Drug Misuse and Dependence UK Guidelines on Clinical Management 2017

(Prepared by Clinical Guidelines on Drug Misuse and Dependence Update 2017 Independent Expert Working Group.)

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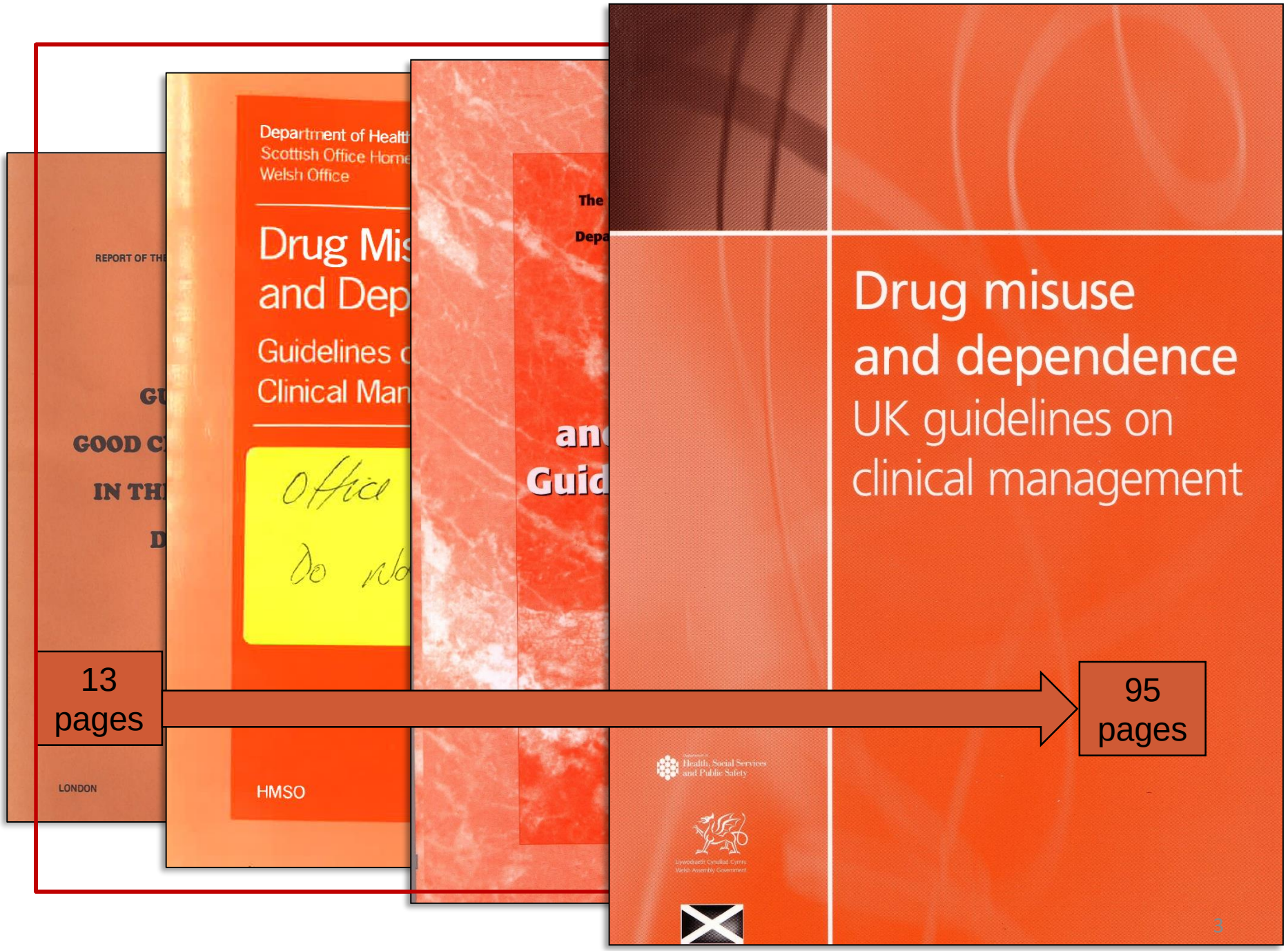
Remit

- *updating* the 4th Ed (2007) Guideline
- Process
  - Developing evidence-based recommendations
  - BAP 2012 template
  - Working groups
    - Recommendations
    - Full working group input
    - Consultation draft/Feedback
- Priority areas
- Recommendations
- Potentially contentious issues


13 pages
95 pages
Drug misuse and dependence
UK guidelines on clinical management
Health, Social Services and Public Safety
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Drug m dependence
UK guidelines on management

Published 7th July, 2017

- 2014 CMOs of the UK tasked the DH with supporting independent working group. Coordinated by Public Health England , published on behalf of the health depts of the four devolved UK nations.
- Agreed to issue single set of guidelines for the UK to provide a skeleton framework of best practice upon which locally appropriate policies and procedures could be based.
- Provides the backbone guidance to support practitioners in the field of dependence on illicit and licit drugs
- *(P 11)*

Working Group

- 28 members of Working Group (5 from Scotland).
- Observers: Scottish Gov/ Welsh Gov/ DoH NI / PHE / DoH Eng / GPhC / NMC.
- User and Carer Representatives.
- External speakers, evidence reviews / topic synopses on a range of subjects.
- Sub groups formed to examine specific topics

Target Audience

- Healthcare professionals
- Providers and commissioners of treatment for people who misuse or are dependent on drugs
- Professional and regulatory bodies
- Service users and carers

BAP Guidelines 2012

Journal of Psychopharmacology
http://jop.sagepub.com/

Evidence-based guidelines for the pharmacological management of substance abuse, harmful use, addiction and comorbidity: recommendations from BAP

Anne R Lingford-Hughes, Sarah Welch, Lesley Peters and David J Nutt

J Psychopharmacol published online 23 May 2012
DOI: 10.1177/0269881112444324

The online version of this article can be found at:
http://jop.sagepub.com/content/early/2012/05/15/0269881112444324

A more recent version of this article was published on - Jun 25, 2012

Published by:
SAGE
http://www.sagepublications.com

On behalf of:

British Association for Psychopharmacology

National Treatment Guidelines – OST Sub-group – Proposed Template for presentation of evidence

The evidence to be presented to the National Treatment Guidelines Group will be allocated a "weight" based on the following criteria (from Lingford-Hughes et al 2012)

Categories of evidence and strength of recommendations

Categories of evidence for causal relationships and treatment
Ia: evidence from meta-analysis of randomised controlled trials
Ib: evidence from at least one randomised controlled trial
IIa: evidence from at least one controlled study without randomisation
IIb: evidence from at least one other type of quasi-experimental study
III: evidence from non-experimental descriptive studies, such as comparative studies, correlation studies and case-control studies
IV: evidence from expert committee reports or opinions and/or clinical experience of respected authorities

Proposed categories of evidence for observational relationships
I: evidence from large representative population samples
II: evidence from small, well-designed, but not necessarily representative samples
III: evidence from non-representative surveys, case reports
IV: evidence from expert committee reports or opinions and/or clinical experience of respected authorities

Strength of recommendation
A: directly based on category I evidence
B: directly based on category II evidence or extrapolated recommendation from category I evidence
C: directly based on category III evidence or extrapolated recommendation from category I or II evidence
D: directly based on category IV evidence or extrapolated recommendation from category I, II or III evidence
S: Standard of care

We should aim to make changes based on significant new primary evidence [i.e. strength A] in the first instance. If an issue has been considered by another expert group/national guideline or professional body [category IV], we should also aim to clarify the quality of the primary evidence on which this recommendation is based. Though we may not change advice – we may want to reframe or alter emphasis. If there is read-over a number of topics – the evidence should be cited specifically for each recommendation

Priorities for review/consideration

- **Choice of specific pharmaceutical agents**:
  Methadone or buprenorphine; HAT; Non-licensed drugs – Physeptone tablets, DHC etc.

- **Reducing risk**
- **Optimising outcomes - responding to "partial benefit" Maximising recovery**
- **Specific settings - hospitals & prisons**

Department of Health

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Final Content

Drug misuse and dependence

UK guidelines on clinical management

Drug Misuse and Dependence
UK Guidelines on Clinical Management

7. Chapters (Key Points)

Chpt 2: Essential Elements of Treatment Provision

Chpt 3: Psychosocial Components of Treatment

Chpt 4: Pharmacological Interventions

Chpt 5: Criminal Justice System

Chpt 6: Health Considerations

Chpt 7: Specific Situations and Populations

Annexes

- Includes.....
- Governance
- Marketing Authorisations
- Writing Prescriptions
- Interactions
- Travelling Abroad with Controlled Drugs
- Drugs and Driving

Chpt 2: Essential elements of treatment provision

- "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"
- *(p17)*

- "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" *(p39)*

Chpt 2: Essential elements of treatment provision.

- “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” *(p40)*
- “Consideration should be given to creating a balanced and wide treatment team , with representation from both professionals and people in recovery”
- *(p40)*

Chpt 4: Pharmacological interventions

(p83).

- Methadone and buprenorphine are both effective medicines for maintenance treatment for heroin dependence, particularly when taken within the optimal dose range.

- 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.

- 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.

Chpt 4: Pharmacological interventions

(p83)

- 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.

Chpt 4: Pharmacological interventions.

- "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"
- *(p93)*

- "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 ……. Optimising the dose of oral opioid replacement is an appropriate strategy for the prescriber to use to address unsuccessful treatment" *(p98)*

Chpt4:Pharmacological interventions , Assessing and responding to progress and failure to benefit.

- "It is clear from the available evidence that OST treatment offers protection against a range of harms including risk of contracting or spreading BBVs, risk of overdose and risk of offending" *(p104)*
- "Clinicians should always consider optimising treatment by increasing the intensity of the programme rather than reducing it"
- *(p105)*

Chpt 4: Pharmacological interventions (Injectable opioid treatments)

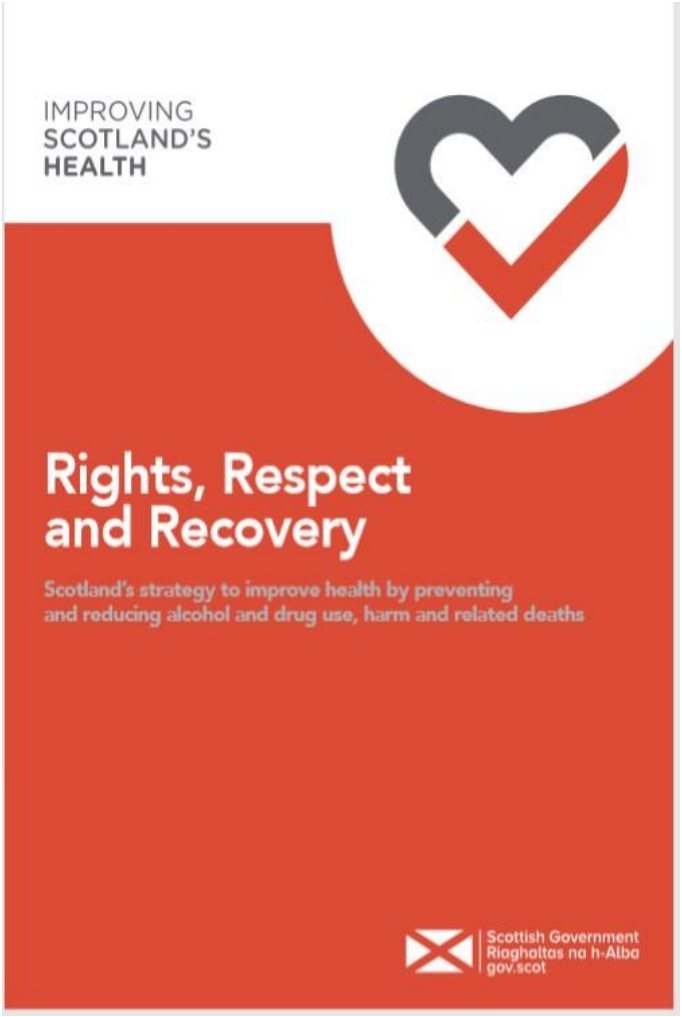
- "There is compelling evidence for making injectable opioid treatment (IOT), usually diamorphine, available for those who continue to be at risk despite optimised oral OST"
- *(p113)*

- "Evidence has been published ,from the UK and other countries , supporting the value of targeted injectable opioid treatment programmes……This evidence base has been systematically reviewed in recent publications…..cost effectiveness (despite high up front costs) has been demonstrated (Byford et al 2013)." *(p113)*

Chpt4: Pharmacological interventions (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 the 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" *(p174)*

- “Problematic alcohol and drug use disproportionately impacts deprived communities”
- *(p 11)*



BMJ Open

The positive pharmacy care law: an area-level analysis of the relationship between community pharmacy distribution, urbanity and social deprivation in England

Adam Todd,[1,2] Alison Copeland,[2] Andy Husband,[1,2] Adetayo Kasim,[2] Clare Bambra[2,3]

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► Prepublication history for this paper is available online. To view these files please visit the journal online (http://dx.doi.org/10.1136/bmjopen-2014-005764).

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ABSTRACT

Objectives: To: (1) determine the percentage of the population in England that have access to a community pharmacy within 20 min walk; (2) explore any relationship between the walking distance and urbanity; (3) explore any relationship between the walking distance and social deprivation; and (4) explore any interactions between urbanity, social deprivation and community pharmacy access.

Design: This area level analysis spatial study used postcodes for all community pharmacies in England. Each postcode was assigned to a population lookup table and lower super output area (LSOA). The LSOA was then matched to urbanity (urban, town and fringe or village, hamlet and isolated dwellings) and deprivation decile (using the Index of Multiple Deprivation score).

Primary outcome measure: Access to a community pharmacy within 20 min walk.

Results: Overall, 89.2% of the population is estimated to have access to a community pharmacy within

Strengths and limitations of this study

- Our study is the first to systematically examine whether there is an inverse care law in relation to community pharmacies and the first to analyse geographical access to services in England.
- A key strength of this study is that we examined accessibility of community pharmacies by walking distance; the cost of driving and using public transport can be significant barriers to travel and, as such, may not give a true account of community pharmacy accessibility.
- A possible limitation is that a 20 min walk from each community pharmacy was represented using a straight-line distance from the central point of each pharmacy's postcode to create a buffer. This assumes people walk in straight lines while, in reality, people are constrained to pathways that curve or are sometimes cut-off by barriers.

Is this pattern of distribution reflected in Scotland ?

Joint Statement RCGP/RPS. "Breaking down the barriers – how community pharmacists and GPs can work together to improve patient care" Sep 2011

- 32. Drug misusers should continue to have convenient access to supervise administration of substitution treatments and be encouraged to make greater use of these interactions for other health interventions.

- 33. Pharmacists with the appropriate expertise should have opportunities to contribute more to care planning and review of treatment objectives, building on the knowledge of the drug misuser acquired through daily contact.

Joint Statement RCGP/RPS. "Breaking down the barriers – how community pharmacists and GPs can work together to improve patient care" Sep 2011

- 34. Consideration should be given to using pharmacist prescribers' working within a locally agreed shared care protocol to titrate doses, including during dose induction and detoxification.

- 35. Pharmacists should use the opportunities afforded by supervised administration to promote other health interventions, including blood-borne virus testing and immunisation.. influenza immunisation and appropriate counselling.

CHEMISTS GIVEN ADDICT HIT KITS

Revealed: £36million bill to provide methadone to drug users

GREENOCK TELEGRAPH, Wednesday, 1 July, 2009 www.greenocktelegraph.co.uk

DRUGS KIT SLAMMED

THE controversial scheme to give drug addicts 'One-Hit Kits' over the counter has received a thumbs-down from *Tele* readers.

By David Moroney

established needle exchanges in the Greenock area.

NHS Greater Glasgow and Clyde

"If they are getting handed kits over the counter, there's no incentive to stop."

John McIntosh, 21, from Greenock, said: "It's a double-edged sword. It

Jamie Kincaid, 21, from Greenock, said: "I think it's ridiculous to encourage them.

"If you give them a clean needle, they are going to go and get whatever they

Daily Record AND SUNDAY MAIL

THE shocking scale of Scotland's multi-million pound methadone industry can be revealed in the Daily Record today.

Hundreds of chemists, from high street giants Boots to small independent pharmacies, are being paid tens of thousands of pounds of taxpayers' cash to dish out the heroin substitute.

Details of the main players in the £36million-a-year business - and the extraordinary sums of public money paid to them - have been kept secret by the NHS until now.

Summary

- “ Pharmacists are the most accessible healthcare professionals and see the greatest number of patients without an appointment on a daily basis. Pharmacists, located in almost every local community, are ideally placed to promote public health and facilitate a reduction in health inequalities”

- *Royal Pharmaceutical Society of Great Britain 2007.*

Chpt 4: Pharmacological interventions

- " 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 the risk to the public, and to address public nuisance and fear" *(p176)*