interactions in substance misuse

Interaction type	Which medicines or other substances?	How?	Effect?
Alcohol/ritonavir oral solution (42% v/v alcohol)	<ul style="list-style-type: none"> • disulfiram • calcium carbimide • metronidazole • 5-nitroimidazoles e.g. tinidazole 	<ul style="list-style-type: none"> • affects metabolism of alcohol • accumulation of acetaldehyde in the blood stream 	<ul style="list-style-type: none"> • disulfiram-like reaction • flushing of the face, neck, tachycardia, breathlessness, giddiness, hypotension, nausea and vomiting. • avoid combination (extended for up to 14 days after end of treatment for disulfiram)
Alcohol	<ul style="list-style-type: none"> • cocaine 	<ul style="list-style-type: none"> • cocaine metabolite produced in presence of alcohol (cocaethylene) is more toxic than cocaine 	<ul style="list-style-type: none"> • enhanced euphoria, CNS depressant effect of alcohol
Cannabis	<ul style="list-style-type: none"> • clozapine 	<ul style="list-style-type: none"> • CYP1A2 induction 	<ul style="list-style-type: none"> • cessation of cannabis may lead to clozapine intoxication

Interaction type	Which medicines or other substances?	How?	Effect?
Naltrexone and nalmeferne (opioid receptor antagonist)	<ul style="list-style-type: none">opioid analgesics	<ul style="list-style-type: none">medicines metabolised by CYP450 and UGT enzymes	<ul style="list-style-type: none">avoidance of opioid analgesics advised by manufacturer

Table 11: Some important interactions with HIV and hepatitis treatments

Protease inhibitors	B	M	NNRTIs	B	M	NRTIs	B	M	Entry & integrase inhibitors	B	M	Fusion inhibitors	B	M	NS5A inhibitor	B	M
Atazanavir	↑	◇ R	Delavirdine	↑	↑	Abacavir		↓	Dolutegravir			Enfuvirtide			Ombitasvir	↑	
Cobicistat (+ATV or DRV)			Efavirenz	↓	↓	Didanosine		↓	E/C/F/TAF						Ledipasvir		
Darunavir		↓ R	Etravirine		↑	Emtricitabine			Efvitegravir/ Cobi/FTC/TDF						Daclatasvir		
Fosamprenavir			Nevirapine	↓	↓	Lamivudine			Maraviroc								
Indinavir			Rilpivirine		↓	Stavudine			Raltegravir						NS5B inhibitor		
Lopinavir		↓ R				Tenofovir									Dasabuvir	↑	
Nelfinavir		↓				Zidovudine		◇							Sofosbuvir		
Ritonavir	↑	↓															
Saquinavir		X R															
Tipranavir	◇	↓ R															
Amprenavir		↓															
Telaprevir		↓															
Boceprevir		↓															
Simeprevir	↑																
Paritaprevir	↑																

Key:

- X Not to be prescribed together B Buprenorphine
- ↑ Increase in plasma level M Methadone
- ↓ Decrease in plasma level R Boosted with Ritonavir
- ◇ Interaction different/unknown consequence

Major	Highly clinically significant. Avoid combinations; the risk of the interaction outweighs the benefit.
Moderate	Moderately clinically significant. Usually avoid combinations; use it only under special circumstances. Monitor regularly for withdrawal, toxicity, recognised adverse effects particularly if combinations are stopped or started or doses are changed
Minor	Minimally clinically significant. Minimise and assess risk, take steps to avoid interaction risks and/or institute a routine monitoring care plan.

A6: Travelling abroad with controlled drugs

A6.1 General

When travelling abroad for any length of time, controlled drugs are carried at the risk of the individual, who is subject to legal requirements and restrictions of the country or countries of transit and destination. These can be checked with the relevant embassies and consulates to enquire about any restrictions in the country to be visited (contact details can be found at www.gov.uk/travelling-controlled-drugs).

In general medicines should:

- be carried in original packaging
- be carried with a letter from the prescriber confirming the patient's name, destination, and details and amounts of medicine
- meet carriers' requirements for hand and hold luggage (for example, restrictions on volumes of liquids in hand luggage on aeroplanes*)

*These restrictions on the quantity of liquid allowed into the cabins of commercial aircraft mean a patient on methadone OST is unlikely to be able to travel safely with sufficient methadone solution for a stay of more than a day. Methadone tablets may need to be provided for longer trips.

A6.2 Travelling for less than three months

People in receipt of a prescription for a controlled drug can travel abroad with their supply. A Home Office licence is not necessary for planned stays of less than three months. The requirements listed previously still apply.

A6.3 Travelling for three months or more

A Home Office personal export licence is required for planned stays of three months or more. The patient should complete a form, available online and from Home Office Licensing Section, and return it to them along with a letter from the prescriber stating:

- the name and address of the person
- the person's date of birth
- the strength
- the form

- the quantity of the medicine
- the daily dose prescribed
- the person's date of departure and return countries being visited.

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

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

Anyone applying for a licence should allow at least 10 working days, assuming all the information needed is contained in the letter from the prescriber, for the processing of the application.

A licence is obtainable from the Home Office Licensing Section.

Email: DFLU.ie@homeoffice.gsi.gov.uk

The form can be downloaded from www.gov.uk/travelling-controlled-drugs

The requirements described in this section are similar for all/most prescribed medicines contained in Schedules 2, 3 and 4 of the Misuse of Drugs Regulations 2001 (as amended).

As an alternative to taking large quantities of medicines out of this country and trying to take them into another, patients might be better advised to enquire about registering with a doctor in the country they are visiting for the purpose of receiving further prescriptions.

A7: Drugs and driving

All psychoactive drugs can impair driving. The mechanisms for this are varied but primarily relate to the stimulant, depressant and psychedelic effects of psychoactive drugs, effects on judgement and reaction to normal situations, any withdrawal effects and any relevant after-effects such as tiredness.

A7.1 Key points

- Drug misuse, whether or not amounting to dependence, is regarded as a disability in this context.
- The responsibility to inform the licensing agency of their current medical status lies with the licence holder, not the prescribing clinician or drug service.
- Use of a supratherapeutic dosage of benzodiazepines outside BNF guidelines constitutes misuse or dependence for licensing purposes – whether in a programme of substance withdrawal or maintenance, or otherwise.
- GMC's guidance states that a doctor should explain to a patient, "a. that the condition may affect their ability to drive and b. that they have a legal duty to inform the DVLA or DVA about the condition".
- Certain drugs prescribed at stable doses are associated with neuroadaptation and development of stable tolerance that reduces or eliminates their previous impairing effects. This effect underpins the DVLA/DLA rules permitting return of driving licences for some patients stabilised on methadone and buprenorphine.

A7.2 Offences related to drug use and driving in the UK

A7.2.1 Unfit to drive through drink or drugs

It is an offence to be in charge of a vehicle if 'unfit to drive through drink or drugs'. This applies to any drug, whether it is an illicit or prescribed medicine. There is no defence available that the drug was prescribed. There does, however, have to be evidence of 'unfit driving', so simply taking a prescribed drug like methadone and driving does not lead to liability to prosecution for this offence.

A7.2.2 Driving above a specified limit for certain controlled drugs (applies only in England and Wales)

In England and Wales, there is now an offence of driving when certain controlled drugs are above a specified level in the blood. Some of these are valid medicines (for example, methadone, morphine, amphetamine and six different benzodiazepines). However, a medical defence exists for those 'over-the-limit' on their medicine, as long as they were taken 'in line with professional advice'. Patients can therefore be reassured they should continue taking their medicines as advised.

Police currently collect an oral fluid sample at the roadside, using a screening test to detect the presence of the specified drugs, and if positive the motorist can be taken to the police station for a blood test to confirm the level. Patients driving while taking medication covered by this offence may wish to consider keeping some proof of treatment with them when driving, as police can take this in to account.

The full list of drugs covered by the offence is:

Firstly:

- amphetamine (e.g. dexamphetamine or selegiline)
- benzodiazepines (clonazepam, diazepam, flunitrazepam, lorazepam, oxazepam and temazepam)
- methadone and morphine (morphine may be produced by a number of drugs such as codeine, tramadol and fentanyl)

These commonly used medicinal drugs have had higher blood limits set to reflect their use as medicines and to reflect a level around which there is known to be significant road safety risk.

Secondly:

- cocaine (testing for benzoylecgonine and cocaine)
- cannabis (testing for tetrahydrocannabinol (THC))
- ketamine
- LSD
- methylamphetamine
- MDMA
- heroin (testing for 6-monoacetylmorphine).

These have little or no legitimate use so have all had very low levels set, such that any use is liable to result in detection if tested.

A7.3 Driving licence requirements

Under the legislation, the Road Traffic Act, "holders of a driving licence" are required to inform the DVLA or DVA in Northern Ireland of "... any disability likely to affect safe driving". Drug misuse, whether or not amounting to dependence, is regarded as a disability in this context.

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

The focus of the driver agencies (Driver and Vehicle Licensing Agency (DVLA) in Great Britain and Driver and Vehicle Agency (DVA) in Northern Ireland) is on dependent and persistent misuse that is likely to impair driving. If dependent, then the use of prescribed medication to treat drug misuse constitutes a relevant disability and is subject to specific rules to obtain permission to continue to retain a licence (DVLA 2016). Use of a supratherapeutic dosage of benzodiazepines outside BNF guidelines constitutes misuse or dependence for licensing purposes – whether in a programme of substance withdrawal or maintenance, or otherwise.

Currently, consultant supervised oral methadone maintenance, or an oral buprenorphine programme, are the only drug treatments under which a patient may be so licensed, subject to specified conditions. In the context of heroin dependence where methadone treatment is prescribed as a substitution therapy, the licence would usually be refused or revoked until a patient on methadone met certain criteria of sustained stability after which they would be licensed to drive again while they remained stable on treatment.

The GMC's guidance states that a doctor should explain to a patient, "a. that the condition may affect their ability to drive..., and b. that they have a legal duty to inform the DVLA or DVA about the condition".

“5. If a patient refuses to accept the diagnosis, or the effect of the condition on their ability to drive, you can suggest that they seek a second opinion, and help arrange for them to do so. You should advise the patient not to drive in the meantime.

6. If a patient continues to drive when they may not be fit to do so, you should make every reasonable effort to persuade them to stop. As long as the patient agrees, you may discuss your concerns with their relatives, friends or carers.

7. If you do not manage to persuade the patient to stop driving, or you discover that they are continuing to drive against your advice, you should contact the DVLA or DVA immediately and disclose any relevant medical information, in confidence, to the medical adviser.

8. Before contacting the DVLA or DVA you should try to inform the patient of your decision to disclose personal information. You should then also inform the patient in writing once you have done so. Before contacting the DVLA or DVA you should try to inform the patient of your decision to disclose personal information. You should then also inform the patient in writing once you have done so.” (GMC 2009).

The DVLA's guide to assessing fitness to drive (DVLA 2016) also provides advice on disclosure and breaching confidentiality.

Whether clinicians should take the step of breaching confidence and informing the driver licensing agency without a patient's consent – if they are concerned about a patient's ability to drive or if the patient is driving passengers or heavy goods vehicles – is a complex but real ethical issue. Clinicians should make, and document, an assessment of risk before deciding whether to break confidentiality in the public interest.

A7.4 Risk assessment for driving

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

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

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

A7.5 Responsibilities of the prescribing clinician

The prescribing clinician needs to be able to give simple advice to patients regarding:

- the effects and side-effects of their medication including any risks for driving
- the risks of using illicit drugs and driving
- the offence of being unfit to drive through drink or drugs, which applies even if driving while unfit due to their medication
- the offence of driving, in England and Wales, with above a certain level of specified controlled drugs in their blood (including the medicines methadone, morphine and diazepam), with the reassurance that a medical defence to this offence applies for anyone who has taken their medicine in line with professional advice
- the patient's own responsibility as licence holder to inform the licensing agency of their current medical status, including any treatment for drug dependence
- that doctors are expected to disclose relevant medical information to DVLA/DVA if patients do not follow advice they may have been given on stopping driving because of 'unfitness to drive'.

A7.6 Information for patients

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

In situations where patients continue to drive, relevant advice can include (appropriately worded for your patient(s)):

- Do not drive after taking your medicines until you know how they affect you.
- Do not drive if your driving may be impaired, such as if you feel drowsy, dizzy, feel you have poor concentration or poor coordination, unable to make decisions, or if you have blurred or double vision.

- Report sedation, unsteadiness or cognitive decline immediately to the prescriber so that reduction in dosage can be initiated.
- Do not make any changes in your medication regimens without consulting or informing the prescribing service.
- Do not drive at times when the risk may be temporarily increased, for example, when first starting, or when first increasing or reducing the dose of, a medicine that may potentially impair your driving (such as for 4-5 days after beginning an opioid treatment or after a dose increase).
- Take particular care in circumstances that may increase the risk of driving being impaired while taking your medicine, and avoid driving if this occurs. Such situations could include:
 - if another prescribed medicine is added that could also impair your driving alongside the already potentially impairing medicine(s)
 - if you take an over-the-counter medicine that could also potentially impair your driving alongside the prescribed medicine
 - if you are getting medicines from other prescribers that may have an impact on your driving
 - if you have developed a medical condition that could increase the risk of the impairing side-effects from the prescribed medicine (for example, during the development of a serious illness with recent marked loss of weight)
 - if you take any new medicines that are known to be able to affect the metabolism of your existing medicine
 - other relevant situations, such as the effects of increasing age or the re-initiation of a medicine that previously caused you a period of sleepiness that impaired your driving
- Be aware that alcohol taken in combination with other impairing drugs can substantially increase the risk of accidents.
- Check the leaflet that comes with your medicines for information on how your medicines may affect your driving ability.

A patient suffering with a condition that is being treated by a medicine that is also one of the specified drugs for the new offence should normally still be encouraged to keep taking their prescribed medicine for that clinical condition in accordance with the advice of the prescriber or pharmacist. If the patient has been driving in line with such advice, and has no reason to think themselves impaired to drive (for example, not having developed new symptoms such as sleepiness), they can be advised they will be entitled to raise the statutory 'medical defence'.

A7.7 References

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A8: Glossary

Amfetamine (including dexamfetamine) is used in line with 2004 MHRA changes that brought the British Approved Name (BAN) of medicinal products in line with the recommended International Nonproprietary Name (rINN). It is not used to describe nonmedicinal products (illicit drugs) – in these cases the established “ph” spellings (amphetamine(s), dexamphetamine, methamphetamine) are used.

Carers is used throughout to refer to partners, family, friends and concerned others who are affected by someone else’s drug use. Some people prefer alternative terms but the working group adopted it because it has a specific meaning in law as someone who looks after a partner, relative or friend who is ill or disabled, and is entitled to an assessment of their needs and to support if they meet eligibility criteria.

Clinician is used throughout the 2017 Clinical Guidelines to refer to the range of professionals working in treatment settings with drug misusers. In the past, the Clinical Guidelines were targeted principally at doctors and, while doctors are still the primary audience, clinicians increasingly covers other professions, including nurses, pharmacists, psychologists and drug workers.

Dependence vs. addiction. Dependence is the preferred term in these Clinical Guidelines. The term ‘addiction’ has generally been avoided except in relation to addiction psychiatry.

Drug terminology

Drug is used to describe a psychoactive substance (other than alcohol) used illicitly or illegally, except in the term ‘controlled drug’ where it refers to a substance defined by and controlled under the Misuse of Drugs Act.

Medicine is used to describe a substance made up into a suitable formulation for use in treatment, except where the term ‘controlled drug’ is used to describe a substance defined by and controlled under the Misuse of Drugs Act. The term ‘drug’ may also be used when describing the properties of a chemical used as a medicine, or when used in a widely accepted compound term such as ‘non-steroidal anti-inflammatory drug’ or z-drug.

Opiate vs. opioid. Opioid is used in line with the WHO definition to refer to the whole group of natural, semi-synthetic and synthetic compounds that act on opioid receptors. However, opiate is also used at times for substances derived from the poppy plant and for the semi-synthetic drug diamorphine (heroin).

Solution vs. mixture. Methadone solution is used throughout as the MHRA-preferred term to describe methadone oral solution. Methadone mixture is an older term still in common use.

Substance is used to describe the wider range of drugs, volatile substances and alcohol often misused by young people.

Person or people who use(s)/inject(s) drugs – these terms are used throughout, except where an alternative aids clarity and readability or is specifically appropriate, in which cases ‘patient’ or ‘service user’ or other term are used. For these same reasons of clarity and readability, contractions such as PWUDs and PWIDs have been avoided.

Recovery

No single definition of recovery was used by the working group but the following discussions and definitions from other documents are helpful:

“There is a large literature on the concepts of recovery and many have defined it, with varying degrees of success and acceptance. Work by many people and organisations (most notably the Betty Ford Institute (2007), UKDPC (2008) and SAMHSA (2011), and more broadly the mental health movement in the UK) captures something of the spirit of recovery, which we endorse – that it is, or should be:

- an individual process or journey rather than a predetermined destination
- built on hope, in order to sustain motivation and support expectations of an individually fulfilled life
- about enabling people to gain a sense of control over their own problems, the services they receive, and their lives
- helping people to find opportunities to participate in wider society
- culturally appropriate.”

(Recovery Orientated Drug Treatment Expert Group (2012) Medications in Recovery: Re-Orientating Drug Dependence Treatment. London: National Treatment Agency for Substance Misuse)

As McLellan and White said in their Druglink commentary on Medications in Recovery:

“it is neither the presence nor the absence of an opioid medication that defines recovery – it is other important qualities of the lifestyle.” (McLellan AT & White W (2012). Come Together. Druglink 27(4): 12-13)

Scotland’s Road to Recovery described the importance of care being centred around the person, not the addiction. It said that, “Recovery is a process through which an individual is enabled to move-on from their problem drug use towards a drug-free life and become an active and contributing member of society” ... “it incorporates the principle that recovery is most effective when service users’ needs and aspirations are placed at the centre of their care and treatment.”

“There is no right or wrong way to recover. Recovery is about helping an individual achieve their full potential – with the ultimate goal being what is important to the individual, rather than the means by which it is achieved.”

(The Scottish Government (2008) The Road to Recovery: A New Approach to Tackling Scotland’s Drug Problem. Edinburgh: The Scottish Government)

Treatment and recovery care plan/planning. Different terms are in use to describe processes for, and the product of, agreeing with a service user a plan for what they wish to address in their treatment and recovery, and how. These are generally variations on and combinations of care plan, treatment plan and recovery plan. These guidelines use the all-encompassing term ‘treatment and recovery care plan’ and ‘treatment and recovery care planning’, though these may be abbreviated at times for clarity.

- NB These conventions may not be maintained where the text is quoted from elsewhere.

