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1 Introduction

The impact of drug misuse on individuals, families and communities is well documented. Liverpool like all major European cities, is not immune to this health and social problem. The complexity of tackling drug misuse means that no single agency or professional group can address the needs of drug users and their families on their own. Over the last 18 months a task force made up of GPs, clinical specialists in drug misuse treatment, criminal justice and social service agencies, and voluntary sector organisations, has been working steadily to develop the range and quality of treatment and care. Through their efforts and those of the agencies they represent, the following services have been developed or enhanced:

- Community based detoxification programmes
- Residential detoxification programmes
- Harm reduction and stabilisation programmes
- Supervised consumption schemes
- Structured day care
- Relapse prevention
- Rehabilitation and Training
- Arrest Referral and Bail Support Programmes
- Drug Treatment and Testing Orders
- Family support
- Syringe Exchange Services.

Developing shared care for drug users between the different agencies involved in the interventions listed above has been a central concern for the Task Force. Recognising the major role played by General Practitioners, the Task Force has sought to strengthen the support available to primary care. This support includes remuneration for GPs participating in the shared care programme described in these clinical guidelines, additional specialist drug work support to these surgeries and improved access to advice and assessment from the specialist drug services.

These clinical guidelines provide all of the professionals and the agencies offering care for drug users with a shared understanding of the treatment options and support services available in Liverpool.

Rod Thomson, Chair of the Liverpool Drug Misuse Task Force

Foreword

Over a number of years, GPs have been very critical about the lack of services and poor co-ordination of services for drug users in Liverpool. This has resulted in long waits for Patients to be assessed and receive treatment within the Drug Dependency Unit, which has resulted in consequent strain on primary care services. Moreover, because of the fact that working with drug misusers can be a very difficult task and may lead to some disruption within the primary care setting, some GP colleagues have, understandably, not wished to treat or manage misusers in the community.

Liverpool LMC has been working closely with the Substance Misuse Management Group, to formulate a set of clinical guidelines which can be used across the primary, community and secondary care settings to promote a consistent and effective approach to addressing the needs of drug misusers within the community. GPs who subscribe to these guidelines can be assured of the quality controls that will be provided by various agencies working with drug misusers, under the auspices of the Drug Dependency Unit. A consistent approach will allow practices and drug misusers the confidence of knowing that they are relating to named drug workers and that should problems arise, patients will be handled in an effective but streamlined manner.

These guidelines are only a start, and obviously will be modified with time and experience. The LMC supports their introduction and hopes that the use of an integrated shared care process will improve the experience of dealing with drug misusers for doctors, primary and community care staff, as well as the patients themselves.

Dr Rob Barnett, Local Medical Committee

Acknowledgements to the members of the Task Force for their commitment and support given in compiling these guidelines.

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Dr Martin Smith	Central West PCG
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2 Shared Care Guidelines

Shared Care for drug misusers was defined in EL(95)114 as:

"The joint participation of GPs and specialists (and other agencies as appropriate) in the planned delivery of care for patients with a drug misuse problem, informed by an enhanced information exchange between routine discharge and referral letters. It may involve the day to day management by the general practitioner of a patient's medical needs in relation to his or her drug misuse. Such arrangements would make explicit which clinician was responsible for different aspects of the patient's treatment and care. This may include prescribing substitute drugs in appropriate circumstances."

In the context of these guidelines the term 'substitute drug' refers only to Methadone. (Drugs used as part of a detoxification will be addressed in another section of these guidelines)

Aim

The principal aim is to provide a comprehensive service to drug users that should reduce drug-related harm. It is based upon a partnership between primary healthcare teams and the Community Drugs Team (CDT).

Objectives

- Establish a good working partnership between GPs and Community Drugs Teams, and other support agencies.
- Develop consistent codes of practice for prescribing and management of drug dependence. This will be developed through clinical audit.
- Promote a range of appropriate services for drug users.
- Provide accessible community based management of drug dependence.
- To assist GPs and the Primary Care Team in the management of problem drug users.

Desired Outcomes:

1) Reduced complications from drug use.

2) Improved professional, user and carer satisfaction.

3) Prevention of Communicable Disease associated with drug use.

4) Easier access to services for patients who have travel difficulties to CDT clinics.

5) Increased access to rehabilitation opportunities through connections with CDT workers.

There are two options under which GPs may receive a fee for participation in shared care arrangements. These are defined under section 10, as Schemes 1 and 2. Schemes 1 and 2 provide support to GPs through a CDT liaison worker, scheme 1 involving minimal input by the GP. Under Scheme 2, the GP undertakes continuing care according to an agreed care plan with some support from a CDT liaison worker. Fees are graduated accordingly.

(Three months notice to withdraw from any of these schemes should be given by either side)

3 Scheme 1

Introduction

Scheme 1 is intended to provide support for largely stable drug users who have been transferred from the care of the community drugs team to primary care. Such patients will already be registered with the practice.

General Practitioner Responsibilities

3.1 With Scheme 1, the responsibility for initial assessment and continuing review of a drug user rests largely with the CDT liaison worker. The CDT liaison worker will monitor the drug user's progress and offer advice to the GP regarding the appropriate management of that patient.

The GP will:

3.1.1 Be available to the liaison worker to discuss the caseload and individual treatment plans.

3.1.2 See patients as appropriate, and provide a regular weekly/fortnightly prescription for the duration of the Action Plan.

3.1.3 Record any consultation and prescriptions in the patient's case notes when the patient has a GP consultation.

3.1.4 Establish good communication and sharing of information with the liaison worker.

3.1.5 Establish and encourage Hepatitis B screening and vaccination to patients, where appropriate, e.g. if they test negative for exposure to the Hepatitis B Virus (advice to be given to offer referral to individuals who are Hepatitis B antigen positive or Hepatitis C positive to the appropriate specialist services for further assessment).

3.1.6 If individuals are abusing alcohol, check for Hepatitis C and advise on risk of continued alcohol intake if they are positive.

3.1.7 Review the action plan with the liaison worker as appropriate (at least six monthly).

Remuneration

GPs participating in this scheme will receive payment of £77.25 per patient per annum with an annual inflationary uplift as agreed with the LMC Practices involved in the scheme will be expected to provide appropriate data to the National Drug Treatment Monitoring service base at John Moores University in accordance with the Department of Health guidance. The drug worker attached to the practice may undertake this duty.

CDT Liaison Worker Responsibilities

3.2 Within Scheme 1, the CDT liaison worker undertakes the leading role for the assessment, monitoring and review of a drug user on behalf of the GP. The CDT worker will offer regular advice to the GP regarding the patient's progress and recommend appropriate changes in the management of the patient.

3.2.1 Assess the patient's suitability for care in a GP setting and consult with the GP.

3.2.2 Negotiate an Action Plan with the patient and doctor, incorporating short and long-term objectives. The patient will also be provided with a copy of 'Service User Guidelines' detailing general information regarding their treatment.

3.2.3 Attend initial patient appointment with the GP and provide full patient management support through the provision of regular practice based clinics.

3.2.4 Organise urinalysis as appropriate to review drug user compliance in a treatment programme, and assist in on-going monitoring of the patient's Action Plan.

3.2.5 Initiate prescribing in accordance with the clinical guidelines.

3.2.6 Record consultations in CDT held case notes, and advise the GP of changes in the Action Plan.

3.2.7 Prioritise patients to the CDT should they need more intervention than the GP can provide, i.e.:

- Chaotic drug use and lifestyle
- Pregnant mothers
- On methadone tablets or ampoules
- Continued illicit drug use on a regular basis
- Poly-drug use
- Severe and enduring mental health problems
- Ongoing problems with social services where child protection issues are paramount
- Challenging behaviours
- Sex workers

3.2.8 Refer patients to other services as indicated in the Action Plan, e.g. Detoxification, Welfare Rights, HIV Prevention etc.

3.2.9 Complete Regional Database Notification Form.

3.2.10 Liaise with dispensing pharmacies.

3.2.11 Advise and support practice administration staff who envisage problems with drug using patients.

3.2.13 Review and renegotiate Action Plan as appropriate with GP and patient.

4 Scheme 2

Introduction

Scheme 2 is also intended to provide support for largely stable drug users who have been transferred from the care of the community drugs team to primary care. Such patients will already be registered with the practice. As GPs participating at this level will have undertaken additional training (to the standards being set by the RCGP), they may wish to provide care to registered patients who have not been under the care of the CDT. For this scheme, participating GPs are expected to provide a dedicated session within the practice to ensure that the appropriate level of assessment, treatment and care is provided. (The Shared Care Monitoring Group will consider applications from practices wishing to integrate the service they provide to drug users, however it will need to be satisfied that a sufficiently high standard of care will be offered to merit the remuneration associated with this scheme.)

General Practitioner Responsibilities

4.1 Though the CDT liaison worker will assist a GP by carrying out an initial assessment of a drug user's suitability for inclusion in the scheme, and will provide a twice yearly review of the drug user's progress, the lead responsibility for on going care rests with the GP.

The GP will:

4.1.1 Be available to the liaison worker to discuss the caseload and formulate treatment plans.

4.1.2 See each patient and provide a regular weekly/fortnightly prescription for the duration of the action plan. At least every two months, review the drug treatment programme.

4.1.3 Record consultation and issue of a prescription in the patients case notes, when the patient has a GP consultation.

4.1.4 Initiate prescribing in accordance with the clinical guidelines.

4.1.5 Establish good communications and sharing of information with the liaison worker.

4.1.6 Offer and encourage Hepatitis B screening and vaccination for all patients, where appropriate.

4.1.7 If individuals are abusing alcohol, check for Hepatitis C and advise on risk of continued alcohol intake, if they are positive.

4.1.8 Review action plan with the liaison worker, as appropriate (at least twice yearly).

4.1.9 **Remuneration:** an annual fee of £7725 with an annual inflationary uplift as agreed with the LMC will be paid to appropriately qualified GPs who provide a weekly clinic within the practice. The figure is based on the provision of a dedicated three-hour session. (The Shared Care Monitoring Group will consider applications from practices wishing to offer a smaller time provision, with a commensurate decrease in the remuneration provide.) In this scheme the GP will be expected to supply appropriate data to the Drug Treatment Monitoring Service in line with the Department of Health guidance.

CDT Worker Responsibilities

4.2 Within this scheme, the liaison worker provides support to the GP by undertaking the initial assessment of a drug user and recommending a suitable care plan. In addition the liaison worker will provide a twice-yearly review of the drug user's care plan and recommend to the GP any appropriate changes.

4.2.1 Assess the patient's suitability for care in a GP setting and consult with GP.

4.2.2 Negotiate an Action Plan with the patient and doctor, incorporating short and long-term objectives. The patient will also be provided with a copy of 'Service User Guidelines' detailing general information regarding their treatment.

4.2.3 Attend initial patient appointment with GP and future review appointments, if required.

4.2.4 Organise urinalysis as appropriate to review drug user compliance in a treatment programme, and assist in on-going monitoring of the patient's Action Plan.

4.2.6 Record consultations in CDT held case notes and advise the GP of any recommended changes to the action plan.

4.2.7 Prioritise patients to CDT should they need more intervention than the GP can provide, i.e.:

- Chaotic drug use
- Pregnant mothers
- On methadone tablets or ampoules
- Continued illicit drug use on a regular basis
- Poly-drug use
- Significant mental health problems
- Ongoing problems with social services and/or probation
- Challenging behaviours
- Sex workers

4.2.8 Complete Regional Database Notification Form

4.2.9 Liaise with dispensing pharmacies.

4.2.10 Advise and support practice administration staff who envisage problems with drug using patients.

4.2.11 Review action plan as appropriate with GP and patient.

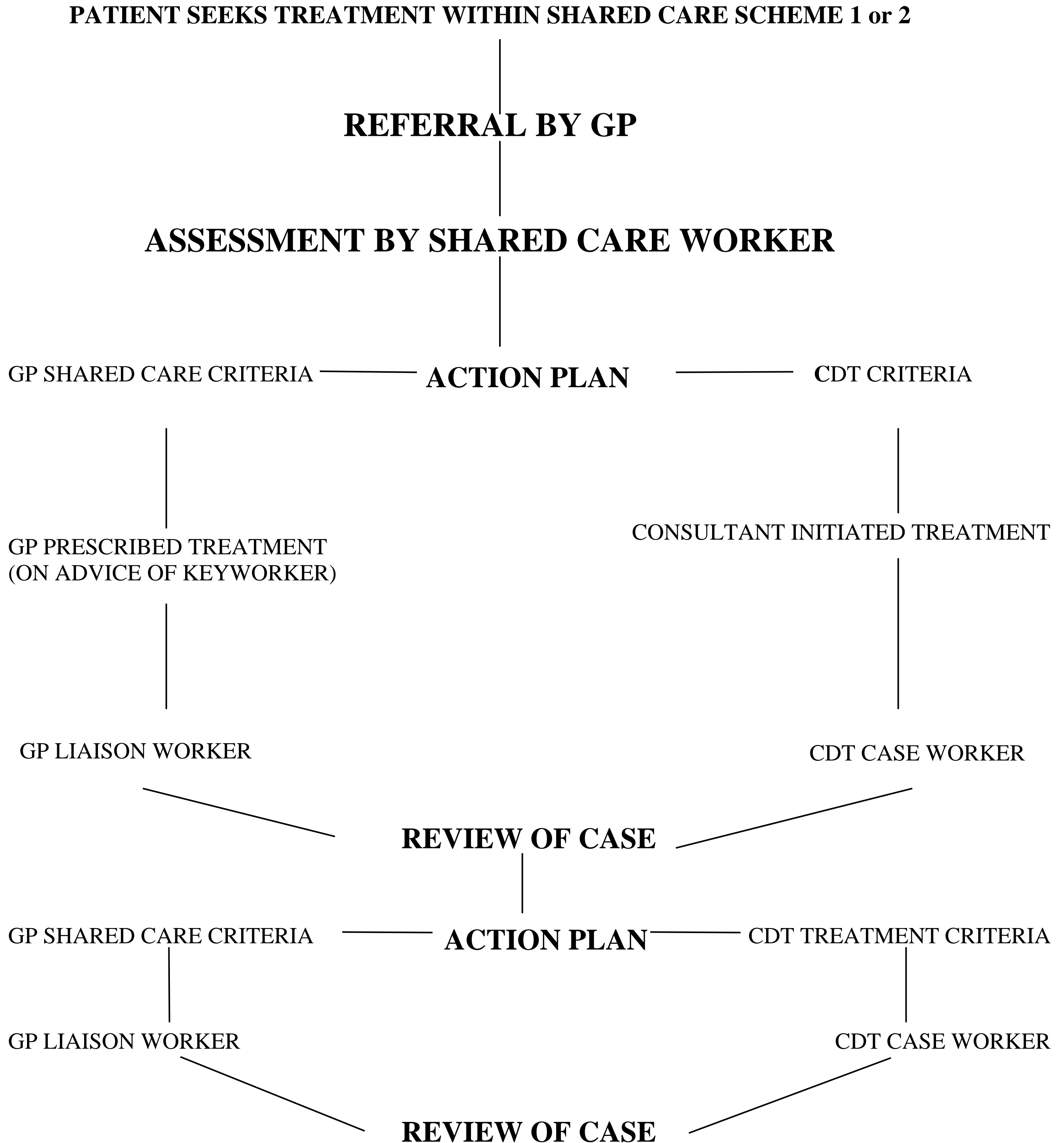
5 Clinical Audit

5.1 For both General Practitioners and Community Drugs teams, regular audit of the treatment and care of drug users in the Shared Care Scheme will be an essential part of monitoring and evaluating this form of care. Set out below are some of the areas that could be included in such Audits.

- Hepatitis B screening and vaccination programme
- Review of patient action plan
- Admission and Discharge Criteria
- Prescribing patterns
- Record keeping

The Shared Care Monitoring Group will review audit arrangements. The monitoring tools currently in use by the CDT will be extended for use with the shared care scheme. An Annual contact interview to each participating practice by a CDT Consultant Psychiatrist to review the programmes of care will form part of the Audit. On behalf of the Local Expert Monitoring Group, the Consultant Psychiatrist will be able to monitor prescribing patterns and continuing education needs across the district and offer advice to both the panel and to individual GPs.

6	**Access To Treatment Flow Chart**



7 Guide to Treatment Within Shared Care

7.1. **New patient's first attendance at GP surgery:**

- Drug using patient seeks treatment for drugs misuse from GP.
- GP contacts the liaison worker on (Tel:) to arrange an assessment appointment and advises the patient that the community drug team will contact him to arrange an initial appointment.
- **NB it is advisable *never* to prescribe methadone without a full assessment.**
- Liaison worker in conjunction with the GP assesses the drug user.

7.1.2 a) If the patient is suitable for treatment at a GP clinic, initial treatment is planned and prescription supplied following the assessment. An appointment given for next appropriate GP drug clinic.

- Drug user attends GP drug clinic to see liaison worker.
- Negotiation and development of Action Plan (see 3.2)

b) If unsuitable for GP drug clinic, patient is either assessed as a priority into treatment at the CDT or referred to CDT waiting list. The patient should also be referred to other support services as appropriate.

The following list offers examples of the types of patients who may be more suited to one form of management than another.

7.1.3 **CDT Management**

- Chaotic drug use/continued illicit drug use on a regular basis.
- Child protection issues.
- A dependent IV drug user.
- Significant Social Criminal Justice/mental health/physical health problems related to drug use.
- Pregnancy.
- The prescribing of injectable methadone required..
- Commercial sex trade workers.
- HIV positive clients

7.1.4 **GP Liaison Management**

- Prescribed methadone mixture.
- Stable, infrequent or no illicit drug use.
- A non injector.
- No significant social/criminal justice/mental health/physical health problems related to drug use.

7.2 Assessment and Development of Action Plan

A full assessment needs to be made and documented at the initial visit, encompassing medical and drug/alcohol history, criminal activity, family circumstances, and risk assessment. This will help to develop Action Plans and enable an audit of treatment to be carried out. (Assessment forms are available through the CDT).

Action plans are essential. They ensure service users receive appropriate, supportive and relevant services.

7.2.1 Assessment

A comprehensive assessment is required that identifies the range of needs to be addressed within the care process.

The key areas will include:

1) Socio-demographic data (e.g. name, address, gender).

2) Pattern of substance use.

3) Health, social, economic and legal consequences of substance misuse.

4) Are there childcare issues. If so what are these issues and is their social service involvement. For children under 5 years of age routine liaison with the relevant health visitor to be initiated.

5) The patient's perception of need.

6) Are other agencies involved with the patient and if so which.

7) Do other agencies need to be involved.

8) Target outcomes for the care process.

7.2.2 Action Planning

Once the assessment has been completed, each patient will have an Action Plan that will contain:

1) Present or potential problems.

2) Patient's short and long term goals.

3) Drug Treatment options.

4) Additional Social Care Arrangements including other agencies involved.

5) Case worker actions - associated with each goal as a means of resolving/ alleviating the problem.

6) Date for review i.e. 3 - 6 months.

7) Interagency liaison and communication

The delivery of the care service should be recorded accurately in case notes. These should reflect progress towards the Action Plan goals and any other relevant information that may impact upon the outcome of the Action Plan.

7.2.3 **Care Review**

The Action Plan and its delivery should be reviewed regularly:

1) Relevance of the care package.

2) Effectiveness of the care package.

3) Identify unmet needs.

It is essential for the review to establish:

1) Change in pattern of drug use.

2) Changes in health, housing, legal circumstances.

3) Changes in child care issues.

4) The patient's perception.

5) Staff assessment of progress.

6) Involvement of other agencies.

Progress towards outcomes - Social
- Criminal activity
- Drug use

8 Prescribing For Opiate Dependence

8.1 There is a distinction between the terms reduction, detoxification and maintenance. In practice these categories overlap and the distinction between them is not entirely clear.

8.2 The aim of detoxification is to assist a patient to become drug free within a short time. Detoxification can be achieved either in an impatient setting or as part of a home based programme. A methadone reduction programme is one way to assist detoxification and may take place over a lengthier period. A maintenance regimen recognises that longer term prescribing is required, accepting that the patient will remain dependant on substitute medication (normally oral Methadone) until he or she is ready to move towards a drug free status. The aim of maintenance is to minimise harm both for the user and the wider society

8.3 **Methadone reduction prescribing**

8.3.1 Methadone reduction regimes can be divided into several components – commencement, stabilisation and reduction.

8.3.2 Commencement dosing is that intended to achieve effective physical and psychological comfort for the patient whilst minimising the possibility of harm through overdose. Stabilisation of dosage usually requires initial regular attendance. Once stable the patient should be encouraged to abstain from heroin. Dose reductions can then be negotiated with the patient (see 8.6).

8.4 **Methadone maintenance prescribing**

Methadone maintenance should not be seen as the treatment of first choice when the patient presents. Ideally detoxification options should be explored initially. Where maintenance prescribing is commenced it should be reviewed at regular intervals (not greater than 3 months) and be part of a broader social and psychological package. There is extensive research evidence both in the UK and Internationally that well supported methadone programmes reduce the level of injecting behaviour, decrease illicit opiate use, reduce criminal activity and are cost effective Where this is available it has been shown to reduce harm from injecting behaviour, illicit opioid use, criminal activity and costs to society.

8.5 **Who should receive a script?**

Before commencing prescribing of methadone, the following points should be considered as part of the assessment and care planning process:

- Are opiates being used daily?
- Is there clear evidence of opiate dependency (including objective signs of withdrawals)?
- Is the patient dependent on alcohol or any other drug?
- Is opiate present in the urine?
- Has there been a full assessment?
- Is the patient motivated to stabilise drug use?

Do **NOT** prescribe if any of the following apply:

- Before urine screening confirms opiate present in the urine. An opiate positive urine test does not mean that the individual is opiate dependent and must be used in conjunction with a full assessment.
- Great caution should be exercised in prescribing methadone to patients who have just been released from prison or just left the detoxification or rehabilitation centre as their tolerance to opiates will have gone down and they are at higher risk of overdose.
- Young people under 16.
- It is the patient's first consultation (unless patient is already being scripted and details have been transferred).
- The patient has not had a full assessment.
- Patient is taking drugs to become intoxicated and wishes to continue to do so.
- Suspicion of pregnancy.
- The patient is dependent on alcohol or any other drugs.

8.6 Prescribing appropriate amounts

Scripting opiate users is a matter of negotiation. The following points should be remembered:

- Some users may overestimate their usage to obtain a bigger script.
- Some users may underestimate their usage in order to please you.
- Some users may have unrealistic expectations of the script he/she ought to receive.
- When in doubt about the appropriate course of action, please contact MerseyCare NHS Trust-Substance Misuse Directorate.
- If in doubt, begin with low doses (not usually more than 40mg of methadone and usually lower) and titrate subsequent small increases (i.e. 5-10mg) against withdrawals.
- Once stabilised (usually by the sixth week of treatment) the methadone dose may be reduced by 5-10mg every fortnight with the agreement of both patient and doctor.

8.7 Drugs conversion chart

The following chart is a **guide** to converting other opiates to methadone and should not be used as a 'menu.'

DRUG	DOSE	METHADONE EQUIVALENT
Street Heroin	Dose cannot be accurately estimated because street drugs vary in purity. Titrate dose against withdrawal symptoms. Initial prescription dose should be negotiated at assessment.	
Pharmaceutical Heroin (Diamorphine)	10mg Tablet (or Ampoule) 30mg Ampoule	20mg 60mg
Methadone	10mg Ampoule Mixture (1mg/ml) 10ml Linctus (2mg/5ml) 10ml	10mg 10mg 4mg
Dipipanone (Diconal)	10mg Tablet	4mg
Dihydrocodeine	30mg Tablet	3mg
Dextromoramide (Palfium)	5mg Tablet 10mg Tablet	5-10mg 10-20mg
Pethidine	50mg Tablet 50mg Ampoule	5mg 5mg
Buprenorphine Hydrochloride (Temgesic, Subutrex)	200microgram S/L Tablet 300microgram S/L Tablet 400microgram S/L Tablet	5mg 8mg 10mg

DRUG	DOSE	METHADONE EQUIVALENT
Pentazocine (Fortral)	50mg Capsule 25mg Tablet	4mg 2mg
Codeine Phosphate	Linctus (15mg/5ml) 100ml 15mg Tablet 30mg Tablet 60mg Tablet	10mg 1mg 2mg 4mg
Gee's Linctus 100ml	16mg Anhydrous Morphine	10mg

8.8 **Preparation of prescriptions**

- The blue prescription form [FP10(MDA)] should be used for prescribing as it is designed for dispensing in installments. A maximum quantity covering 14 days supply is allowed for on each form.
- Do not provide prescriptions allowing for installments of greater than seven days to be dispensed unless there are exceptional circumstances (e.g. holiday). The blue FP10(MDA) should be used routinely as it allows the dates of supply to be stated.
- A nominal upper limit of 80mg of methadone daily is recommended.
- Prescribing of benzodiazepines is not helpful and must be avoided (see Section 9).
- Methadone tablets and ampoules must not be prescribed within shared care arrangements. Only methadone mixture 1mg/ml will be considered for substitute prescribing in line with national guidelines. Methadone ampoules and tablet prescribing should be restricted to patients of the DDU.
- A first prescription is never urgent and should not be issued prior to assessment. If a patient is moving from services in another part of the country, he or she should have made arrangements with that existing service to cover the move. It is that existing service's responsibility to arrange transfer of care.
- **Prescriptions may be computer generated where the prescriber has an exemption from the handwriting requirements for Controlled Drugs. (There is still a requirement for the prescriber to sign and date the prescription in his or her own hand in indelible ink.). Suitable computer software may be available through discussion with the liaison worker.**

8.9 **Prescribing of other substitute opiate drugs**

Naltrexone (Nalorex)

Naltrexone is licensed for use as an adjunct in the prevention of relapse following detoxification. It acts as an opiate antagonist and attempts to overcome this block can result in acute opiate intoxication. General Practitioners are not required to initiate naltrexone within the shared care guidelines. GPs should be encouraged to continue naltrexone prescribing within the scheme with input continued to be provided by the shared care workers. Where GPs are willing to accept clinical responsibility for prescribing, they should do so within clear shared care arrangements with the specialist service.

Lofexidine (BritLofex)

Lofexidine is licensed for the management of opiate withdrawal symptoms and is often used as part of detoxification programmes. It is used as a short course, usually for about a week to ten days. Marked bradycardia and hypotension can occur and individuals on a Brufexidine scheme require monitoring of pulse rate and blood pressure. GPs would not be expected to prescribe or oversee a Lofexidine detoxification or may get involved within the Community Detox Team.

Dihydrocodeine

Dihydrocodeine is a short acting relatively weak opiate. It is not licensed for management of drug dependence. Users should have their dihydrocodeine dose converted to methadone before prescribing is commenced. If opiate users have pain relief requirements where possible they should be prescribed non opiate base pain relief, if however they require Dihydrocodeine or other opiate based medications caution should be taken that this is for a short period only and that the cause of their pain is adequately investigated.

Buprenorphine (Subutex)

Currently buprenorphine is not considered suitable for prescribing within local shared care arrangements for drug misusers. It is only suitable for use in dependent patients at lower levels of methadone dosing (maximum 30mg methadone daily). Subutex is being used currently by the community detox team for detoxification and that there is probably a place for Subutex in substitute prescribing but that currently it is not considered suitable within local shared care arrangements although in the future it may well be added once protocols have been agreed and training provided.

8.10 **Prescription issue record**

Name			D.O.B.		
Address					
Date issued & initials	Daily dose & total	Start date	End date	Pick-ups	Chemist & script no.

8.11 National Drug Treatment Monitoring System (NDTMS)

National Drug Treatment Monitoring System notification is required under shared care arrangements whenever a patient is seeking treatment for dependency to any drug (including any opiate or non-opiate drug listed below). Notification is not required for patients who are not seeking treatment for drug dependency but are, coincidentally, indulging in drugs use.

Opiate drugs	Non-opiate drugs
Diamorphine (Heroin)	Cocaine
Dipipanone (Diconal)	Amphetamine (Dexedrine)
Dextromoramide (Palfium)	Benzodiazepines
Buprenorphine (Temgesic)	Cannabis
Morphine	MDMA (Ecstasy)
Hydromorphone (Palladone)	LSD
Oxycodone (OxyNorm, OxyContin)	Cocaine/Crack Cocaine
Papaveretum	
Opium	
Pethidine	
Methadone (Physeptone)	
Phenazocine (Narphen)	
Pentazocine	
Dihydrocodeine	

Form: CCR- E

NATIONAL DRUG TREATMENT MONITORING (New DMD)

Drug Treatment Agencies Client Review Form

For statistical purposes only; approved by the Department of Health via the Review of Central Returns Steering Committee (ROCR) and Ministers.

Please complete review at the end of the [financial] year. Please read notes on the back.

CLIENT PROFILE

B1 CLIENT DETAILS

Forename

Surname

Date of Birth (dd/mm/yy)

Gender M/F

Address OR, if NFA tick here

Number/Street

District

Town

Local Authority

Postcode

Agency Client Number

CONTACT STATUS

B2 CONTACT DETAILS

Date of Most Recent Contact

Is the client still in contact with the agency? Y/N

IF NOT, why no longer in contact?

1=Treatment completed, drug free	7=Moved away
2=Treatment completed	8=Prison
3=Treatment withdrawn/breach of contract	9=Died
4=No appropriate treatment available	10=Other
5=Referred on	11=Don't know
6=Dropped out/left	

TREATMENT INTERVENTIONS PROVIDED TO CLIENT - 1st APRIL - 31st MARCH

B3 PRESCRIBING BY YOUR SERVICE OR THROUGH A SHARED CARE ARRANGEMENT (1st April to 31st March)

Has client received substitute/detox prescribing? If yes, still receiving? Y/N DK Date Started

Drugs Prescribed (tick all prescribed)

- Methadone mixture
- Methadone other
- Methadone amps
- Lofexidine
- Benzodiazepines
- Dihydrocodeine
- Naltrexone
- Buprenorphone
- Other drugs — Specify

OR, tick here if client is still waiting for prescribing

Has client been urine tested?

Has client had daily pick up?

Has client had supervised consumption?

B4 SHARED CARE ARRANGEMENTS (1st April to 31st March)

Shared Care with GP or Drug Agency? If yes, still receiving? Y/N/DK Date Started

B5 NON PRESCRIBING TREATMENT BY YOUR SERVICE (1st April to 31st March)

Structured counselling? If yes, still receiving? Y/N/DK Date Started

Structured day programme? If yes, still receiving? Y/N/DK Date Started

Other interventions? If yes, still receiving? Y/N/DK Specify

B6 HEPATITIS B VACCINATION (1st April to 31st March)

Previously vaccinated? Y/N/DK

Vaccination started this year by your service? Y/N If yes, number completed 1 2 3 4 DK

DRUG TREATMENT AGENCY

B7 AGENCY DETAILS

Name/ Code of agency

Form completed by

9 Prescribing of Benzodiazepines

This guidance is based on a number of considerations :

1) Illicit benzodiazepine use is widespread and causes a wide variety of harm related to ingestion (intoxication, bizarre behaviour) injection (thrombosis, amputation) and withdrawal (psychosis, fits).

2) The illicit market only exists at all because benzodiazepines are widely *prescribed*.

3) The prescription of benzodiazepines to young people for the treatment of sleeping problems, anxiety or other psychological difficulties is rarely justified.

4) Prescription of prolonged reducing doses of benzodiazepines to a person with an *illicit* benzodiazepine habit rarely results in abstinence and more often ends in long-term prescribing and continued illicit use. It is therefore nearly always ill advised.

5) Drug misusers often maintain a pattern of "binge" use of benzodiazepines and can often be withdrawn more rapidly than patients with chronic daily use for anxiety.

9.1 Prescribing Guidelines:

The central aim of this guidance is therefore to reduce all benzodiazepine prescribing in younger persons to an absolute minimum and to strongly discourage *any* benzodiazepine prescribing in *all* persons with a history of drugs misuse.

- All illicit drug users who are being prescribed a repeat benzodiazepine should be given a reducing regime over 4-8 weeks and then stopped. Where this presents difficulty, advice should be sought from the DDU.

- Benzodiazepines should not be prescribed unless there is positive presence of benzodiazepines in the urine.

- New patients requiring benzodiazepines for therapeutic purposes (e.g. severe short term anxiety) and who are not poly-drug users should be prescribed benzodiazepines for not more than **ten** nights as an hypnotic or **four** weeks as an anxiolytic. Benzodiazepines should not be commenced on a **repeat** prescription.

- There is *no* requirement for "immediately necessary treatment" with benzodiazepines and this route should not normally be available. The patient's GP should always be contacted. In extreme circumstances (particularly out of hours) a *minimum* supply may be given until details can be confirmed with the patient's GP or Drugs Services.

- Requests, which arise through external (e.g. voluntary) agencies to prescribe benzodiazepines to problem drug users, are at variance with the above advice.

- Other drugs similar to benzodiazepines are likely to produce similar problems and should not be substituted for benzodiazepines.

Note: Benzodiazepines: Guidelines for use and management of withdrawal, October 1994 (Sefton Health Authority). Dealing with these drugs in therapeutic use, is in the process of being updated for use by General Practitioners in both Liverpool and Sefton Health Authority areas.

9.2 Withdrawal of benzodiazepines

In general patients can be withdrawn at a rate of one-eighth (range one tenth to one quarter) of the daily dose every week. A suggested withdrawal protocol for patients who have difficulty is:

- Transfer patient to equivalent dose of diazepam preferably taken at night.
- Reduce dose in weekly steps depending on the dose being taken; if withdrawal symptoms occur maintain this dose until symptoms improve.
- Reduce dose further, if necessary in smaller steps; it is better to reduce too slowly than too quickly.
- Stop completely.

9.3 Benzodiazepine equivalent doses

Drug	Dose
Diazepam	10mg
Temazepam	20mg
Nitrazepam	10mg
Lorazepam	1mg
Loprazolam	1mg
Oxazepam	30mg
Chlordiazepoxide	30mg

10 Community Detoxification Information

Please find below information relating to home detox that may be of help to you.

- Lofexidine (Britlofex) patient information sheet
- Lofexidine (Britlofex) data sheet
- Specimen Lofexidine (Britlofex) regime
- Naltrexone (Nalorex) data sheet. The DoH Guidelines suggest that Naltrexone be initiated within a specialist setting but may be continued to be prescribed in a primary care setting.

Should you require further information please do not hesitate to contact:

Detox Co-Ordinator and Team Members based at the Gateway Centre 0151 709 2231.

BRITLOFEX ™ TREATMENT FOR OPIATE DETOXIFICATION

What is BritLofex™ ?

BritLofex™ (CHEMICAL NAME Lofexidine) is a tablet that is effective in reducing the symptoms associated with opiate withdrawal or 'cold turkey' such as chills, sweating, stomach cramps, diarrhoea, muscle pain, runny nose and eyes.

How does it work?

When opiates are stopped abruptly the brain produces too much of the chemical noradrenaline which causes the withdrawal symptoms. BritLofex™ works by reducing the levels of noradrenaline and so reduces the severity of the symptoms.

Is it addictive?

No. It is not an opiate and has no addictive properties of its own.

How do I take it?

The initial does of BritLofex™ should be 1 tablet twice a day. Your doctor may ask you to increase this by 1 to 2 tablets per day (up to a maximum of 12 tablets per day) according to the severity of the withdrawal symptoms.

Providing you do not use opiates, the detoxification should take 7-10 days. At the end of treatment the dosage should be reduced gradually over a period of 2-4 days rather than stopped suddenly. Physically you will then be through the withdrawal.

Your doctor or drug dependency unit may give you a different dosage to that above. Always take BritLofex™ as directed by your doctor or drug dependency unit.

Are there any side effects?

You may possibly experience a dryness of the mouth, throat and nose. You may also feel slightly drowsy or dizzy. If you are affected do not drive or operate machinery.

Is counselling needed as well?

BritLofex™ is not the magic answer to opiate addiction. You may well still crave drugs and wish to use them after you are successfully detoxified. Therefore BritLofex™ can only be seen as part of a programme aimed at getting you to the point where you don't use drugs any more. Counselling may help you to overcome these and other problems.

DATA SHEET

BritLofex™ Tablets 0.2mg

Presentation

Round, peach, film coated tablets; 6.5mm diameter containing 0.2mg lofexidine hydrochloride.

Uses

To relieve symptoms in patients undergoing opiate detoxification.

Dosage and administration

Initial dosage should be one 0.2mg tablet twice daily. This dose may be increased by increments of 0.2 - 0.4mg per day up to a maximum of 2.4mg (12 tablets) per day, according to the patient's response. In cases where no opiate use occurs during detoxification, a duration of treatment of 7-10 days is recommended. In some cases a longer treatment period may be warranted.

At the end of treatment dosage should be reduced gradually over a period of at least 2-4 days (see under Precautions).

Contra-indications, warnings, etc.

Contra-indications: Lofexidine is contra-indicated in cases of sensitivity to other Imidazoline derivatives.

Interactions: Lofexidine may enhance the CNS depressive effects of alcohol, barbiturates and other sedatives, although concurrent medication to aid sleeping has frequently been used in withdrawal studies. Concomitant use of tricyclic antidepressants may reduce the efficacy of Lofexidine.

Pregnancy: The safety of lofexidine in pregnant women has not been established and it should only be administered during pregnancy if the benefit outweighs the potential risk to mother and foetus. It is not known whether lofexidine is excreted in human milk and caution should be exercised when it is administered to nursing mothers.

Community Detox Team

Lofexidine Regime

PATIENTS NAME…………………………… START DATE……………….

KEYWORKER CONTACT NO:………………………

DOSE TIMES	0800	1000	1200	1400	1800	2000	2200		2400
								/ /	

DOSE TIMES	**0800**	**1000**	**1200**	**1400**	**1800**	**2000**	**2200**		**2400**
Monday (2 tablets)		1			1				
Tuesday (4 tablets)		1			1	1	1		
Wednesday (8 tablets)	1	1	1	1	1	1	1		1
Thursday (10 tablets)	2	1	1	1	1	1	2		1
Friday (14 tablets)	2	2	1	1	2	2	2		2
Saturday (12 tablets)	2	1	1	1	1	2	2		2
Sunday (10 tablets)	2	1	1	1	1	1	1		2
Monday (8 tablets)	1	1	1	1	1	1	1		
Tuesday (6 tablets)	1		1	1	1	1	1		
Wednesday (4 tablets)	1		1		1		1		
Thursday (2 tablets)		1			1				
Friday (2 tablets)		1			1				

- 2400 hrs medication indicated in this column should only be taken on the advice of your Detox Worker.
- Please inform your Community Detox Worker if you deviate from these guidelines. To do so is not advisable.

Naltrexone Prescribing

Naltrexone is an opiate antagonist that is prescribed for 3-6 months once a patient has become drug free. Initial doses can be commenced within drug teams however, if the General Practitioner feels confident in prescribing Naltrexone, the GP should be encouraged to do so.

The procedure is outlined as follows:

1) Patient should be drug free for a minimum of 10 days. This can be verified through urinalysis (a patient should not bring in urine samples to be tested but provide a sample on site).

2) A Liver Function Test should be processed to eliminate concerns of liver damage, as Naltrexone is contra indicated with liver problems.

3) A test dose of Naltrexone 50 mgs OD should be administered within the surgery or clinic. The patient must stay at the site for a minimum of 30 minutes once the tablet has been administered. This is to monitor any side effects that may arise.

4) Once the test dose assessment has taken place, the patient should receive a weeks worth of Naltrexone to self-administer. Patients may return if problems arise or side effects such as inability to sleep, tremor etc. occur. The patient MUST BE MADE AWARE of the risk of taking opiate painkillers whilst being prescribed Naltrexone and encouraged to carry an information card on their person.

5) The patient should be reviewed regularly, at least once a month the dosage has been established.

For further information please contact your local Community Drug Team.

Referral guidelines for GPs making referrals to the Community Detox Programme

1) GPs should satisfy themselves that their patient meets the referral criteria outlined in the referral criteria.

2) Once the GP is satisfied that the patient meets the referral criteria, they can then refer them to The Community Detox Team using the Detox Referral sheet.

3) Once the patient has been referred to the Community Detox Team they will be offered an assessment.

4) If the patient is deemed suitable for the Community Detox, the GP will be updated regarding a commencement date and progress throughout the programme.

5) If the patient is deemed not suitable for commencement on the programme, then they will be referred back to the GP with the relevant reasons given. The feedback given back to the GP will indicate whether any necessary preparation work will be required and state who will be responsible for this preparatory work. This non-acceptance should not mean that the patient couldn't be referred for a Community Detox at a later date once the necessary changes have occurred.

6) When accepted onto the programme, follow up care and support can be expected.

7) A fully structured programme will be discussed and agreed with the patient and a medical assessment will be carried out by a Doctor within The Substance Misuse Service to assess for medical suitability.

8) A prescription of Lofexidine or Subutex or other appropriate drugs for the period of the Detox Programme will be issued. Monitoring and observation for illicit drug use will form part of the programme.

9) Information and Orientation of the nature of the programme will be given both to the patient and the carers or relatives.

10) There will be daily visits from the Detox Worker to monitor physical, psychological and social conditions.

11) The patient will have continual access to advice and information for the Detox Team via telephone.

12) There will be on going assessment and supervision for the patient from the worker throughout the programme.

13) Discussion and planning for the longer-term future and referral on to other rehabilitation agencies will take place.

14) Following completion of the programme, the GP will be notified of the outcome and on going arrangements for rehabilitation.

Community Detox Team - Referral Criteria (ref to 5.0)

Referral criteria for patients being considered for this type of treatment will Include:

- Patients who are on 40mgs or less of methadone only per day and demonstrating a degree of stability.
- Patients who are not poly-drug users, in particular benzodiazepine users.
- Patients who have a good support from their family/community.
- Patients who are highly motivated in showing evidence of reducing methadone that they are prescribed.
- Patients who have positive and realistic plans for their futures (re: education, employment, relapse prevention etc.).
- Patients who are prepared to assist in the formulation of a follow-up following a successful detoxification.
- Female patients must have a negative pregnancy test.
- Patients with a history of enduring mental illness, may need to be assessed by a consultant or designated member of their team as to be suitable for detox.
- If you have any concerns or questions regarding the suitability of a particular patient please contact the Detox Co-ordinator on 07771 794 461 for clarification.
- Subutex will cause marked Opiate withdrawal symptoms if administered to an addicted patient who is not starting to show typical withdrawal symptoms. The equivalent dose of Buprenorphine to the Opiate it is replacing is variable and dose titration is required for up to seven days until stability is achieved. Patients need to be on a stable dose before commencing a withdrawal regime. Stability is defined when no signs of Opiate withdrawal symptoms are experienced over the full 24 hour period as assessed by staff.
- It is recommended that Liver Function Tests should be carried out prior to initiating Subutex.
- Urine screening will be carried out – it should be noted that Subutex is not detected routinely on most urine toxicology.

Screen Tests - Community Detox Team using Subutex

- On assessment the Community Detox Team will discuss with the patient whether they are suitable for home detoxification, and who may then be offered a Subutex detox as an alternative to Lofexidine.

- The Community Detox Team will use a rapid dose reduction regime that will be tailored to individual clients patients drug use and response to treatment.

- At the onset Subutex will be prescribed only to patients undergoing a structured programme with the Community Detox Team with the intention that the GP will prescribe at a later date.

Indicated in the table below are the recommended regimes outlined expected dosages:

Total daily doses of buprenorphine are shown in the columns below							
DAy	Crossover phase from methadone 30mg	DAy	Crossover phase from heroin £30	DAy	Crossover phase from methadone 20mg	DAy	Crossover phase from heroin £20
1	4mg			1	4mg		
2	8mg			2	6mg		
3	8mg	1	4mg	3	6mg	1	4mg
4	8mg	2	8mg	4	6mg	2	6mg
-	Reduction phase	-	Reduction phase	-	Reduction phase	-	Reduction phase
1	6mg	1	6mg	1	4mg	1	6mg
2	4mg	2	4mg	2	4mg	2	4mg
3	2mg	3	2mg	3	2mg	3	4mg
4	2mg	4	0.8mg	4	2mg	4	0.8mg
5	1.6mg	5	0.4mg	5	1.6mg	5	0.4mg
6	1.2mg			6	1.2mg		
7	0.8mg			7	0.8mg		
8	0.8mg			8	0.8mg		
9	0.4mg			9	0.4mg		
10	0.4mg			10	0.4mg		
Three days after the last dose of buprenorphine the patient can be started on Naltrexone							

Symptomatic treatment of withdrawal symptoms will be in line with the directorates policy/guidance in relation to prescribing as follows:-

Stomach Cramps discomfort	HYOSCINE (Buscopan) 20mg Q.D.S. Maximum. X3 days
Leg Cramps	QUININE SULPHATE 300mg NOCTE. X 5 nights
Vomiting	METOCLOPRAMIDE 10mg 8hriy Symptomatically
For pain relief	DICLOFENAC SODIUM 50mg T.D.S. Maximum Symptomatically
An alternative for pain relief	IBUPROFEN 200mg to 400mg Q.D.S. Maximum Symptomatically NB: Note precautions when using – NS Anti-inflammatories
Insomnia	ZOPICLONE 7.5 to 15mg NOCTE Maximum X 3 nights

The above list is a recommendation only and prescribing doctors may wish to prescribe other medications in some cases.

Before any of the above interventions are considered it is policy that patients clients are offered and have tried alternative methods of relief for all of the above symptoms which are on offer from the Detox Team worker.

In general, patients will be seen daily and symptomatic medical treatment will be offered as required. Those include Buscopan for abdominal cramps and diarrhoea, hypnotic intervention for insomnia and a range of complimentary therapies. If analgesia is required it would be prescribed on an individual basis.

- All patients will be given relevant Subutex information leaflets.

- All patients will have daily-supervised consumption until stability is achieved.

- Any patient found to be misusing their Subutex prescription will have treatment immediately discontinued.

- It is an expectation that all patients comply with urine testing as and when required.

- Patients who are found to be **significantly** misusing alcohol and benzodiazepines will have their treatment urgently reviewed and it may be discontinued.

- All prescriptions for Subutex to be done on pink FP10s, which allows for installment prescribing and dispensing.

SAMPLE AGREEMENT

Sample Agreement

Name………………………………… Date……………………

Doctors, Staff and many Patients have been upset by the behaviour of some Surgery attenders. Many of these people are attending for prescriptions of addictive drugs. You are now receiving a regular prescription for addictive medication and we require you to accept these rules.

Behaviour

1) I agree to attend appointments promptly and quietly.
2) I agree not to upset the Receptionists or other patients in the Waiting Room
3) Due to restriction of space in the Waiting room. I agree to attend my appointments unaccompanied whenever possible.

Behaviour outside these limits may result in the Receptionists or Doctors asking you to leave the Surgery premises. If necessary, the Police will be called and you may be removed from the Practice List and no longer be seen at this Surgery.

Prescription, Medication and Appointment:

1) I agree to be responsible for making my appointments and checking that my appointment is correct in our appointment book - most practices use computers these days.
2) I accept responsibility for turning up for my appointment on time.
3) I agree to attend only the Doctors mentioned below, on this form, and to discuss my prescription only with them.
4) I agree not to use emergency appointments or house calls to discuss my prescription.
5) I agree to be responsible for my prescription and medication and recognise that these cannot be replaced.
6) I agree that no alteration will be made to my prescription without my own Doctor's permission.

My doctor is Dr…………………………….. his/her half day is:………………………

I have read the above rules, I understand what they mean and I agree to abide by them. If I do not abide by these rules then I understand that certain sanctions may be imposed. I understand that these sanctions are at the discretion of the Doctor and include:

1) Withdrawal of privileges e.g. take-away medication, supervision of medication ingestion.
2) Transfer to another Doctor/Treatment Centre.
3) Reduction in prescribed methadone.
4) Immediate discontinuation of methadone.
5) Removal from Doctor's medical list.

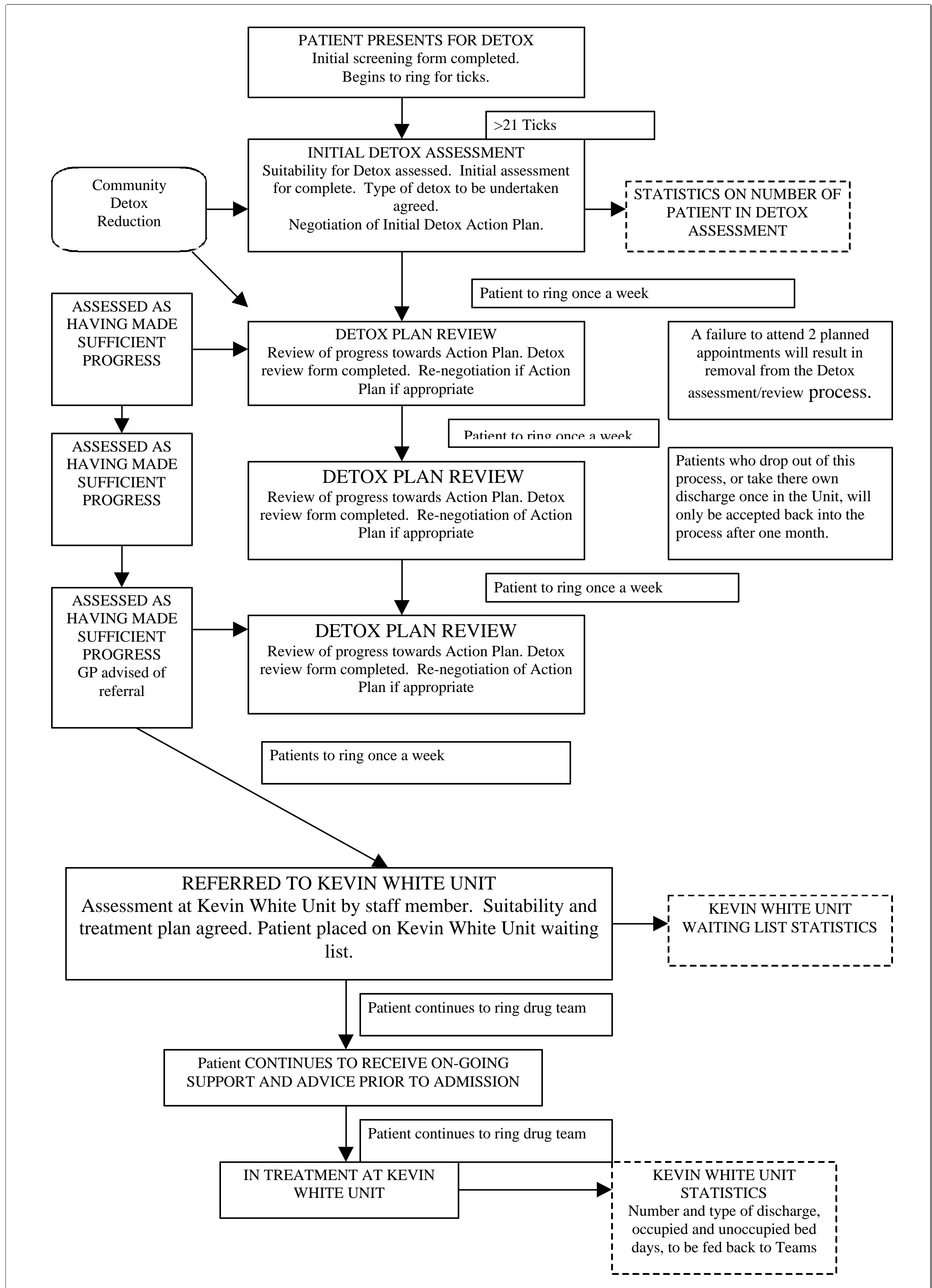
These sanctions will be at the Doctor's absolute discretion.

Signature: ………………………….(Patient) Date: ……………………

Signature: ………………………… (Doctor) Date: :…………………

Key worker contact no……………………..

Kevin White Unit Entry into treatment Flow Chart



11 Supervised Methadone Mixture Consumption Scheme

Aims of Scheme

To provide a service to drug misusers, clinicians and CDT workers, which will help ensure that prescribed methadone is consumed under professional supervision and appropriate information is recorded.

Objectives

- To ensure that the patient takes the correct doses of medication as prescribed.
- To prevent prescribed medication being diverted to the illegal market .
- To reduce the possibility of accidental poisoning of children.

Principles of Scheme

- Supervised consumption is recommended for the target groups for a period of 3 months.
- The need for supervised consumption should take into account the patients' social factors including employment and child care responsibilities.
- Supervision may create a form of secondary dependence. Referral to the scheme should not be viewed as a punishment. Once established, patients should be trusted to take their medication home, beginning with a daily pickup.
- Supervised consumption shall be available for a minimum of 6 days each week.
- Community pharmacists will be supported by the patients keyworker and the CDT/prescriber.
- The patient enters into a "contract" with the pharmacist to promote appropriate patient behavior.
- A designated private area shall be made available to maintain the dignity of the patient and other customers.
- All designated pharmacists shall attend accredited training course(s) to remain eligible to continue in the scheme.

Referral Criteria

The prescriber/key worker will refer new patients onto the scheme after full discussion with the patient and community pharmacist. Target candidates will include all new patients especially:

- Those recently discharged from prison.
- The mentally ill.
- Vulnerable patients who may have been bullied into giving away or selling their methadone.

Existing patients may be referred to the scheme if:

- Collection of medication is erratic.
- Unsatisfactory urine tests are produced.
- There are concerns over diversion or inappropriate use of medication.
- The patient shows a continued and unstable pattern of drug misuse.

Supervision will normally be for a maximum period of 13 weeks.

Liaison

It is important that links are established and built upon between the CDT/prescriber and community pharmacists involved in the scheme. To avoid confusion and mixed messages, each patient will have a key worker who will remain in contact with the pharmacist. This will include the passing on of any relevant information the pharmacist may require on the patient's background when they enter the scheme. Regular contact between the key worker/prescriber and pharmacist may provide information on drug/alcohol intake, physical appearance, general health, etc.

Practical Aspects

Before any patient is referred onto the scheme, the nominated pharmacist who will supervise consumption should be contacted in order to obtain consent for supervision. A time at which the patient can attend the pharmacy for the first dosage should be arranged. This should be mutually convenient for the patient and pharmacist.

Any prescription issued to a patient requiring supervision should:

- Be on form FP10(MDA) or FP10 ((HP)(ad).
- Be for daily consumption but make allowances for weekends and bank holidays where take home doses shall be given
- State ***"Supervised Consumption"*** and the name of the participating community pharmacy.
- Comply with all legal requirements.
- Cover a maximum time period of 14 days.
- Be legible.

The patient should be instructed to take the prescription only to this pharmacy. The patient will also be expected to sign a "contract" detailing the terms of entry into the scheme.

It will include:

- Time for attendance at the pharmacy. This will be negotiated between the parties.
- Standards of behaviour.
- Arrangements when the pharmacy is closed.
- Consequences of missed doses.
- Notification that feedback to CDT/key worker is an integral and non-negotiable part of the scheme.
- Pickup by others is not possible.

The contents of this document should be covered during the consultation between the prescriber and patient.

The patient should be given a letter of introduction to give to the pharmacist. This must be signed by the patient and witnessed by the prescriber/key worker. This will provide a form of identification to help ensure the patient who consumes the methadone at the pharmacy is the person for whom it was prescribed.

Feedback from Pharmacists

Each supervising pharmacist will provide feed back to the key worker/prescriber (Appendix 1) This will take the form of:

- Routine information detailing the patient's attendance, health, general behaviour, etc. This feedback will occur monthly.

- Minor incident reporting such as verbal abuse or deteriorating behaviour. This will be made on a weekly basis (Appendix 2).

- Major incident reporting e.g. the patient is very aggressive, appears intoxicated or attacks a customer/member of staff. In such cases the prescriber/key worker will be informed immediately by telephone. A written incident report will be made using the appropriate form. The supervising pharmacist has the authority to withhold medication if he/she deems necessary.

Standardized forms are available for such reporting.

When a patient shows continued progression consideration should be given to moving from supervised consumption to daily collection. The feed back offered from the supervising pharmacist should be taken into consideration before making such a decision.

A written protocol will be in place in the pharmacy to maintain continuity from those providing the supervised service. The protocol will include

- A standard operating procedure.
- Detailed procedures to follow when a new patient enters the scheme.
- Maintenance of records and feedback to CDT/prescriber/key worker.
- Procedures to ensure correct identification of patient and key worker.

The pharmacist may also contact the CDT/Prescriber/key worker if:

- The patient appears ill.
- The patient misses one or more doses.
- The patient tries to avoid supervision.
- The patient is intoxicated with drugs or alcohol.
- The behaviour of the patient is unacceptable, e.g. shoplifting, verbal abuse, erratic time keeping, etc.

Patient Contract

While you are receiving methadone, to be taken under the supervision of the pharmacists, there are some rules which we ask you to follow. Failure to do so may result in your prescription being stopped. Please read the guidelines below and sign to show that you understand and accept them.

1) Your medication will be prepared and ready for you to take on the premises each day that the Pharmacy is open.

2) You should attend the Pharmacy at the arranged time each day. This time will be negotiated between yourself and the pharmacist.

3) You must take your medication in front of the pharmacist, followed by a drink of water, which will be provided.

4) Your medication must be taken in the Pharmacy on the days stated on your prescription. **The pharmacist cannot dispense to you on any other days than those stated**. Missed doses cannot be dispensed in retrospect.

5) On days when the Pharmacy is closed. e.g. Sundays, Bank Holidays, you will be given a dose to take away on the day prior to closure. You must ensure it is stored in a safe location away from children.

6) Once you have been handed your medication, it is your responsibility to take care of it. If you drop your methadone it cannot be replaced.

7) Where possible, you should be unaccompanied when you attend the Pharmacy.

8) Aggressive or disruptive behaviour in the Pharmacy is unacceptable, and will result in expulsion from the Pharmacy. The pharmacist may call the police if deemed necessary. If the pharmacist considers you to be intoxicated, the dose will be withheld while the CDT is contacted.

9) The pharmacist will pass on any information regarding your health and progress to the prescriber/CDT.

Signed.. Date.........................

Print Name..

Appendix 1

Name Key worker	Address

Prescription serial number:

Date	Dose taken	Appearance	Behaviour	Notes
	Y / N	1 2 3 4 5	1 2 3 4 5	
	Y / N	1 2 3 4 5	1 2 3 4 5	
	Y / N	1 2 3 4 5	1 2 3 4 5	
	Y / N	1 2 3 4 5	1 2 3 4 5	
	Y / N	1 2 3 4 5	1 2 3 4 5	
	Y / N	1 2 3 4 5	1 2 3 4 5	
	Y / N	1 2 3 4 5	1 2 3 4 5	
	Y / N	1 2 3 4 5	1 2 3 4 5	
	Y / N	1 2 3 4 5	1 2 3 4 5	
	Y / N	1 2 3 4 5	1 2 3 4 5	
	Y / N	1 2 3 4 5	1 2 3 4 5	
	Y / N	1 2 3 4 5	1 2 3 4 5	
	Y / N	1 2 3 4 5	1 2 3 4 5	
	Y / N	1 2 3 4 5	1 2 3 4 5	

1 = good
3 =acceptable
5 = unacceptable

Comments

Appendix 2

Minor Incident Report

For your information.

Client: …………………………………………………………………

Date:……………………………………………………………………

Was key worker/prescriber informed? Y/N

Date of incident: ..... /..../.....

Details

Outcome

Major Incident Report

Client:……………………………………………………………………………….

Date:………………………………………………………………………………

Was key worker/prescriber informed? Y/N

Date of incident ..... /..../.....

Was medication withheld Y/N

Police informed Y/N

Details

12 Child Protection

All those working in the field of health have a professional responsibility to protect children, and their participation in interagency support to Social Services Departments is essential if the interests of children are to be safeguarded.

Primary Care staff are well placed to identify children who are being harmed or who may be at risk of harm and should be aware of the signs and symptoms of abuse and the procedures to follow:

- The protection of the child is paramount.
- Advice is available from Specialist H.V. Fran Fitzgerald based at Liverpool DDU for DDU patients (telephone 709-0516).
- Where there is risk to the life of a child or likelihood of serious injury, the agencies with the statutory child protection powers must secure the immediate safety of the child (Social Services and Police).
- Alder Hey Children's Hospital provides the Rainbow Centre, a specialist service for the examination of children who are alleged victims of abuse.
- Referral to Liverpool Social Services.

	Telephone Number	**Fax**
Child Protection Register Custodian/Snr. Manager (Child Protection Unit –Central Office)	0151-225-3375	0151-225-6058
Emergency Duty Team	0151-524-1165	0151-525-8821
Designated Nurse – L. Rodgers Rathbone Hospital	0151-250-3663	0151-252-5120
Designated Doctor – Dr. M. Walters Community Child Health	0151-228-4811 (Ext. 3063)	0151-252-5120

Child Protection Facilitators, Health Visitors with responsibility for Child Protection (depending on child's address).

		Telephone Number	**Bleep**
South Sefton	J. Croll	0151-924-9151	0893-599912
South Liverpool	T. Birch	0151-733-0191	0945-333111
Central Liverpool	A. Jennings	0151-726 9099	0345-333111
North West Liverpool	J. Scott	0151-261-0519	0345-333111
North East Liverpool	R. Sawle	0151-228-3846	0345-333111

- Refer to Child Protection Procedures Manual.
- NMCT provide specialist support and advice to staff on intervention and prevention of child abuse.

13 The Pregnant Drug User

The Liverpool Women's Hospital/Aintree Centre for Women's Health employs Drug Liaison Midwives. They can be contacted on:

LWH Bookings – Kath Siney: **Telephone:** 0151-708-9988 ext 4014 **Bleep:** 201

Aintree Centre for Women's Health Bookings: Carol O'Keefe }
Jackie Connolly } 0151 529-3969

All pregnant drug users will be seen and treated as a priority within the drug services and managed by a multidisciplinary team of professionals, who have an interest in pregnant women.

Treatment of a pregnant drug misuser will include the following steps:

- Full assessment of drug history before treatment by key worker in liaison with the midwife.
- Reduce anxiety *(anxiety leads to greater drug abuse).*
- Stabilise then detoxify if possible.
- Encourage regular antenatal care on a variety of sites, as appropriate. Seen monthly for antenatal care and by the drug liaison midwife or other appropriately qualified professional.

Interagency

- Information Sharing and Communication

Remember!

- Advise the woman to avoid alcohol and try to stop smoking.
- Advise on diet and nutrition.
- Advise slow reduction of regular opiates and benzodiazepines
- Misuse of non-opiate drugs should be discouraged.
- If injecting change to oral
- Liaison with Social Services and referral for assessment if unborn child at risk of significant harm.

All pregnant drug users will be seen and treated as a priority.

If you wish to discuss any issues or seek advice, please contact the drug liaison midwife on the above contact numbers.

14 Liverpool and Sefton - Service Provision – Directory 2002/2003

Statutory Services	
The Gateway Centre 8 Maryland Street Liverpool L1 9BX Tel: 0151-709-2231 Fax: 0151-709-7815	Part of Mersey Care NHS Trust HIV Prevention Services Outreach Team Needle/syringe exchange Pre/post HIV testing, hepatitis screening and vaccination Annex to Liverpool Drugs Dependency Unit Home detox team base, separate to HIV prevention services Dual diagnosis care programme approach programmes
Liverpool Drug Dependency Unit Hope House 26 Rodney Street Liverpool L1 2TQ Tel: 0151-709-0516 Fax: 0151-707-2721	Part of Mersey Care NHS Trust Drug Treatment Services Support Groups Prescribing Referral for detoxification Pregnancy support clinic with a visiting midwife Complimentary therapies Dual diagnosis care programme approach programmes
North Liverpool Community Drug Team Queens Drive Family Health Clinic Moor Lane Walton Liverpool L4 6SD Tel: 0151-523-4550 Fax: 0151-524-5232	Part of Mersey Care NHS Trust Counselling Syringe exchange scheme Advice and support Prescribing Midwife clinic Dual diagnosis care programme approach programmes
Southport Community Drug Team 46 Hoghton Street Southport PR9 0PQ Tel: 01704 533133 Fax: 01704-501289	A partnership between Mersey Care NHS Trust and Merseyside Drug Council One to one counselling General health team Syringe exchange scheme Outreach team Dual diagnosis care programme approach programmes
South Sefton Community Drugs Team 18 Great George's Road Waterloo Liverpool L22 1RB Tel: 0151-928-8441 Fax: 0151-928-3406	Part of Mersey Care NHS Trust Substance Misuse Directorate Multi-agency team offering information, advice, counselling and prescribing, Syringe exchange services Midwife clinic Dual diagnosis care programme approach programmes

Voluntary Services	
Merseyside Drugs Council (Liverpool Project) 27 Hope Street Liverpool L1 9BQ Tel; 0151-709-0074 Fax: 0151-708-7603	Bail support GP liaison Counselling Support groups Arrest Referral Scheme
Drug Free Duncan House 64-66 Islington Liverpool L3 8LG Tel: 0151 207-1133 Fax: 0151 207-1146	Advice and support (Black box) Befriending Fitness programmes Relapse Prevention services
Liverpool 8 Project Unit 5 Myrtle Parade Liverpool L7 7EL Tel: 0151 709-8100 Fax: 0151 707-1500	Referral Service for black and visible minority groups
Dare to Care 112 Mill Lane Liverpool L8 5UB Tel: 0151-709-8528 Fax: 0151 709 8528	Acupuncture Alternative Therapies
Merseyside Drugs Council Stanley Road Project Station Road Bootle L20 5AF Tel: 0151-933-6411 Fax: 0151-933-6411	Needle and syringe exchange Primary Health Care Counselling Outreach work Alternative therapies
NHS Direct 0845 4647	24 hour Nurse led service offering confidential healthcare advice and information
National Drugs Helpline Tel: 0800 776600	Help advice and information.
HIT Hanover House Hanover Street Liverpool L1 3DZ Tel: 0870 990 9702 Fax: 0870 990 9703	Advice and information on drugs Resource library
Boscoe Project 59/61 Merton Road Bootle Liverpool L20 7AP Tel: 0151 944 1818 Fax: 0151 944 1818	Accommodation for homeless drug addicts Methadone programme Training courses related to the building/catering trade Wood construction

Rehabilitation Units

Rehabilitation Units	
Kevin White Unit Sefton General Hospital site Smithdown Road Liverpool L15 2HE Tel: 0151-330-8074 Fax: 0151-330-8077	Consultant led service Part of Mersey Care NHS Trust Inpatient detoxification from all illicit drugs Stabilisation on oral medication telephone support , advice and follow up Counselling Support groups Referral onto other agencies Naltrexone support group Complimentary and alternative therapies
Phoenix House Upton Road Bidston Wirral L43 7QF Tel: 0151-652-2667 Fax: 0151-653-6118	Rehabilitation programmes Support groups Detoxification
Turning Point Substance Misuse Project 27 Hoole Road Chester CH2 3NH Tel: 01244-314320 Fax: 01244-325875	Information, Advice & Counselling Group work Structure programmes Residential drug and alcohol detoxification programmes
Birchwood Arch Initiatives Oliver Street East Birkenhead CH41 6HH Tel 0151 647 8633 Fax: 0151 650 0912	Rehabilitation programmes
Integrated Care Team 1-7 Brougham Terrace West Derby Road Liverpool L6 1AE Tel: 0151 225 4933 Fax: 0151 225 4942	Partnership by Health, Primary Care ,Social Services and Probation Multi agency approach to shared care within a primary care setting Assessment, support, review and ongoing work with GPs and patients
Liverpool Social Services Substance Misuse Team 1-7 Brougham Terrace West Derby Road Liverpool L6 1AE Tel: 0151 225 4933 Fax: 0151 225 4942	Referral to social work teams in regard to child protection Referral to rehabilitation services Assessment team

Rehabilitation Units	
SHADO (supportive help against drugs organisation) The Paul Thompson Centre 88-93 Stonebridge Lane Croxteth Liverpool L11 4SJ Tel: 0151-546-1141 Fax: 0151-548-6972	Support, information and aftercare General counselling Creche facilities Family support service Drop in Complimentary therapy Young people's group
Walton and District Family Support 5/6 Tetlow Way Walton Liverpool L4 4QS Tel: 0151-298-1058	Local telephone helplines Family support groups Drop in Centre parent group meetings Advice and information
Sahir House P.O. Box 11 Liverpool L69 1SN Tel: 0151-709-9000 Fax: 0151-707-1716	HIV/AIDS Support groups HIV Race and Equality Worker Complementary Therapies Telephone helpline
Parents Against Drug Abuse (PADA) The Ellergreen Multipurpose Activity Centre Ellergreen Road Norris Green Liverpool l11 2RY Tel: 0151 270 2108 Fax: 0151 285 0124	Support and Advice for parents and families. Educational programmes Complimentary therapies.
CITA (council for involuntary tranquilliser addiction) Cavendish House Brighton Road Waterloo L22 5NG Tel: 0151-949-0102	Information and assistance to people withdrawing from benzodiazepines and anti depressants

<table>
<tr><th colspan="2">Education, Employment and Training</th></tr>
<tr><td>Alternative MDC Ltd.
Huyton Training Workshops
Link Road
Huyton
Knowsley
Merseyside L36 6AP

Tel: 0151 449 1929
Fax: 0151 482 7177</td><td>Skills based organisation for drug users concentrating on carpentry and metalwork</td></tr>
<tr><td>Independence Initiative
64-68 Balliol Road
Bootle
Liverpool L20 7EJ

Tel: 0151 2841100
Fax: 0151 286 0015</td><td>Facilitate drug users into mainstream education, employment
Facilities</td></tr>
<tr><td>The Social Partnership (Transit)
Canning Place
Liverpool L1 8BT

Tel: 0151-709-1123
Fax: 0151-709-7779
e-mail transit@thesocialpartnership.co.uk</td><td>Drug Prevention
Day Care Rehabilitation Project</td></tr>
<tr><th colspan="2">Alcohol Services</th></tr>
<tr><td>Sefton Alcohol Service
22 Union Street
Southport
PR9 OQE

Tel: 01704 542332
Fax: 01704 542332</td><td>Counselling
Family support
Primary care led service</td></tr>
<tr><td>Alcohol Services (CIC) Liverpool
4th Floor
Merseyside House
9 South John Street
Liverpool L1 8BN

Tel: 0151-707-1221
Fax: 0151-709-1576</td><td>Counselling
Family support
Hospital and community visiting
Assessment and information</td></tr>
<tr><td>Windsor Clinic Alcohol Treatment Service
University Hospital Aintree
Lower Lane
Liverpool L9 7AL

Tel: 0151 529 2450
Fax: 0151 529 2454</td><td>Part of Mersey Care NHS Trust
24 hour service
Treatment and intervention
Information and advice
Group work
Counselling
Detoxification</td></tr>
<tr><td>Alcoholic Anonymous (AA)

Tel: 0151 709 2900
National Tel: 0845 7697555</td><td>Help and advice on alcoholism
Telephone helpline
Literature</td></tr>
</table>

National Helplines	
Release 388 Dale Street London EC1 9LT Tel: 020 7729 9904	Advice and information regarding rights on arrest
Narcotics Anonymous Tel: 0207 730 6009	24 hour drug helpline Range of self help groups throughout Sefton and Liverpool
Mainliners Tel:0207 582 3338 Fax: 0207 582 6999	Advice and information for people affected by drugs/HIV
Same day HIV testing Ward 24 University Hospital Aintree Longmoor Lane Liverpool L9 7AL Tel: 0151 529 3490 Fax: 0151 529 3109	Same day HIV testing Hep B + C screening Advice and support Counselling
National AIDS Helpline Tel: 0800 567123	24 hr helpline Advice and information on AIDS/HIV Information on any aspect of HIV/AIDS to the general public.
Terence Higgins Trust 52-54 Grays Inn Road London WC1X 8JU Tel: 020 7831 0330 Fax: 020 724 20121	Advocates on behalf of people affected by HIV/AIDS Health promotion Develops innovative models of care
National AIDS Trust New City Chester 196 Old Street London GC1V 9FV Tel: (0)207 814 6767 Fax: (0)207 216 0111	Fundraiser and grant making trust Campaigns to promote effective prevention, quality treatment and care

15 Pharmacy Syringe Exchange - 2002-2003 – Liverpool

1. Blacks
   101 Wavertree Road
   Liverpool
   L7 1PG
   Tel. 0151 263 1112

2. Houghton & Lappin
   15 Saint Oswald Street
   Liverpool, L13 2BD
   Tel. 0151 228 3108

3. Riverside
   (Jacobsons)
   Riverside Health Centre
   Liverpool, L8 6AP
   Tel. 0151 706 8305

4. Kays
   3-5 Shaw Street
   Liverpool, L6 1HH
   Tel. 0151 207 5117

5. Moss
   (Kingsleys)
   206 Boaler Street
   Liverpool, L6 6AW
   Tel. 0151 263 2731

6. Landford
   34 Landford Avenue
   Liverpool, L9 6BR
   Tel. 0151 525 1615

7. McCanns
   28 Lark Lane
   Liverpool, L17 8US
   Tel. 0151 727 3076

8. Melwood
   10 Deysbrook Way
   Liverpool, L12 4XF
   Tel. 0151 228 0810

9. Moffat
   (Ford)
   157 Lodge Lane
   Liverpool, L8 0QQ
   Tel. 0151 733 5477

10. Moss
    68-70 London Road
    Liverpool, L3 5NF
    Tel. 0151 709 5271

11. Normans
    155 Walton Road
    Liverpool, L4 4AH
    Tel. 0151 207 0331

12. O'Briens
    50 Saint Marys Road
    Liverpool, L19 2JD
    Tel. 0151 427 4948

13. Cohens
    (Sunscript)
    9 Townsend Lane
    Liverpool, L6 0AX
    Tel. 0151 263 1715

14. Speke Health Centre
    North Parade
    Liverpool, L24 2XP
    Tel. 0151 486 1259

15. Houghton & Lappin
    (Woods)
    66 Muirhead Avenue East
    Liverpool, L11 1EN
    Tel. 0151 226 1374

15 Pharmacy Syringe Exchange - 2001-2002– Sefton

1. Crowthers Chemist Ltd
   127 Cambridge Road
   Southport PR9 9SD
   Tel. O1704 228437

2. McDougalls Pharmacies
   35 Upper Aughton Road
   Birkdale
   Southport
   Tel. 01704 568401

3. SK Chemists
   103 Marsh Lane
   Bootle L20 4B
   Tel. 0151 9441013

4. Hirshmans Chemist
   Dryblend Ltd
   56/62 Station Road
   Southport
   PR8 3HW
   Tel. 01704 577376
5.
   Davey's Chemist
   59 Randall Drive
   Ford
   Liverpool
   L30 2PB
6. Tel. 0151 4760007

   Superdrug Pharmacy
   10 Eastbank Street
   Southport
   PR8 1AF
7. Tel. 017045 30994

   Seaforth Pharmacy
   59 Seaforth Road
   Seaforth
   Liverpool
   L21 3TX
   Tel. 0151 928 3733