

Department of Health
Scottish Office Department of Health
Welsh Office
Department of Health and Social Services,
Northern Ireland

Drug Misuse and Dependence – Guidelines on Clinical Management

An Executive Summary

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Who are these Guidelines for?

These Guidelines have been ratified by the Department of Health, The Scottish Office Department of Health, the Welsh Office and the Department of Health and Social Services, Northern Ireland. They will serve as a framework for all doctors working within the NHS and private health care system within the UK.

These Guidelines are written with a particular focus on generalist practitioners but the working relationships between different types of practitioners are also considered.

These Guidelines are written for all doctors. They are intended particularly for those doctors who are ‘generalists’ in the sense that they do not have any particular expertise in drug misuse e.g. general practitioners, physicians, surgeons and obstetricians; and for those practitioners who have varying degrees of training and expertise in treating drug misusers, including specialists in drug misuse and some general practitioners.

Background to these Guidelines

The previous Clinical Guidelines were published in 1991. Since then, both the nature of drug misuse (the extent, type and quantity of drugs used) and the delivery of health care (expansion of primary health care teams, primary care groups, primary care trusts, integrated community mental health and primary health care, salaried GPs, nurse practitioners) have changed considerably. The Clinical Guidelines reflect these changes, as well as the increased prominence of drug misuse on the national agenda, with the appointment of a United Kingdom Anti Drugs Co-ordinator and a ten-year Drug Strategy.

Evidence-based practice

Given the broad range of clinical topics covered in these Guidelines and the variable level of the evidence available, the Guidelines working group has, by a process of consensus, selected the best available evidence from whatever source. It has relied substantially on the major undertaking of the Task Force to review the evidence base for services for drug misusers. The group has attempted to incorporate all significant evidence that has been published since the publication of the task force review. In the context of the process of systematic reviewing there are currently, with some exceptions, only a limited number of rigorous reviews available in the field of drug misuse. We would recommend that systematic reviews be further developed along the lines of the Cochrane Collaboration and that any such reviews are incorporated in a future review of these Clinical Guidelines.

Key principles

The key principles underpinning the Clinical Guidelines are summarised below.

The details of clinical management are presented within individual chapters. These include general principles, assessment, detoxification, maintenance and relapse prevention.

1. Drug misusers have the same entitlement as other patients to the services provided by the National Health Service. It is the responsibility of all doctors to provide care for both general health needs and drug-related problems, whether or not the patient is ready to withdraw from drugs. This should include the provision of evidence-based interventions, such as hepatitis B vaccinations and providing harm-minimisation advice.
2. These Guidelines stress the importance of a shared care approach (predominantly between primary and secondary care) in the management of drug misusers. Shared care is seen as a rational model to improve service delivery, utilising different skills in the most effective manner. Shared care schemes should not be limited to prescribing, they should cover a range of treatment options which can be offered to the patient.
3. Medical practitioners should not prescribe in isolation but should seek to liaise with other professionals who will be able to help with factors contributing to an individual's drug misuse. A multidisciplinary approach to treatment is therefore essential.
4. In instances where there are no local specialist services with which a shared-care agreement can be developed, it is the responsibility of the health authority to ensure that appropriate services are in place. This might mean developing a shared-care arrangement with a more distant specialist service, or, in some cases, with a service in the independent or private sector. It could also involve providing support for primary care practices to develop as secondary providers i.e. specialised generalists. The guiding principle is that support for GPs should include expert clinical advice (including prescribing advice) and guidance on medico-legal matters, and be grounded in knowledge and experience of treating more complex cases (e.g. polydrug dependence, pregnant drug misusers and mental illness).

Good prescribing practice

Assessment and initiating treatment

Prescribing should be seen as an enhancement to other psychological, social and medical interventions.

Good assessment is vital 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 assessment is completed. Assessment skills are vital for all members of the multidisciplinary team, including drugs workers, psychologists, nurses and doctors.

The clinician has a responsibility to ensure that the patient receives the correct dose and that sufficient effort is made to ensure that the drug is used appropriately and not diverted onto the illegal market.

Dose induction

Doctors need to understand that the first two weeks of treatment with methadone is associated with a substantially increased risk of overdose mortality. Starting a prescription requires careful assessment for evidence of opiate dependence, withdrawal and tolerance, and the use of confirmatory tests such as urine screening. Furthermore, a good knowledge of the pharmacology and toxicology of the drugs prescribed, as well as a careful induction regimen, is critical. This should ensure that, in the early phase, dosages of the drug are not prescribed that could result in a fatal overdose, either alone or in combination with other prescribed or non-prescribed drugs.

Supervised consumption

In order to ensure compliance and reduce diversion, it is good practice for all new prescriptions to be taken initially under daily supervision for a minimum of three months, and supervision should be undertaken at any stage during a prescription if there are doubts about compliance.

Reduction regimens

A dose reduction intervention should be shaped by a realistic appraisal of jointly agreed treatment goals and outcomes between the patient, the doctor and others involved in the patient's care. Treatment aims and goals should be adjusted according to patient progress.

Maintenance approaches

There is now a choice of substances available for use in opiate maintenance prescribing. There is a need to monitor research progress in this field and to adjust future treatments in the light of new treatment evaluations.

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There are a number of drugs listed in the Clinical Guidelines, which are used outside the licensed indication. It is important to note that prescribing of licensed medications outside the recommendations of the product's licence alters (and probably increases) the doctor's professional responsibility.

Methadone maintenance treatment, incorporating psychosocial interventions, can enable patients to achieve stability, reduce their drug misuse and criminal activity, and improve health. For these reasons, such treatment should form an important part of drug misuse services.

As well as opiate maintenance and detoxification prescribing, clinicians need to be aware of the potential benefits of prescribing opiate antagonists, such as naltrexone, for the prevention of relapse in those who have achieved abstinence. Strategies for the induction and maintenance of naltrexone should be a treatment option decided between specialised and primary care services.

Review

Clinicians need to understand the crucial role of broader psychosocial interventions in achieving and maintaining abstinence. Such an approach will usually involve multidisciplinary team care. Quarterly reviews of patients' treatment aims, goals and outcomes, involving the professionals concerned (including pharmacists, drugs workers and doctors), should ensure good quality care.

The management of drug misuse and dependence presents a considerable clinical challenge to all practitioners. However, delivering treatment well and gaining good outcomes, enhances clinicians' competence and confidence in tackling these complex problems, to the benefit of the individual patient and to society.

Conclusion

In conclusion, these new Guidelines offer much more than guidance on prescribing. They are referenced and guide the reader through the pros and cons of some controversial issues such as maintenance and injectable prescribing. Additional information is included in the form of annexes, which cover issues ranging from drugs and driving to caring for someone with drug misuse problems and co-morbid mental illness. As with all interventions, pragmatic clinicians need to take a realistic view of the range of outcomes possible with this type of problem and with the particular patients to whom they are providing care.