



Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Clinical Guidelines

for Opioid Substitution
Treatment



College of
Psychiatrists
of Ireland



I am pleased to issue the 'Clinical Guidelines for Opioid Substitution Treatment' on behalf of the Primary Care division of the HSE. The Guidelines arise from a recommendation in the 'Introduction to the Opioid Treatment Protocol' to develop joint guidelines against which future audits could be measured.

The HSE established a working group, chaired by Mr Joe Doyle from the Social Inclusion Office, comprising representatives from the College of Psychiatrists of Ireland, the Irish College of General Practitioners, the Pharmaceutical Society of Ireland and HSE Addiction Services. The group reviewed existing national and international guidelines, consulted with key stakeholders and staff working in the service and considered submissions in detail. Expert opinion from Professor Michael Farrell, Director of the National Drug and Alcohol Research Centre at the University of New South Wales, was obtained both during the process and on completion.

The resulting document represents a significant step forward in delivering evidence based approaches to enhance the quality and safety of care that the HSE Addiction Service provides. I wish to commend the Working Group for their hard work over a significant period of time and in particular to thank Mr Joe Doyle for his effort and commitment to completing this work.

John Hennessy
National Director of Primary Care

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Introduction

The HSE established a clinical guideline working group towards enacting two specific recommendations in the Introduction of the Opioid Treatment Protocol (2010) report. These recommendations were to develop joint guidelines that would enable benchmarks against which future audits could be measured and to move to less urine testing (with an elimination of supervision) and a greater clinical focus on the use of the results of drug testing samples.

The committee was comprised of representatives from the College of Psychiatry of Ireland, the Irish College of General Practitioners, the Pharmaceutical Society of Ireland, HSE Addiction Service Managers, and chaired by the National Social Inclusion Office. The committee drew on relevant guidelines, such as the UK guidelines 'Drug Misuse and Dependence: UK Guidelines on Clinical Management', the NICE guidelines on Methadone and buprenorphine for the management of opioid Dependence, the Eurometh Methadone Guidelines, and the relevant ICGP Guidelines. Expert opinion was sought during the drafting process and key stakeholder groups were consulted at two points of the drafting process (chapter 2 drug testing and when a composite draft was finalised). The committee considered each submission in detail and adapted the Guideline accordingly.

The Guidelines are based on the principles that people who use drugs have the same entitlement as other patients to the services provided by the HSE. Service users have a right to be heard, listened to and taken seriously and should be consulted and involved in all matters and decisions that may affect their lives. The Guidelines have been developed in order to outline evidence-based care to standardise and improve the quality and safety of care to the patient.

The main illicit opioid used in Europe is heroin, which may be smoked, snorted, or injected. A range of other synthetic opioids are also illicitly available, such as Oxynorm/ Oxycontin, codeine, fentanyl, methadone, and buprenorphine. In 2011, eleven European countries reported that 10% or more of their first-time opioid clients entering specialised treatment were using opioids other than heroin.

In Ireland, Opioid Substitution Treatment (OST) refers to the provision of both methadone and buprenorphine/ buprenorphine-naloxone. At the end of 2014, there were 9764 people in receipt of OST in HSE Addiction Clinics and GPs, compared with 9,116 in 2013. There were 726 new first time patients in 2014, compared to 552 first time patients in 2013. There were 468 people in receipt of OST in prisons, compared to 539 in December 2013. There were 159 new first time patients in prisons, compared to 169 in 2013. 1

1 Most recent information on drug treatment, visit <http://www.hrb.ie/health-information-in-house-research/alcohol-drugs/ndtrs/> . For interactive tables on drug treatment, visit <http://www.drugsandalcohol.ie/>

The involvement of the community pharmacists in the dispensing of methadone has continued to expand over the past decade. At the end of December 2013, there were 6,265 (69%) patients receiving their medication in 628 pharmacies, compared with 3,740 (58%) patients in 329 pharmacies at the end of 2003.

Drug use has a detrimental impact on individual service users, their children, families, and society in general. Drug-related mortality rates in Ireland are among the highest in the EU. National and international evidence consistently shows that drug treatment is effective. The Research Outcome Study in Ireland (ROSIE) shows drug treatment leads directly to less involvement in crime and to improvements in employment and training (Comiskey et al., 2009). OST has proven to be effective: the focus should now shift to optimising outcomes.

These Clinical Guidelines are the first national guidelines applicable in HSE treatment clinics, as well as in primary care settings; they update and replace the 2008 ICGP guidelines: Working with Opiate Users in Community Based Primary Care and will provide guidance on the treatment of opioid dependence in Ireland. The Guidelines are targeted at clinicians and patients in the management of Opioid Substitute Treatment (OST), but also for the community and voluntary services that are supporting people's treatment and rehabilitation.

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OST plays an intrinsic role in supporting patients to recover from drug dependence. Assessment and recovery care-planning is an ongoing process and, once stabilised on OST, collaborative and active care planning (e.g. using mapping tools and motivational approaches) to consider options across a wide range of personal recovery goals is an important part of a recovery-orientated culture. Treatment should seek to maximise outcomes across a range of domains, including drug and alcohol misuse, health, and psychosocial functioning.

There are currently 1,000 people working in the addiction services. The Guideline is based on the assertion that interventions must be carried out by trained and competent people, with a clear understanding of the impact of problematic drug use. Investment in upskilling key competencies and the provision of professional support and supervision is essential.

It is hoped that the Guidelines will now set the parameters for audit process. The involvement of service users in this process will be crucial, as will the completion of a brief instrument, such as the Treatment Outcome Profile, to provide important information on the performance of individuals and on the overall performance of the service (in line with the Introduction of the Opioid Treatment Protocol). The updated and revised National Drug Treatment Reporting System (NDTRS) form will also inform on service provision; covering data on key working and case management, interventions carried out, information on detoxification, and the condition of the service user at discharge.

I would like to thank the drafting committee for their patience and commitment to developing this multi-stakeholder guideline. Thanks also to the numerous individuals and stakeholder groups for submitting feedback at various stages. Finally, I would like to gratefully acknowledge the significant contributions of Aoife Davey in drafting and editing this document.

Joseph Doyle
Chairperson

1

2

3

4

5

6

7

A

B

Table of Contents

Chapter 1: Guiding principles of Opioid Substitution Treatment (OST) . 10

- 1.1 Key Points 10
- 1.2 Principles underpinning good governance for treatment provision 10
- 1.3 Therapeutic Alliance..... 11
- 1.4 Information sharing..... 11

Chapter 2: Rehabilitation and psychosocial components of OST..... 12

- 2.1 Key Points 12
- 2.2 OST as a component of rehabilitation 12
- 2.3 OST within an integrated care plan 12
- 2.4 Psychosocial interventions: matching treatment to service user need 13
- 2.5 Psychosocial interventions 13
- 2.6 Key steps involved in the integrated care pathway 14

Chapter 3: Principles and key operational stages of pharmacological interventions for OST 16

- 3.1 Key points 16
- 3.2 Aims and objectives of OST..... 16
- 3.3 Legislative requirements for Prescriptions and requisitions and initiation of OST 16
 - 3.3.1 Methadone 16
 - 3.3.2 Buprenorphine/Naloxone 17

- 3.4 Provision of information to the patient 17
 - 3.4.1 Prescribers 17
 - 3.4.2 Pharmacists..... 18
 - 3.4.3 Involvement of family/carers 18
- 3.5 Communication between Prescriber, Dispensing Pharmacist and other relevant members of the multidisciplinary team 19
- 3.6 Contingency management..... 20
- 3.7 Diversion of opioid substitution medication 21
- 3.8 Supervised consumption..... 21
- 3.9 Ongoing assessment of OST 23
- 3.10 Referral procedure for change of OST location (not applicable to prison transfer). 23

Chapter 4: Assessment of dependence and management of OST 25

- 4.1 Key points 25
- 4.2 PHASE 1: ASSESSING DEPENDENCE..... 25
 - 4.2.1 General health assessment..... 26
 - 4.2.2 Physical Examinations, Assessments, Investigations and Vaccination 27
 - 4.2.3 Drug testing at assessment phase 29
 - 4.2.4 Drug testing at assessment phase 29
 - 4.2.5 Referral to Level 2 GP/HSE Addiction Clinic..... 30

1

2

3

4

5

6

7

A

B



Table of Contents

4.3 PHASE II INDUCTION PHASE	30	4.6.3 Drug testing at detoxification phase	35
4.3.1 Methadone Induction	31	4.6.4 Frequency of supervision	35
4.3.2 Buprenorphine/buprenorphine-naloxone induction	31	4.6.5 Symptomatic treatment of withdrawal	35
4.3.3 Drug testing at induction phase	31	4.6.6 Relapse prevention	35
4.3.4 Frequency of supervision of drug consumption	31	4.6.7 Naltrexone	36
4.4 PHASE III: STABILISATION	31	Chapter 5 Drug Testing	37
4.4.1 Methadone stabilisation	31	5.1 Key points	37
4.4.2 Buprenorphine/buprenorphine-naloxone stabilisation	31	5.2 Objectives of drug testing	37
4.4.3 Drug testing at stabilisation phase	32	5.3 Why and when drug testing can be useful	37
4.4.4 Frequency of supervision of drug consumption	32	5.4 Choosing an appropriate drug test	38
4.5 PHASE IV: MAINTENANCE	32	5.4.1 Drug Screen	38
4.5.1 Methadone maintenance	32	5.4.2 Confirmatory tests	39
4.5.2 Buprenorphine/buprenorphine-naloxone maintenance	32	5.5 Procedures for drug testing	39
4.5.3 Transfer onto buprenorphine/buprenorphine-naloxone from methadone	33	5.6 Urine sample adulteration	40
4.5.4 Transfer from buprenorphine/buprenorphine-naloxone onto methadone	33	5.7 Supervision of the provision of urine samples	41
4.5.5 Drug testing at maintenance phase	33	5.8 Testing for Alcohol	41
4.5.6 Frequency of supervision of drug consumption	33	5.9 Testing for Z-drugs	41
4.6 PHASE V: DETOXIFICATION	34	Chapter 6: OST and associated health considerations	42
4.6.1 Methadone detoxification	35	6.1 Key points	42
4.6.2 Buprenorphine/buprenorphine-naloxone detoxification	35	6.2 Responses to continued drug and alcohol misuse for patients in OST	42

1

2

3

4

5

6

7

A

B



Table of Contents

6.3 Mental health	44	6.9.3 Dealing with overdose emergency; naloxone	55
6.3.1 Treatment for mental health problems.	44	Chapter 7: Specific treatment situations and populations	56
6.4 Viral Infections	46	7.1 Key points	56
6.4.1 Hepatitis A.	46	7.2 Hidden Harm	56
6.4.2 Hepatitis B.	46	7.3 Criminal justice system	57
6.4.3 Hepatitis C	46	7.3.1 Garda custody	57
6.4.4 HIV	47	7.3.2 Drug Treatment Court	57
6.5 Hepatitis A and B vaccinations (Department of Health Immunisation Guidelines for Ireland 2012).	48	7.3.3 Probation orders.	58
6.6 Health implications for continued drug and alcohol use when patients are on OST	49	7.3.4 Prison	58
6.6.1 Alcohol.	49	7.3.5 Discharge from prison setting	59
6.6.2 Benzodiazepines and Z-compounds	50	7.3.6 Phases of OST within the prison setting; detoxification	59
6.6.3 Stimulants (cocaine & amphetamines)	52	7.4 Opiate dependent patients in hospital.	59
6.6.4 Cannabis	53	7.4.1 Other drugs of misuse.	60
6.6.5 Tobacco	53	7.4.2 Discharge from hospital	61
6.7 Pain management for drug misusers	53	7.5 Pregnancy and neonatal care.	61
6.8 ECG Monitoring	54	7.5.1 Antenatal care.	62
6.9 Drug Related Deaths	54	7.5.2 Prescribing for pregnant drug users.	62
6.9.1 Overdose	55	7.5.3 Effects of drugs on the foetus and baby.	62
6.9.2 Reducing drug-related deaths	55	7.5.4 Early neonatal care and withdrawals	63
		7.5.5 Breast feeding.	64

1

2

3

4

5

6

7

A

B



Table of Contents

7.6 Young people	64	Appendix 1: Clinical Governance	69
7.6.1 Methadone induction for under-18s	65	Appendix 2: Initial Assessment Template	71
7.6.2 Buprenorphine/buprenorphine-naloxone induction for under-18s	66	Appendix 3: Care plan templates	92
7.6.3 Stabilisation for under-18s	66	Appendix 4: Sample Methadone Prescription Form	93
7.6.4 Maintenance for under-18s	66	Appendix 5: Recommendations re appropriate patient cohort for buprenorphine / naloxone	94
7.6.5 Detoxification for under-18s	66	Appendix 6: Pharmacy Transfer Form	95
7.6.6 Under-18s and benzodiazepine use	66	Appendix 7: National Waiting List Information Sheet	96
7.6.7 Under-18s and co-morbid disorders	66	Appendix 8: Central Treatment List Entry Form	97
7.7 Older current and ex-drug users	67	Appendix 9: Drug to drug interactions with methadone	98
7.8 Palliative care and life-limiting conditions	68	Appendix 10: Drugs that may help symptoms in the end stages of detoxification	100
		Appendix 11: Different Matrices for Drug Testing, adapted from TAP 32	101
		Appendix 12: Approximate Durations of Detectability of Selected Drugs in Urine/Oral Fluid	103
		Appendix 13: Guiding principles for working with clients with Co-Occurring Disorders (COD)	104
		Appendix 14: Roles and responsibilities of Mental Health and Addiction Services under Children First National Guidelines	105
		Appendix 15: Summary Tables of Vaccinations for Hepatitis A and B	106
		Bibliography	107

1

2

3

4

5

6

7

A

B



List of Acronyms

6-AM	6-acetylmorphine (one of three active metabolites of heroin)
ANC	Antenatal Care
BBVs	Blood Borne Viruses
BCT	Behavioural Couples Therapy
CAMHS	Child and Adolescent Mental Health Services
CBCS	Cognitive Behaviour Coping Skills
CBT	Cognitive Behaviour Therapy
CDETb	City of Dublin Education and Training Board
CM	Contingency Management
CMHTs	Community Mental Health Teams
COWS	Clinical Opioid Withdrawal Scale
CRA/CRAFT/ACRA	Community Reinforcement Approach/Community Reinforcement Approach and Family Training/Adolescent Community Reinforcement Approach
CTL	Central Treatment List
DBT	Dialectical Behaviour Therapy
DTC	Drug Treatment Court
EDDP	2-ethylidene-1,5-dimethyl-3,3-diphenylpyrrolidine (the main methadone metabolite)
EtG	Ethyl Glucuronide (a metabolite of alcohol which indicates recent consumption of alcohol even when all of the alcohol has been metabolised)
GAD-7	Generalised Anxiety Disorder
HADS	Hospital Anxiety and Depression Scale
HBV	Hepatitis B

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4

5

6

7

A

B



List of Acronyms

HCV	Hepatitis C
HIV	Human Immunodeficiency Virus
HSE	Health Service Executive
IPS	Irish Prison System
MI	Motivational Interviewing
NAS	Neo-natal abstinence syndrome
NDRIC	National Drugs Rehabilitation Implementation Committee
NDRF	National Drug Rehabilitation Framework
NDTRS	National Drug Treatment Reporting System
NPS	New Psychoactive Substances
NWL	National Waiting List
OOWS	Objective Opiate Withdrawal Scale
OST	Opioid Substitute Treatment
PCRS	Primary Care Reimbursement Service
PIL	Patient Information Leaflet
POCTs	Point of Care Tests
QuADS	Quality in Alcohol and Drug Services
SAOR	Support, Ask and Assess, Offer Assistance and Referral: The National Screening and Brief Intervention Programme for Problem Alcohol and Substance Use
SIDS	Sudden Infant Deaths
TB	Tuberculosis

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6

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A

B

Chapter 1: Guiding principles of Opioid Substitution Treatment (OST)

1.1 Key Points

1.2 Principles underpinning good governance for treatment provision

1.3 Therapeutic Alliance

1.4 Information sharing

1.1 Key Points

- » Opioid Substitute Treatment (OST) plays an intrinsic role in supporting patients to recover from opioid dependence.
- » OST should be provided at the lowest level of complexity, matching the patient's needs, and as close to the patient's home as possible.
- » Service users should be fully involved in the development of their care plans, setting appropriate treatment goals and reviewing their progress in treatment.
- » It is good practice to involve service users in the design, planning, development, and evaluation of services.
- » One of the special features and strengths of drug treatment and rehabilitation in Ireland is the valuable partnership between statutory drug treatment services and the community/voluntary sectors which comprise significant service provision in some areas.
- » Services should be proactive, with regard to their engagement with family members, but there should be recognition that they have separate and distinct needs from service users.
- » A good therapeutic alliance is crucial to the delivery of any treatment intervention.

1.2 Principles underpinning good governance for addiction services incorporating OST

Treatment and rehabilitation models available in Ireland have primarily been determined by how services developed locally; often being influenced by factors such as geography, community acceptance, and the available health provision infrastructure.

Whatever the local treatment system model, the following principles should apply:

- » **Clinical governance:** The principles of good clinical governance are outlined in the HSE document *Achieving excellence in clinical governance – towards a culture of accountability* (2010). See Appendix 1 for the HSE Guiding Principles of Clinical Governance.
- » **Standards:** All health services should implement the Standards for Safer Better Health Care (2012); continuing to improve the day-to-day experience and outcome for patients and their families and begin to demonstrate compliance with them. Quality in Alcohol and Drug Services (QuADS) has been embedded within the National Standards for Safer Better Health Care.
- » **Partnership:** Local statutory, community and voluntary-based services should work with primary care providers to ensure service provision meets the changing needs of communities within defined resources.

Drug use trends and potential treatment populations can change rapidly. Local service providers need to work together to ensure services respond appropriately.

- » **Competencies:** All agencies should have the necessary competencies to respond to the complex issues associated with substance use.
- » **Involving service users:** Involving service users as active partners in their drug treatment is essential and is associated with better outcomes. Service users should be fully involved in the development of their care plans, setting appropriate treatment goals and reviewing their progress in treatment. It is also good practice to involve service users in the design, planning, development and evaluation of services, and in advocacy and support groups linked to local drug treatment. Service users may also be involved in peer education schemes e.g. to reduce the risk of overdose and blood-borne viruses.
- » **Involving families/carers:** Services should be proactive with regard to their engagement with family members/carers, but there should be recognition that they have separate and distinct needs from service users and may even have needs that conflict with them. At all stages in the continuum of care, family members should be offered the opportunity to engage with supports for themselves. Family or guardian

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4

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6

7

A

B



Chapter 1: Guiding principles of Opioid Substitution Treatment (OST)

1.1 Key Points

1.2 Principles underpinning good governance for treatment provision

1.3 Therapeutic Alliance

1.4 Information sharing

involvement should be the norm in the treatment of under-18 year olds.

- » **Informed consent:** The HSE National Consent Policy² means the need for consent extends to all interventions conducted by or on behalf of the HSE on service users in all locations. Consent must be obtained before starting treatment or investigation, or providing personal or social care for a service user or involving that individual in teaching and research. This requirement is consistent with fundamental ethical principles, with good practice in communication and decision-making, and with national health and social care policy. The need for consent is also recognised in Irish and international law.

1.3 Therapeutic Alliance

Forming a therapeutic alliance is a consistent predictor of engagement and retention of clients in drug treatment. The initial time devoted to the development of an early therapeutic alliance is vital.

2 For national consent advisory group policy documents see www.hse.ie

The key competencies of developing a therapeutic alliance are:

- » The ability to engage a service user appropriately while demonstrating satisfactory levels of warmth
- » The ability to build trust, and to be able to adopt a personal style consistent with and engaging with the service user
- » An ability to adjust the nature of the intervention according to the capacities of the service user
- » An ability to deal with and recognise the importance of discussion and expression of client's emotional reactions, particularly intense emotions, while also working with the patient's motivation
- » The ability to engage a service user appropriately while demonstrating satisfactory levels of understanding (Roth and Pilling, 2007)

Other factors identified in ensuring effective therapeutic alliance include: taking a non-blaming, non-judgmental stance, use of motivational dialogue, being a good listener, being in good psychological health, and developing a helping alliance and a collaborative relationship with the service user (Wanigaratne, 2005).

Equally, an awareness of factors that reduce the possibility of forming a positive therapeutic alliance is important. These might include rigidity, impatience, criticism, inappropriate self-disclosures, being distant, aloofness, being distracted, and making inappropriate use of silence (Wanigaratne, 2005).

1.4 Information sharing

It is important to maintain public confidence in the confidential nature of personal health information while, at the same time, optimising use of such information. Identifiable information about patients must not be given to others unless the patient consents or if disclosure without consent can be justified.³ The National Protocols and Common Assessment Guidelines to Accompany the National Drugs Rehabilitation Framework (NDRIC, 2011) provides a set of protocols for interagency working arrangements. This is the Framework within which addiction services operate.

3 Reasons for non-consensual disclosure:

- If a court or tribunal orders to disclose medical information, or when obliged by law or Public Health Regulations.
- If there is a need to protect children under the 'Children First Guidelines'
- If there is a substantial and immediate risk to the service user or another person's welfare.

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4

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A

B



Chapter 2: Rehabilitation and psychosocial components of OST

2.1 Key Points

2.2 OST as a component of rehabilitation

2.3 OST within an integrated care plan

2.4 Psychosocial interventions: matching treatment to service user need

2.5 Psychosocial interventions

2.6 Key steps involved in the integrated care pathway

2.1 Key Points

- » All drug users entering treatment and rehabilitation should have a care plan based on assessed need, which is regularly reviewed.
- » All drug users entering treatment and rehabilitation should have full risk assessments to evaluate immediate health concerns, mental health issues, and risks to children.
- » The needs of all drug users should be assessed across the domains of drug and alcohol use, health (physical and psychological), offending, and social functioning (including housing, employment and relationships).
- » Key working is a basic delivery mechanism for interventions in addiction services.
- » Psychosocial interventions, which address assessed needs, are a fundamental part of drug and alcohol treatment.
- » Psychosocial interventions are the mainstay of treatment for the use of cocaine and other stimulants, cannabis, and hallucinogens.
- » Psychosocial interventions can also address common associated or co-occurring mental disorders, such as depression or anxiety.
- » Self-help and mutual aid approaches have been found to be highly effective for some individuals and service users seeking abstinence should be signposted to them.
- » Contingency management (CM), CRA/CRAFT/ACRA and family and couples interventions should be offered, where appropriate.

2.2 OST as a component of rehabilitation

OST is considered a key component in the treatment of opioid dependence and plays an important role in rehabilitation and recovery. Well-delivered OST provides a platform of stability and safety that protects people and creates the time and space for them to move forward in their personal recovery journeys. OST has an important and legitimate place

within recovery orientated systems of care. We need to ensure OST is the best platform it can be, but focus equally on the quality, range, and purposeful management of the broader care and support it sits within (Strang, 2012, p.5).

2.3 OST within an integrated care plan

Given the diversity of the supports that may be required during rehabilitation, it is unlikely

that one service alone could meet all the needs or goals of an individual. Depending on the complexity of need, an individual may require supports from statutory, voluntary and community services. The care planning and case-management process (of the National Drugs Rehabilitation Framework) is intended to co-ordinate the services being received and to identify, through assessment, which supports should be sought. The service user's needs and input should be central to the development and ongoing implementation of an individual care plan.

A care plan should be fully drawn up within the first three months of treatment and should clearly document the patient's aims and goals for treatment and outline the range of treatments required to achieve the user's goals. A formal care plan review should be undertaken every 3 months and when a change in a service user's circumstances makes it necessary. The date of next care plan review should be explicitly stated in the care plan at the end of the care planning session and at the end of each subsequent case review. Patients should be provided with a copy of their care plan.

OST should be provided with a range of medical and psychosocial interventions.⁴

⁴ As outlined in the National Drugs Rehabilitation Framework (2011).



Chapter 2: Rehabilitation and psychosocial components of OST

2.1 Key Points

2.2 OST as a component of rehabilitation

2.3 OST within an integrated care plan

2.4 Psychosocial interventions: matching treatment to service user need

2.5 Psychosocial interventions

2.6 Key steps involved in the integrated care pathway

The recognised system for substance misuse services to share information in order to develop shared care plans is outlined in the NDRIC National Protocols and Common Assessment Guidelines (2011).

2.4 Psychosocial interventions: matching treatment to service user need

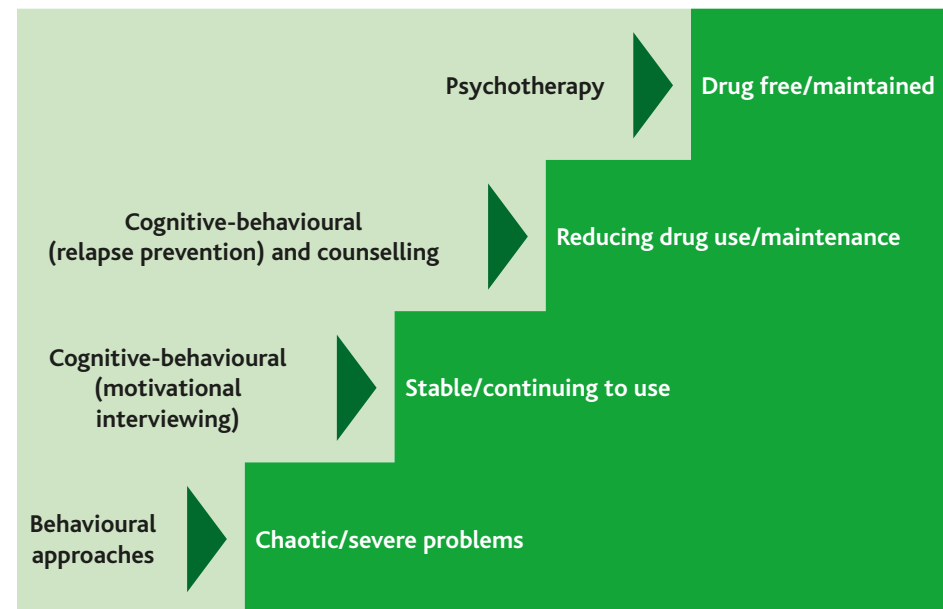
Following a comprehensive assessment, it is important to match a treatment programme to the needs identified with the service user in their care plan. The severity of needs will determine the length and type of treatment required. Evidence supports the effectiveness and efficiency of reserving more intensive services for service users with more severe problems.

The effectiveness of treatment may not be based on the number of counselling sessions received but on the provision of targeted interventions directed towards the specific problem identified with the service user. Service users with more severe alcohol and drug problems or who are more depressed tend to do better in highly structured, behaviourally orientated treatments.

Service users' needs should be addressed in a 'stepped care approach': less intensive interventions initially, and then ratcheting up, depending on the complexity of issues, degree

of dependence, co-morbidity, and polydrug use identified (Figure 1).

Stepped-care model for the treatment of substance misuse problems



Source: Wanigaratne and Keaney, 2002.

Figure 1: Stepped-care model for the treatment of substance misuse problems

All interventions should be delivered by people who are qualified and accredited in delivering the intervention. They should also receive appropriate line management supervision to ensure competency and that the interventions being provided are appropriate to their role.

2.5 Psychosocial interventions

For opioid, polydrug and alcohol users, psychosocial interventions may be provided in combination with pharmacological intervention. There is evidence that the effectiveness of methadone maintenance is

Chapter 2: Rehabilitation and psychosocial components of OST

2.1 Key Points

2.2 OST as a component of rehabilitation

2.3 OST within an integrated care plan

2.4 Psychosocial interventions: matching treatment to service user need

2.5 Psychosocial interventions

2.6 Key steps involved in the integrated care pathway

enhanced by the provision of psychosocial interventions.⁵

For stimulant use, including cocaine, and for cannabis use, there is no effective substitution agent. Hence, the mainstay of treatment is evidence-based psychosocial intervention.

The NICE guidelines (2007) on psychosocial interventions in alcohol and drug use identify a number of formal psychosocial treatments as having high quality evidence base. The Community and Voluntary sector, in partnership with the HSE, have been important innovators and deliverers of psychosocial interventions and have adapted their programmes to suit emerging drug trends. These include brief interventions, drug-related advice and information, advice and support for social problems, harm reduction, complementary and alternative therapies, cognitive behaviour therapy (CBT)/coping skills (CBCS), motivational interviewing (MI), relapse prevention, dialectical behaviour therapy (DBT), node-link mapping, contingency management, counselling and psychotherapy, community reinforcement approach, family interventions, family therapy, strengthening families programme, behavioural couples therapy (BCT), and mutual aid/self-help approaches (AA, NA and SMART Recovery).

⁵ Amato *et al.*, 2004.

Many drug users also have considerable co-morbid problems, particularly common mental health problems, such as anxiety and depression. There is evidence that a range of evidence-based psychosocial interventions, as described in relevant NICE guidelines, can be beneficial.

There is a growing body of evidence indicating that a significant percentage of clients who present for substance abuse treatment are dealing with the impact of some form of trauma. A report commissioned by SAMHSA⁶ states that two-thirds of individuals, presenting to substance use treatment, report childhood abuse or neglect, and 75% of women in treatment programmes report having being sexually abused. In addition, the report states that "there is a high probability of drug or alcohol relapse when trauma is not addressed and no alternative means of coping with the pain are provided". SAMHSA has developed treatment guidelines⁷ that recommend all services working with individuals presenting with substance use issues be trauma informed. A 'trauma-informed' system is one in which all components of a given service system have been reconsidered and evaluated, in light of a basic understanding of the role that violence

⁶ Jennings, 2004.

⁷ Harris & Fallot, 2001.

plays in the lives of people seeking mental health and addictions services.

2.6 Key steps involved in the integrated care pathway

The key steps involved in the integrated care pathway for rehabilitation, as outlined in the National Protocols and Common Assessment Guidelines to accompany the National Drugs Rehabilitation Framework (NDRIC, 2011), are:

1. A **drug and alcohol screen** in line with the HSE SAOR model of screening and brief intervention.
2. An **initial assessment** to determine the seriousness and urgency of the drug problem. Depending on the outcome, a service user may be offered a further service within the assessing agency and/or be referred on to a more appropriate service. The type of intervention/support required may vary from a counselling session to inpatient detoxification or a combination of service interventions (See Appendix 2 for assessment templates).
3. A **comprehensive assessment** is appropriate for service users with more complex needs (See Appendix 2 for assessment templates). It will identify the services to be involved in the shared care plan. It should be ongoing and include the following:

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2

3

4

5

6

7

A

B



Chapter 2: Rehabilitation and psychosocial components of OST

2.1 Key Points

2.2 OST as a component of rehabilitation

2.3 OST within an integrated care plan

2.4 Psychosocial interventions: matching treatment to service user need

2.5 Psychosocial interventions

2.6 Key steps involved in the integrated care pathway

- a. Identification of all drug and alcohol use and measurement of severity.
- b. Assessment of other domains, including psychological, physical and legal problems, as well as social issues, such as training, family support, and housing services.
- c. Specific attention will be required for people who experience both mental health and substance use problems. It is essential that the assessing agency is competent in identifying possible mental health issues and is proactive in referring the service user for assessment of their mental health needs, where necessary.

Regarding the assessment of young people, in addition to the above,

- » Assessment should be comprehensive and multidisciplinary, and may include Child and Adolescent Mental Health Services (CAMHS), social services, and youth probation services.
- » All domains of functioning should be assessed, including developmental needs, educational and language attainment, and emotional and physical health and safety.
- » Assessment of strengths and weaknesses of the family system is also vital.

4. Implementation of the care plan to support an individual rehabilitation pathway.

This is a holistic, documented care plan between the service user and service provider based on SMART (Specific, Measurable, Attainable, Realistic and Time-bound) objectives. Care plans should document and enable review of service user needs, goals, and progress in four specific areas: Drug and alcohol misuse, Health (physical and psychological), Offending, and Social functioning (including housing, employment and relationships). The care plan should be brief and readily understood by all parties involved and should be a shared exercise between the service user and the service provider. It should explicitly identify the roles of specific individuals (including the service user) and services in its delivery. It should be reviewed routinely (every 3 months) and when a change in a service user's circumstances makes it necessary (See Appendix 3 for care plan templates).

5. Risks need to be assessed at all stages.

These may include risks related to overdose, unsafe injecting practices, and unsafe sex. Wider risks may include self-harm, child protection, suicide ideation and intent or harm to others, domestic violence and risk related to crime and debt intimidation to individuals and families.

1

2

3

4

5

6

7

A

B



Chapter 3: Principles and key operational stages of pharmacological interventions for OST

3.1 Key points

3.2 Aims and objectives of OST

3.3 Legislative requirements for Prescriptions and requisitions and initiation of OST

3.4 Provision of information to the patient

3.5 Communication between Prescriber, Dispensing Pharmacist and other relevant members of the multidisciplinary team

3.6 Contingency management

3.7 Diversion of opioid substitution medication

3.8 Supervised consumption

3.9 Ongoing assessment of OST

3.10 Referral procedure for change of OST location (not applicable to prison transfer)

3.1 Key points

- » Good communication between the patient, the prescriber, the pharmacist, and other members of the interdisciplinary team is crucial in providing optimal treatment.
- » Carers should be active partners in drug treatment, where consent is given.
- » Patients should be made fully aware of the risks of their medication and of the importance of protecting children from accidental ingestion. Prescribing, supervision, and dispensing arrangements should also aim to minimise risks to children.
- » Supervision of Methadone has been proven to reduce deaths related to overdose of methadone.
- » Supervised consumption needs to be available for all patients for a length of time appropriate to their needs and risks.
- » Ongoing assessment and care planning is central to the treatment process.

3.2 Aims and objectives of OST

When deciding whether to prescribe, the clinician and the patient should use a care plan to document treatment goals and outcomes within the rehabilitation process (see Appendix 3 for care plan templates). This is within the context of promoting a process of change in drug taking that can incorporate overcoming dependence and:

- » reduce drug use
- » reduce risk-taking behaviour
- » reduce morbidity and mortality
- » reduce offending
- » promote stabilisation and onward progression
- » improve health
- » improve quality of life; functioning as a productive member of society and becoming personally fulfilled

For some people, it will include becoming drug free.

3.3 Legislative requirements for Prescriptions and requisitions and initiation of OST

3.3.1 Methadone

The Methadone Protocol⁸ applies to medical prescribers and pharmacists. Adequate understanding of the law relating to prescribing and dispensing for drug users is vital. This includes the Misuse of Drugs Acts 1977, 1984 and 2015 and the subsequent orders and regulations, such as the Misuse of Drugs Regulations 1988 (S.I. No. 328 of 1988) (as amended), which are applicable to OST prescribing and dispensing. It is an offence to supply methadone other than in accordance with these regulations.

In a community-based practice, OST can only be supplied to a patient if it has been prescribed by their OST Protocol Scheme GP or their locum on the standard methadone prescription form (see Appendix 4 for a

⁸ The Methadone Protocol is the system in place to implement and support the Misuse of Drugs (Supervision of Prescription and Supply of Methadone) Regulations 1998 (S.I. No. 225 of 1998).

1

2

3

4

5

6

7

A

B



Chapter 3: Principles and key operational stages of pharmacological interventions for OST

3.1 Key points

3.2 Aims and objectives of OST

3.3 Legislative requirements for Prescriptions and requisitions and initiation of OST

3.4 Provision of information to the patient

3.5 Communication between Prescriber, Dispensing Pharmacist and other relevant members of the multidisciplinary team

3.6 Contingency management

3.7 Diversion of opioid substitution medication

3.8 Supervised consumption

3.9 Ongoing assessment of OST

3.10 Referral procedure for change of OST location (not applicable to prison transfer)

sample prescription form).⁹ Level 2 prescribers contact the HSE Chief Liaison Pharmacists and GP Coordinator when first prescribing opioid replacement therapy for a patient, in order for a suitable pharmacy to be organised. Pharmacists must also comply with the requirements of the Pharmacy Act 2007 (as amended) and the Regulation of Retail Pharmacy Businesses Regulations 2008 (S.I. No. 488 of 2008). The Pharmaceutical Society of Ireland has published guidance for pharmacists on the safe supply of Methadone from community pharmacies.¹⁰

All patients who are prescribed methadone need to be listed with the Central Treatment List (with the exception of patients prescribed methadone for palliative care or pain relief,

9 Statutory Instrument 323 of 2014 amended the Misuse of Drug Regulations 1988, as amended. Among other things, it removed the handwriting requirements in relation to certain details on prescriptions for controlled drugs specified in the Schedule to the Misuse of Drugs (Supervision and Prescription and Supply of Methadone) Regulations 1998 (S.I. No. 225 of 1998) i.e. Methadone. This amendment removed the handwriting requirement from Regulations 13(1)(f) and 13(1)(g) for Methadone Prescriptions only; including the name and address of the person for whom the treatment is issued; the dose; preparation; form; strength; and total quantity in words and figures. The SI took effect on 11 July 2014.

10 See www.thepsi.ie/gns/pharmacy-practice/practice-guidance/Guidance_on_the_Medicines_Safe_Supply.aspx

when notification is to the Controlled Drugs Department in the Department of Health).

3.3.2 Buprenorphine/Naloxone

The Department of Health Expert Group on the Regulatory Framework, for products containing buprenorphine/naloxone and buprenorphine-only for the treatment of opioid dependence (2012), sets out several recommendations for its use, including the appropriate cohort of patients for its use and when it may not be suitable for use.¹¹ (See Appendix 5 for the recommendations regarding appropriate patient cohort).

Staff of the Central Treatment List maintain, separately, a record of people receiving buprenorphine/naloxone, currently referred to as the 'Suboxone List' (this is an informal agreement in anticipation of the inclusion of buprenorphine/naloxone in the relevant legislation).

Approval from the Primary Care Reimbursement Service (PCRS) for each patient is currently required before buprenorphine products can be reimbursed in a community setting.

11 Increased phased access to buprenorphine/naloxone is currently being progressed by the HSE in the context of its service plan for 2016.

3.4 Provision of information to the patient

3.4.1 Prescribers

Once a decision has been made to prescribe OST, patients should be informed of the rationale for treatment, the expectations placed on them (such as daily attendance for supervised doses), and what they can expect, either verbally or by a written consensual agreement.

The patient should be informed of:

- » What will happen during treatment
- » The risks during induction
- » The dangers of using benzodiazepines and other Central Nervous System (CNS) depressant drugs
- » The planned rate of dose increase and rationale for this
- » Risks to children of ingesting prescribed medication and the importance of safe

1

2

3

4

5

6

7

A

B



Chapter 3: Principles and key operational stages of pharmacological interventions for OST

3.1 Key points

3.2 Aims and objectives of OST

3.3 Legislative requirements for Prescriptions and requisitions and initiation of OST

3.4 Provision of information to the patient

3.5 Communication between Prescriber, Dispensing Pharmacist and other relevant members of the multidisciplinary team

3.6 Contingency management

3.7 Diversion of opioid substitution medication

3.8 Supervised consumption

3.9 Ongoing assessment of OST

3.10 Referral procedure for change of OST location (not applicable to prison transfer)

storage must be emphasised at the first appointment and repeatedly thereafter¹²

- » That assessment of compliance with these safety measures will form part of the decision-making regarding dispensing and supervision arrangements
- » The use of the Patient Information Leaflet (PIL) from the manufacturers of OST may be useful and can be downloaded from www.hpra.ie or www.medicines.ie

3.4.2 Pharmacists

Prior to commencing supply to an OST patient, the pharmacist should discuss with the patient any issue that either deems significant, including:

- » The patient's privacy
- » The patient's and pharmacist's expectations from the service
- » Risks associated with giving methadone or other medicines to another person

.....
¹² See Adfam (2014) 'Medications in drug treatment: tackling the risks to Children' and Adfam (2015) Medications in drug treatment: tackling the risks to children one year on. These reports outline the clear danger to children when OST medication is stored or used incorrectly by their parents; giving case studies where children accidentally ingest OST medication, or are actively given them by their parents and carers.

- » Risks to children of ingesting prescribed medication
- » Risks associated with storing methadone incorrectly
- » General information about their OST therapy: including directions of use, any common side effects, the action to be taken if a dose is missed, interactions with alcohol and other drugs, e.g. benzodiazepines, cautionary notices about driving or operating heavy machinery, and methods for safe disposal

In addition, pharmacists should be cognisant of patients' wider medical and healthcare needs and provide holistic pharmaceutical care. The pharmacist should be available and offer to discuss any relevant issues with the patient, at each dispensing.

Liaison Pharmacists should be contacted for advice on unusual situations such as OST for use abroad/ restrictions on carrying controlled drugs in some jurisdictions/ possible availability of treatment outside Ireland, and assistance when a patient is to receive OST in dual locations e.g. moving from a hospital to go home for weekend leave (and then return to hospital).

There should be a mechanism whereby the treatment provider records that the information regarding safety measures with OST is imparted to the patient.

3.4.3 Involvement of family/carers

Depending on the relationships between a service user and their carers, and bearing in mind the patient's right to confidentiality, information should be exchanged between clinicians and carers in so far as it is possible and practicable. Carers should be active partners in drug treatment, where consent is given. This principle holds for all treatment settings (addiction clinics, community setting, and prison).

Carers should be offered specific information and advice on:

- » The risks from Blood Borne Viruses (BBVs) and overdose and, if appropriate, should be advised on vaccination
- » Risks to children of ingesting prescribed medication and the importance of safe storage
- » Training around overdose prevention and management

It is recommended that practitioners:

- » Make themselves accessible to family members and carers with the consent of the service user
- » Assess and take account of the needs of family members and carers, including the welfare of dependent children, siblings, and vulnerable adults

Chapter 3: Principles and key operational stages of pharmacological interventions for OST

3.1 Key points

3.2 Aims and objectives of OST

3.3 Legislative requirements for Prescriptions and requisitions and initiation of OST

3.4 Provision of information to the patient

3.5 Communication between Prescriber, Dispensing Pharmacist and other relevant members of the multidisciplinary team

3.6 Contingency management

3.7 Diversion of opioid substitution medication

3.8 Supervised consumption

3.9 Ongoing assessment of OST

3.10 Referral procedure for change of OST location (not applicable to prison transfer)

» Provide verbal and written information and advice on the impact of drug use and about treatment and the settings in which it may take place

» Provide information about self-help groups and other individual and group support for families and carers (such as the services directory on www.drugs.ie and the Family Support Network website at www.fsn.ie)

» Consider family or couple-based interventions

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

3.5 Communication between Prescriber, Dispensing Pharmacist and other relevant members of the multidisciplinary team

It is important that robust interdisciplinary policies and procedures are put in place to ensure information and required documentation or prescriptions can be accessed when required.

» The relationship between the prescriber and the dispensing pharmacist is important. The dispensing pharmacist is often the

member of the multidisciplinary team who interacts with the patient most frequently for the supervised consumption of their medication. It is essential that there is regular communication and/or meetings between the pharmacist, the prescribing doctor and any other relevant healthcare professional involved in a patient's care. More frequent communications and/or meetings may be required during the induction phase. These provide an opportunity to discuss patient care and any issues the pharmacist or medical practitioner deems necessary to ensure the patient receives an appropriate standard of care.

» Communication between the pharmacist, prescriber, and other members of the multidisciplinary team is particularly important to ensure continuity of care for patients transitioning between environments, for example, transitioning between HSE addiction clinics, hospitals, prisons, and the community.

» The name and address of the dispensing pharmacist should be written in the patient notes.

» The pharmacist should dispense in line with the Pharmaceutical Society of Ireland's

Guidance for Pharmacists on the Safe Supply of Methadone.¹³

» Pharmacists may, in respect of patient safety, decline to dispense the medications if they have concerns in respect of the medication dose.

Pharmacists should share relevant information with prescribers, for example:

- » Non-attendance or difficulty with consuming a supervised dose.
 - When patients have missed scheduled pick-ups for three days or more, the prescribing doctor should be contacted, as the dosage may need to be modified. It is important, in some circumstances, (for example, during the induction phase) to contact the prescriber if any dose is missed, as there is a particular risk of overdose during this period.
 - After three days without a regular prescribed dose of opioid, patients may have reduced their tolerance to the drug and could be at risk of overdose if the usual dose is ingested. The risks of loss of tolerance are lower with buprenorphine than with methadone.

13 See the PSI website for Guidance for Pharmacists on the Safe Supply of Methadone - http://www.thepsi.ie/gns/pharmacy-practice/practice-guidance/Guidance_on_the_Medicines_Safe_Supply.aspx

1

2

3

4

5

6

7

A

B



Chapter 3: Principles and key operational stages of pharmacological interventions for OST

3.1 Key points

3.2 Aims and objectives of OST

3.3 Legislative requirements for Prescriptions and requisitions and initiation of OST

3.4 Provision of information to the patient

3.5 Communication between Prescriber, Dispensing Pharmacist and other relevant members of the multidisciplinary team

3.6 Contingency management

3.7 Diversion of opioid substitution medication

3.8 Supervised consumption

3.9 Ongoing assessment of OST

3.10 Referral procedure for change of OST location (not applicable to prison transfer)

- Where a patient has not picked up for more than three days, a pharmacist is normally unable to dispense the next day's dose unless they have confirmed with the prescriber that it is safe to do so. Where possible, this should be reviewed and an assessment made on tolerance. In the interest of clarity, a consistent local policy should be developed. Efforts should be made to limit the impact on the patient of being without prescribed medication until a new prescription can be established. The patient should be asked about pick-up details and the clinician should check this aligns with the patient's lifestyle, where appropriate. If the prescriber alters a dose, a new prescription must be received by the pharmacy specifying the new dose.

- » If there are concerns about patients' health or wellbeing
- » If the patient attends the pharmacy in a state of intoxication i.e. under the influence of other drugs or alcohol. Pharmacists should be aware that a patient may have a greater risk of accidental overdose if the patient's full dose is dispensed. It is advised that the pharmacist contacts the prescriber to discuss the clinical situation and, if necessary, contact is to be made with the Liaison Pharmacist. If the prescriber alters a dose, a new prescription must be received which specifies the new dose.

When a patient misses an appointment with their prescribing doctor:¹⁴

- » It is the responsibility of the patient to attend for their prescription. Both doctors and pharmacists should inform patients that, if they miss their appointment and do not obtain a valid prescription, it may affect their treatment regime.
- » A pharmacist may only supply controlled drugs to a patient on foot of a valid prescription and may only supply methadone to a patient if it has been prescribed on the standard methadone prescription form issued by their Methadone Protocol scheme GP.
- » The original prescription must be physically present and reviewed by the pharmacist prior to dispensing OST to the patient. However, it is important to ensure any impact on the patient's ability to access their required medicine is minimised and all clinicians should act both in the best interest of patient and within the confines of legislation to achieve this.

3.6 Contingency management

Contingency Management (CM) operates by providing a variety of incentives in the form of privileges, such as take-home methadone, vouchers, prizes, or modest

¹⁴ This can be particularly relevant for people entering and exiting the criminal justice system.

financial incentives. The most common form of CM in Ireland is the provision of take-home methadone. CM is used to modify a person's drug use or to increase health promoting behaviours. It is contingent on each presentation, for example, a drug negative test (free from cocaine or non-prescribed opioids). Studies have found contingency management to be effective for people engaged in methadone maintenance programmes who are continuing to use illicit drugs.

Criticisms of CM include the observations that rapid relapse, following discontinuation of this specific intervention, is common; that the availability of external incentives for abstinence is often limited if there are no competing reinforcers in the client's environment; and that CM does not specifically address the issue of intrinsic motivation for change. Thus, CM can be used while transitioning clients to other forms of treatment in a stepped model of care.

CM would normally be provided as part of a structured care or treatment plan in combination with other interventions provided by the keyworker/care-team/clinician. This approach has been identified in the NICE guidelines as having the strongest scientific evidence base for the most effective outcomes.

1

2

3

4

5

6

7

A

B



Chapter 3: Principles and key operational stages of pharmacological interventions for OST

3.1 Key points

3.2 Aims and objectives of OST

3.3 Legislative requirements for Prescriptions and requisitions and initiation of OST

3.4 Provision of information to the patient

3.5 Communication between Prescriber, Dispensing Pharmacist and other relevant members of the multidisciplinary team

3.6 Contingency management

3.7 Diversion of opioid substitution medication

3.8 Supervised consumption

3.9 Ongoing assessment of OST

3.10 Referral procedure for change of OST location (not applicable to prison transfer)

CM, in the form of take-home OST medication, is balanced against the need to have safe oversight of the use of OST medicine and the need to be aware of community safety from diversion of methadone. On balance, initiating treatment with supervised dosing, assessing response to treatment, and subsequently allowing unsupervised doses to patients who demonstrate stability appears to substantially reduce diversion, does not diminish efficacy and is supported by patient groups (WHO, 2009). The risk of diversion of prescribed OST to the black market should be considered before take away doses are provided. Potential risks to children of ingesting OST medication and the availability of safe storage should also be considered. The patient should be advised of safe storage requirements.

3.7 Diversion of opioid substitution medication

The risk of diversion and accidental or intentional misuse increases in patients who:

- » Have suicidal ideation or cognitive impairment
- » Are homeless, living in a shelter, or transiently housed
- » Are actively addicted to alcohol, cocaine, benzodiazepines, or other drugs

The last group is at higher risk because they may sell their methadone in order to pay for their drug use, and are at greater risk for overdose.

The criteria for determining appropriateness for take-home doses are based on patient and community safety and on clinical stability, where clinical stability can be defined by:

1. Adherence with treatment directives
2. No recent problematic drug or alcohol use
3. Stable housing
4. Stable dose of methadone (with allowances for occasional dose increases)
5. Emotional stability and good insight into safety issues

Contraindications to receiving takeaway doses of methadone

- » Repeated intoxication on presentation for dosing at the clinic/pharmacy
- » The patient has a child or children living in their household, and there are concerns that the child/children may be at risk of harm
- » Current chaotic and unpredictable behaviour
- » Assessed as at risk of self-harm

» Current hazardous use of drugs (including benzodiazepines or alcohol) as this can increase risks of fatal overdose by respiratory depression

3.8 Supervised consumption

- » Supervision of methadone has been linked to a substantial reduction in deaths due to overdose of methadone (Strang et al., 2010).
- » Supervision by an appropriate professional provides the best guarantee that a medicine is being taken as directed. In the majority of cases, the person supervising will be a pharmacist, however, in some specialist services, this is done through nursing staff.
- » The patient must always be advised of safe storage of medicines at home.
- » No more than 6 days should be prescribed to take home, except for holidays (7 on occasions when Bank Holidays dictate).
- » For take-away supplies for holidays, multiple prescriptions are required, with a direction to dispense unsupervised on specified dates.
- » In the stabilisation phase, which can take up to three months, consumption of OST should be supervised daily.
- » In the maintenance phase, a reduction from daily supervised consumption can be considered when the patient has

1

2

3

4

5

6

7

A

B



Chapter 3: Principles and key operational stages of pharmacological interventions for OST

3.1 Key points

3.2 Aims and objectives of OST

3.3 Legislative requirements for Prescriptions and requisitions and initiation of OST

3.4 Provision of information to the patient

3.5 Communication between Prescriber, Dispensing Pharmacist and other relevant members of the multidisciplinary team

3.6 Contingency management

3.7 Diversion of opioid substitution medication

3.8 Supervised consumption

3.9 Ongoing assessment of OST

3.10 Referral procedure for change of OST location (not applicable to prison transfer)

demonstrated ongoing stability and shown that they can safely manage take home opioid substitution medication.

- » The key elements of 'stability' appear to include housing, employment, not being dependent on multiple drugs, and ceasing to inject after entering treatment.
- » In the detoxification phase, a reduction from supervised consumption from the patient's maintenance phase can be considered. This depends on clinical assessment based on patient need.
- » Where possible, the supervised dose should not be given to a patient in the presence of their child(ren).

See Table 1 for the suggested frequency of supervised consumption of methadone.

Table 1: Frequency of supervised consumption of methadone (for non-prison setting and over-18s)

	Suggested frequency of supervised consumption
PHASE I Pre OST (10 days prior to commencing OST)	N/A
PHASE II Induction	Daily
PHASE III Stabilisation	<ul style="list-style-type: none"> • Daily supervised consumption of methadone is recommended until the patient is stable. • No more than 6 days should be prescribed to take home, except for holidays.
PHASE IV Maintenance	<ul style="list-style-type: none"> • A reduction from daily supervised consumption can be considered when the patient has demonstrated ongoing stability and shown that they can safely manage take home doses. • Caution is needed with take home doses if there is a concern around alcohol or other drug use, as these can increase risks of fatal overdose by respiratory depression. • As a guide, the following is suggested, depending on clinical assessment and patient need: <ul style="list-style-type: none"> » Above 80mgs: Twice weekly supervision » Above 120mgs: Increased supervision should be considered. » No more than 6 days should be prescribed to take home, except for holidays.
PHASE V Detoxification	<ul style="list-style-type: none"> • A reduction from supervised consumption from the patient's maintenance phase can be considered. • This depends on clinical assessment based on patient need. • No more than 6 days should be prescribed to take home, except for holidays.

1

2

3

4

5

6

7

A

B



Chapter 3: Principles and key operational stages of pharmacological interventions for OST

3.1 Key points

3.2 Aims and objectives of OST

3.3 Legislative requirements for Prescriptions and requisitions and initiation of OST

3.4 Provision of information to the patient

3.5 Communication between Prescriber, Dispensing Pharmacist and other relevant members of the multidisciplinary team

3.6 Contingency management

3.7 Diversion of opioid substitution medication

3.8 Supervised consumption

3.9 Ongoing assessment of OST

3.10 Referral procedure for change of OST location (not applicable to prison transfer)

3.9 Ongoing assessment of OST

It is important to note that through the five stages of OST, as outlined in this guideline, ongoing assessment and care planning is central to the treatment process. At all phases, treatment is delivered through active key working and care planning; this is underpinned by psychosocial interventions.

In many cases, stabilisation on OST will be a key priority as an early step to recovery. For others, active support for detoxification, followed by relapse prevention, may be appropriate. However, assessment and recovery care-planning is an ongoing process and, once stabilised on OST, collaborative and active care planning (e.g. using mapping tools and motivational approaches), to consider options across a wide range of personal recovery goals, will be an important part of a recovery-orientated culture. For people to make informed choices through the assessment process, they need information and advice. As well as promoting clear pathways to recovery and abstinence, it is vital the nature of dependence is discussed and any risks of treatment and moving to abstinence are made clear. For collaborative recovery care-planning, people need balanced advice based on evidence, so they can weigh up their preferences and options in an informed way (Strang, 2012).

Treatment should seek to maximise outcomes across a range of domains, including drug and alcohol misuse, health, and psychosocial functioning. While drug treatment has been shown to be effective in reducing drug misuse, patients may not cease all illicit drug use. Clinicians will frequently be faced with decisions concerning what action to take if a patient is demonstrating limited progress on a treatment programme. In these circumstances, clinicians should consider optimising treatment by increasing the intensity of the programme rather than reducing it. Optimising treatment may include ensuring medication is provided within the optimal dose range; changing to another substitute medication if available; increasing key working or psychosocial interventions; and increasing supervised consumption.

Once the care plan is complete (see Appendix 3 for care plan templates) the actions should be addressed and reviewed in regular one-to-one sessions. When a new action is identified, this should be added, with interagency communications being undertaken, as required. A formal review should be undertaken every 3 months (or more frequently if required). The date for the next review should be explicitly stated in the care plan at the end of the session and at the end of each subsequent case review. Clinicians are encouraged to systematically document

progress in treatment under the five domains of care planning: Drug and alcohol misuse; Physical health; Mental health; Social functioning; and Criminal justice (see NDRIC National Protocols and Common Assessment Guidelines, 2011).

3.10 Referral procedure for change of OST location

The outcomes for a referral to change treatment location is that there is agreement and clarity among service providers and service user regarding referral to another service, including steps and timeframes involved and that the patient:

- » Accesses appropriate services in line with agreed assessment/care plan/shared care plan goals/needs.
- » Is supported throughout the process, as required, and appropriate follow-up takes place.
- » Will be tracked and supported to minimise disengagement from services

The transfer **from HSE addiction Clinic to HSE Addiction Clinic** is done through a request to and from the clinical teams, usually facilitated through the GP Coordinator.

1

2

3

4

5

6

7

A

B



Chapter 3: Principles and key operational stages of pharmacological interventions for OST

3.1 Key points

3.2 Aims and objectives of OST

3.3 Legislative requirements for Prescriptions and requisitions and initiation of OST

3.4 Provision of information to the patient

3.5 Communication between Prescriber, Dispensing Pharmacist and other relevant members of the multidisciplinary team

3.6 Contingency management

3.7 Diversion of opioid substitution medication

3.8 Supervised consumption

3.9 Ongoing assessment of OST

3.10 Referral procedure for change of OST location (not applicable to prison transfer)

The transfer **from pharmacy to pharmacy** can be organised by the Chief Pharmacist using the Pharmacy Transfer Form (see Appendix 6).

Transfer **from GP to GP** can be organised by the GP Coordinator.

At all times, to ensure a continuum of care, contact should be made with the previous prescribing dispensing site to check the last date of OST received and also to confirm any other medication that may be prescribed.

The Central Treatment List should be informed of the change of treatment and dispensing location, as a new CTL card needs to be issued to the new community pharmacy.

1

2

3

4

5

6

7

A

B

Chapter 4: Assessment of dependence and management of OST

4.1 Key points

4.2 PHASE I: ASSESSING DEPENDENCE

4.3 PHASE II: INDUCTION PHASE

4.4 PHASE III: STABILISATION

4.5 PHASE IV: MAINTENANCE

4.6 PHASE V: DETOXIFICATION

4.1 Key points

- » Methadone or buprenorphine, used at the optimal dose range, are both effective medicines for OST.
- » Dose induction with methadone should aim to achieve an effective dose, while also exercising caution about the inherent risks of too rapid an increase.
- » Dose induction, with buprenorphine, may be carried out more rapidly, with less risk of overdose.
- » Clinicians should aim to optimise treatment interventions for patients who are not benefiting from treatment, usually by providing additional and more intensive interventions (pharmacological and psychosocial) that may increase retention and improve outcomes.
- » Once stable on OST, at least one dose per week should be supervised.
- » Methadone and buprenorphine are both effective in detoxification regimens.
- » OST is a medical treatment, and should not be used punitively i.e. there should be no dose reduction as a sanction for ongoing illicit drug use.
- » Opioid detoxification should be offered as part of a care plan, including preparation and post-detoxification support in an appropriate setting to patients ready for and committed to abstinence.
- » Health professionals working in isolation must ensure they have an opportunity to discuss and review their work with colleagues working in the field, to maintain up-to-date good practice.

4.2 PHASE 1: ASSESSING DEPENDENCE

A prescription for substitute medication should normally only be considered if there is evidence of current dependence (ICD 10 and DSM-5; download at <http://www.who.int/classifications/icd/en/> also <http://www.dsm5.org>). ICD 10 has been developed by the World Health Organisation and are internationally accepted criteria for establishing dependence (see Table 2 below for quick reference guide).

In addition, opiate withdrawal symptoms can be assessed using the Objective Opiate Withdrawal Scale (OOWS) and the Clinical Opioid Withdrawal Scale (COWS).

1

2

3

4

5

6

7

A

B

Chapter 4: Assessment of dependence and management of OST

4.1 Key points

4.2 PHASE I: ASSESSING DEPENDENCE

4.3 PHASE II: INDUCTION PHASE

4.4 PHASE III: STABILISATION

4.5 PHASE IV: MAINTENANCE

4.6 PHASE V: DETOXIFICATION

Table 2: Quick Reference to ICD10 Criteria for Dependence

Physical

- » Withdrawal manifested by the characteristic withdrawal syndrome or by the use of substance to relieve or avoid withdrawal symptoms.
- » Tolerance is defined by either increased amounts used to achieve intoxication or other desired effect or diminished effects with continued use of the same amount of substance.

Psychological

- » Difficulty in controlling substance use; unsuccessful attempts to cut down or taking the substance in larger amount over a longer period than intended.
- » Continued substance use, despite awareness of negative consequences of drug use.

Social

- » A great deal of time spent in obtaining the substance use, using the substance, or recovering from the effects of substance use.
- » Neglect of important social, occupational, or recreational activities.

Table 3: Objective and subjective signs of withdrawal from opioids

Objective signs of opioid withdrawal	Subjective signs of opioid withdrawal
<ul style="list-style-type: none"> » Yawning » Coughing » Sneezing » Runny nose » Lachrymation » Raised blood pressure » Increased pulse » Dilated pupils » Cool, clammy skin » Diarrhoea » Nausea » Fine muscle tremor 	<ul style="list-style-type: none"> » Restlessness » Irritability » Anxiety <p>The signs listed above may also be useful objective signs</p> <ul style="list-style-type: none"> » Sleep disorders » Depression » Drug craving » Abdominal cramps

4.2.1 General health assessment

All drug users should have a full health assessment completed prior to commencing OST. The aim of this is to identify unmet healthcare needs and improve the general health of the patient.

The history and assessment should include:

- » Current and past medical history
- » Current prescribed and non-prescribed medications, including cigarettes, cannabis, alcohol, and non-prescription medicines
- » Psychiatric history and current symptoms.
- » Drug-related complications such as abscesses, venous thrombosis, septicæmia,

1

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3

4

5

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7

A

B



Chapter 4: Assessment of dependence and management of OST

4.1 Key points

4.2 PHASE I: ASSESSING DEPENDENCE

4.3 PHASE II: INDUCTION PHASE

4.4 PHASE III: STABILISATION

4.5 PHASE IV: MAINTENANCE

4.6 PHASE V: DETOXIFICATION

endocarditis, and constipation. Treatment and referral, as appropriate

- » Assessment of injecting practices and advice given
- » History of accidental and deliberate overdose
- » Presence of past infection with blood-borne viruses (including assessment of risks such as previous injecting or sharing or having tattoos), immunisations for hepatitis A and B, testing for hepatitis A, B, C, and HIV. Advice and information given prior to testing. Referral to specialist service, if required
- » Contraceptive history and cervical screening, menstrual and pregnancy history in women. Provision of contraception advice
- » Sexual health and history of sexually transmitted infections. Advice on safer sex and referral to the local sexual health service
- » Oral Health and referral to appropriate dental service
- » Assessment of diet and nutrition and advice given to improve same. Oral nutritional supplements may be prescribed if criteria for prescribing are evident. Note potential for diversion
- » All allergies and sensitivities

4.2.2 Physical Examinations, Assessments, Investigations and Vaccination

- » Assessment of the service user's physical and mental health
- » Assessment of injection sites in all limbs and inguinal areas if injecting - or has injected previously
- » Measurement of weight and height
- » Consider chest X-ray if appropriate and if considering tuberculosis
- » Urine for drug screening, also checking for glucose, infections, or pregnancy
- » Confirmatory drug testing to test for PH, specific gravity, creatinine levels to confirm integrity of the sample (see section on drug testing)
- » Blood pressure measurement
- » General impression of respiratory, cardiovascular, and other systems and if any symptoms in these areas
- » Examination of the cardiovascular, respiratory systems, including chest x-rays and pulmonary function tests i.e. peak flow. Examination of gastrointestinal system, including the liver
- » Pregnancy testing

- » Blood borne virus screen to include Hepatitis A, B, C, and HIV (all notifiable infections)
- » Vaccination for Hepatitis A and B, and Tetanus
- » Other blood tests, as appropriate – liver function tests, thyroid function, renal function and haematological indices
- » ECG, if cardiac risk factors or QT prolongation risk

Services should include access to:

- » Needle exchange services, harm reduction, advice and information
- » Adequate doses of OST
- » Provision of structured psychosocial interventions

Also, general measures:

- » Availability of injecting equipment and education to reduce sharing
- » Advice on accessing harm reduction services
- » Regular sexual health screening, particularly if involved in sex-work
- » Testing and vaccination for blood borne viruses offered to all drug users and their sexual partners
- » Testing should be repeated if exposure persists

1

2

3

4

5

6

7

A

B



Chapter 4: Assessment of dependence and management of OST

4.1 Key points

4.2 PHASE I: ASSESSING DEPENDENCE

4.3 PHASE II: INDUCTION PHASE

4.4 PHASE III: STABILISATION

4.5 PHASE IV: MAINTENANCE

4.6 PHASE V: DETOXIFICATION

Table 4: Infections for which people who inject drugs may be at increased risk

- » HIV infection
- » Hepatitis A
- » Hepatitis B (HBV)
- » Hepatitis C (HCV)
- » Tuberculosis (TB)
- » Skin and soft tissue infections caused by *Staphylococcus aureus* (including methicillin-resistant staphylococcus aureus, MRSA) and streptococcal infections (e.g. endocarditis, necrotising fasciitis)
- » Severe systemic sepsis (e.g. infections with *Clostridium novyi*, *Bacillus anthracis*)
- » STIs other than infection or hepatitis (e.g. chlamydia infection, syphilis, and gonorrhoea)

Table 5: Health promotion for safer injecting behaviour

- » Use a sterile needle and syringe and clean equipment for each injection: 'one needle – one syringe – one time'. Never share or borrow needles, syringes, or other equipment.
- » Be aware of, and prepared for, situations where it may be difficult to prevent infections. For example, if there is a social pressure to share utensils or if the situation is somewhat chaotic when preparing an injection. Enact strategies to reduce the likelihood of unintentional sharing of injecting equipment (such as using colour-coded or labelled syringes).
- » Encourage peers who do not inject not to start injecting. Encourage peers who do inject to use safe injection practices.
- » Wash hands before and after injecting; clean the skin with alcohol or another disinfectant before injecting; use a filter; avoid the use of dangerous injection sites, such as the neck and groin; avoid injecting under the skin or directly into a muscle; and clean all materials, including the table surface, with a disinfectant, following injection.
- » Rather than injecting, use non-injecting routes such as smoking or orally ingesting the drug. Foil or gelatine capsules can be used for these purposes.
- » Prevent overdose by using smaller amounts of drugs (especially after periods of abstinence or less intense drug use), by not using drugs while alone, and by recognising signs of overdose in injecting partners and calling for help immediately upon their recognition. Take care when using drugs from new or unknown sources, and avoid mixing drugs, such as alcohol, benzodiazepines, and opioids. Utilise supervised health facilities for hygienic injecting, if such services are available.

Ref EMCDDA Prevention & control of ID amongst PWID

1

2

3

4

5

6

7

A

B



Chapter 4: Assessment of dependence and management of OST

4.1 Key points

4.2 PHASE I: ASSESSING DEPENDENCE

4.3 PHASE II: INDUCTION PHASE

4.4 PHASE III: STABILISATION

4.5 PHASE IV: MAINTENANCE

4.6 PHASE V: DETOXIFICATION

4.2.3 Drug testing at assessment phase

» There must be a diagnosis of opioid dependence before a patient is started on OST. This may be assessed through a range of different parameters and criteria, for example, written assessment, collateral history, physical evidence, past knowledge of the patient, and past history of OST treatment

» The recommendation is that at least one random drug test is taken prior to commencement of OST. If the clinician is concerned about the validity of any of the above parameters, additional tests should be carried out. The frequency and type of test required is assessed on an individual basis

» If the clinician is still uncertain of the diagnosis of dependence, additional drug screens may assist in the confirmation of the diagnosis, for example, 6-AM

» If concerns remain, it is prudent to discuss the case with a specialist colleague

4.2.4 Referral to Level 2 GP/HSE Addiction Clinic

For a clinician to make a referral upon assessing dependence to a level 2 GP or to a HSE Addiction Clinic:

» If clinically indicated, a referral is made to either the HSE Addiction service or the GP Coordinator

» If and when the patient is initiated onto OST, it is the responsibility of the Addiction Clinic/Level2 GP to keep in contact with the referrer

» This should be an ongoing communication within the care planning process

4.2.5 Linkage with the Central Treatment List (CTL) and National Waiting List (NWL) and the National Drug Treatment Reporting System (NDTRS)

On assessment, once the clinician is satisfied that:

» The patient has the capacity to consent to the course of treatment

» The patient's needs can be appropriately addressed by the competencies of the staff at the treatment location

» The patient is not already in receipt of OST. This can be confirmed by contacting the Central Treatment List (CTL)

Either the patient:

» Commences OST, if there is a position available. Priority is given to pregnant women, under-18s, patients with HIV

and serious illnesses, and those who have detoxed and recently relapsed

» Or, if there is not a position available, the patient is placed on the Waiting List for the service (this is overseen by the National Waiting List Coordinator in the CTL)

The National Waiting List (NWL)

» The person will remain on the NWL until the service is in a position to commence their OST. A NWL information sheet (see Appendix 7) should be explained and signed by the patient

» The waiting time is determined by numbers and existing caps in clinics and Level 2 GPs, and on the number of community pharmacy places available

» Once a treatment place becomes available, the person exits the NWL and is registered on the CTL

The Central Treatment List

» Once the decision is made to initiate OST:

- The clinician must send a signed 'CTL Entry Form' (see Appendix 8) to the CTL (with the patient's first and surname) and two signed recent passport sized photographs. The CTL is available 9-5 Monday to Friday

- Further details include patient's recent address, the treatment provider details,

1

2

3

4

5

6

7

A

B



Chapter 4: Assessment of dependence and management of OST

4.1 Key points

4.2 PHASE I: ASSESSING DEPENDENCE

4.3 PHASE II: INDUCTION PHASE

4.4 PHASE III: STABILISATION

4.5 PHASE IV: MAINTENANCE

4.6 PHASE V: DETOXIFICATION

and pharmacy details (pharmacy details can be provided at a later date)

- » The CTL issues a patient treatment card (for patients receiving OST in a community pharmacy), with a unique patient number, which is sent to the designated pharmacy and a letter is issued to the GP stating the activation date of the card.
- » The CTL records the patient details on the confidential CTL list.

The National Drug Treatment Reporting System (NDTRS)

- » Treatment demand data are collected from practitioners and agencies in Ireland that report to the National Drug Treatment Reporting System (NDTRS).
- » Providers of addiction services must ensure compliance with the NDTRS; they must provide details on the NDTRS form for each new person coming for first treatment, and each previously treated client returning to treatment in a calendar year.
- » The NDTRS reporting form can be downloaded at <http://www.hrb.ie/health-information-in-house-research/alcohol-drugs/ndtrs/information-collected/>.

4.3 PHASE II INDUCTION PHASE

Methadone is the drug of first choice in the treatment of opioid dependence and therefore should be available to everyone who requires it. If methadone and buprenorphine/buprenorphine-naloxone are equally suitable, methadone should be prescribed as the first choice. See Appendix 9 for list of drug to drug interactions with methadone.

4.3.1 Methadone Induction

Methadone:

- » Should be commenced by suitably trained level 2 GPs and HSE addiction Clinic prescribers.
- » Initial dose between 10-40 mg depending on patient assessment.
- » The initial dose should be maintained for at least 3 days to ensure that the effects of the methadone dose can be fully assessed.
- » Requires frequent monitoring and daily supervision of consumption.
- » Patients and their carers should be alerted to signs of an overdose.
- » Watch for drug interactions.
- » Dose increase should be done at a daily max of 5-10 mg and a weekly max of 20 mg.

Starting patients on too high a dose of methadone may result in toxicity and death. Conversely, too low a dosage may cause withdrawal, which may prompt patients to seek relief from other sources, such as illicit opiates and benzodiazepines.

The critical factor in response to methadone is the degree of tolerance to opioids. In individuals with low tolerance, a starting dose, deemed safe for the majority of patients, may prove toxic. In addition, the prolonged half-life (as long as 55 hours in methadone-naïve individuals) and the slow bioaccumulation of methadone accounts for its insidious onset of overdose. During dose increases, serum levels accumulate over several days, even if the dose is kept the same. Therefore, a dose that is barely adequate on day 1 can be toxic by days 3 to 5.

Concurrent use of benzodiazepines, alcohol, and other sedating drugs substantially increases the risk of death from methadone toxicity. The risk of fatal methadone overdose during the first 2 weeks of OST is estimated to be 6 to 7 times higher than that of heroin users who are not in treatment, and 98 times higher than that of patients on maintenance doses of methadone in treatment for longer periods (Caplehorn and Drummer, 1999). See section on drug related deaths.

1

2

3

4

5

6

7

A

B



Chapter 4: Assessment of dependence and management of OST

4.1 Key points

4.2 PHASE I: ASSESSING DEPENDENCE

4.3 PHASE II: INDUCTION PHASE

4.4 PHASE III: STABILISATION

4.5 PHASE IV: MAINTENANCE

4.6 PHASE V: DETOXIFICATION

4.3.2 Buprenorphine/buprenorphine-naloxone induction

Induction and stabilisation can be more rapid than induction with methadone treatment due to the safer profile of buprenorphine.

Buprenorphine/buprenorphine-naloxone:

- » Can safely be inducted more rapidly than methadone.
- » Should be commenced by suitably trained level 2 GPs and HSE addiction Clinic prescribers.
- » Precipitated withdrawal occurs when buprenorphine displaces both methadone and heroin from opioid receptors. As it is only a partial opiate agonist, this results in rapid reduction in opiate effects, leading to severe withdrawal symptoms in the hours after ingestion.
- » The first dose of buprenorphine/buprenorphine-naloxone must not start until the patient is experiencing withdrawal symptoms; otherwise there is a risk of precipitated withdrawal. Withdrawal symptoms usually commence about 8 hours after last dose of heroin, and at least 24 hours after the last dose of methadone, however, this can vary from patient to patient.
- » The starting dose is usually between 4 mg and 8 mg daily.

- » The dose can be increased by between 2 to 8 mg daily, usually 4 mg, until the patient is stabilised, up to a maximum per day of 24 mg (buprenorphine/naloxone)/32 mg (buprenorphine alone), though lower or higher doses may be appropriate in some patients.

4.3.3 Drug testing at induction phase

- » Drug testing is one of a range of parameters used by clinicians within the induction phase. Other parameters include clinical review, patient self-report and collateral drug history.
- » The recommendation is that at least one random drug test is taken per month, used in conjunction with the above parameters.

4.3.4 Frequency of supervision of drug consumption

- » Daily supervision is recommended.

4.4 PHASE III: STABILISATION

The aim of this phase is to achieve a dose that treats withdrawals, reduces cravings, and supports the patient in achieving a healthier lifestyle.

4.4.1 Methadone stabilisation

- » This phase can take up to 3 months.
- » Should be undertaken by suitably trained level 2 GPs and HSE addiction Clinic prescribers.
- » Doses between 60-120 mg per day are usually required to stabilise a patient. While this is the usual dose range required, some patients may be stabilised on lower doses and some patients may need higher doses.
- » Any dose increase should be carried out at daily max of 5-10 mg and weekly max of 20 mg.

4.4.2 Buprenorphine/buprenorphine-naloxone stabilisation

- » This phase can be shorter than methadone stabilisation; in the region of 4-6 weeks.
- » Should be undertaken by suitably trained level 2 GPs and HSE addiction Clinic prescribers.
- » Doses between 16 mg to 24 mg per day are usually required to stabilise a patient. While this is the usual dose range required, some patients may be stabilised on lower doses and some patients may need higher doses.
- » Any dose increase should be carried out at a daily max rate of 2-8 mg.

1

2

3

4

5

6

7

A

B



Chapter 4: Assessment of dependence and management of OST

4.1 Key points

4.2 PHASE I: ASSESSING DEPENDENCE

4.3 PHASE II: INDUCTION PHASE

4.4 PHASE III: STABILISATION

4.5 PHASE IV: MAINTENANCE

4.6 PHASE V: DETOXIFICATION

4.4.3 Drug testing at stabilisation phase

- » Drug testing is one of a range of parameters used by clinicians within the stabilisation phase. Other parameters include clinical review, patient self-report and collateral drug history.
- » The recommendation is that at least one random drug test is taken per month, used in conjunction with other parameters.

4.4.4 Frequency of supervision of drug consumption

- » Daily supervised consumption of methadone is recommended until the patient is stable.¹⁵
- » No more than 6 days should be prescribed to take home, except for holidays.

4.5 PHASE IV: MAINTENANCE

4.5.1 Methadone maintenance

- » This phase can be undertaken by suitably trained level 1, level 2 prescribers, and HSE addiction Clinic prescribers.
- » The correct maintenance dose is the one which relieves withdrawal symptoms, blocks

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¹⁵ With the exception that OST administration in prison should be dispensed for supervised consumption only.

opiate induced euphoria, and reduces or eliminates cravings over a 24 hour period.

- » Requirements for dose increases once the patient has stabilised are usually infrequent. However, should a dose increase be necessary, the patient may require more frequent review and monitoring until stability has been achieved again.
- » Level 1 prescribers may consider seeking advice from the referral agency (level 2 GP or HSE addiction clinic) when considering a dose increase.
- » Any dose increase should be carried out at daily max of 5-10 mg and weekly max of 20 mg.
- » Patients on long term prescriptions should be offered a care plan review regularly, usually at 3 monthly intervals and should be part of a broader programme of planned social and psychological support.

4.5.2 Buprenorphine/buprenorphine-naloxone maintenance

- » This phase can be undertaken by suitably trained level 1, level 2 prescribers, and HSE addiction Clinic prescribers.
- » The correct maintenance dose is the one which relieves withdrawal symptoms, blocks opiate induced euphoria, and reduces or eliminates cravings over a 24 hour period.

» Requirements for dose increases once the patient has stabilised are usually infrequent. However, should a dose increase be necessary, the patient may require more frequent review and monitoring until stability has been achieved again.

- » Level 1 prescribers may consider seeking advice from the referral agency (level 2 GP or HSE addiction clinic) when considering a dose increase.
- » Any dose increase should be carried out at a daily max rate of 2-8 mg and not exceed a maximum single daily dose of 24 mg.

» After a satisfactory stabilisation has been achieved, the frequency of supervision and/or dispensing may be decreased. A benefit of buprenorphine over methadone is that dosing can be reduced to every second day e.g. a patient stabilised on a daily dose of 8 mg, may be given 16 mg on alternate days, with no dose on the intervening days. This may be useful for patients who cannot attend a pharmacy for daily dispensing or who are completing a reduction/detoxification and do not wish/need to have a daily dose. The dose given on any one day should not exceed 24 mg.

- » Patients on long term prescriptions should be offered a care plan review regularly, usually at 3 monthly intervals, and should be part of a broader programme of planned social and psychological support.

1

2

3

4

5

6

7

A

B



Chapter 4: Assessment of dependence and management of OST

4.1 Key points

4.2 PHASE I: ASSESSING DEPENDENCE

4.3 PHASE II: INDUCTION PHASE

4.4 PHASE III: STABILISATION

4.5 PHASE IV: MAINTENANCE

4.6 PHASE V: DETOXIFICATION

4.5.3 Transfer onto buprenorphine/ buprenorphine-naloxone (referred to as "buprenorphine") from methadone

- » A transfer onto buprenorphine from methadone should be undertaken by suitable trained Level 2 GPs and HSE addiction Clinic prescribers.
- » The dose of methadone should be reduced to and stabilised on 30 mg or less (the lower the dose of methadone, the less likelihood of precipitated withdrawal).
- » A transfer onto buprenorphine for methadone doses greater than 30 mg, should only be undertaken in an intermediate or specialist service/inpatient hospital and in consultation with an addiction specialist.
- » The first dose of buprenorphine should be administered at least 24 to 36 hours after the last use of methadone and preferably with mild to moderate withdrawals (RCGP, 2004).
- » Increasing the time interval between the last dose of methadone and the first dose of buprenorphine reduces the incidence and severity of precipitated withdrawal.

4.5.4 Transfer from buprenorphine/ buprenorphine-naloxone (referred to as "buprenorphine") onto methadone

- » A transfer from buprenorphine onto methadone treatment is less complicated than vice versa.
- » Methadone can be started 24 hours after the last dose of buprenorphine. As with all methadone induction, the initial starting dose should not exceed 40 mg per day (see section 4.3 on induction). It is recommended that patients transferring from 4 mg or less of buprenorphine should be started on low doses of methadone and titrated as appropriately. The doctor should review the patient several hours after the first dose of methadone to adjust subsequent doses accordingly.
- » Factors to be considered when transferring a patient from buprenorphine to methadone are complications with antagonists and opioid based analgesics. In patients who have frequent overdoses, the use of buprenorphine may complicate resuscitation efforts with naloxone. Such patients should be transferred to methadone. Patients requiring frequent opioid analgesia for recurrent acute or chronic pain conditions may be better stabilised on full agonists, such as methadone. (Lintzeris et al., 2006).

- » Care should be taken when increasing the dose of methadone, as buprenorphine may diminish the effects of methadone for several days (blockade effect), and there should be adequate time to allow 'wash out' of buprenorphine prior to marked increases in methadone dose.

4.5.5 Drug testing at maintenance phase

- » Drug testing is one of a range of parameters used by clinicians within the maintenance phase. Other parameters include clinical review, patient self-report and collateral drug history.
- » The recommendation is that at least one random drug test be taken per month, used in conjunction with other parameters.

4.5.6 Frequency of supervision of drug consumption

- » A reduction from daily supervised consumption¹⁶ can be considered when a patient has demonstrated ongoing stability and shown that they can safely manage take home doses.
- » Caution is needed with take home doses if there is a concern around alcohol or other

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¹⁶ With the exception that OST administration in prison should be dispensed for supervised consumption only.

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2

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4

5

6

7

A

B



Chapter 4: Assessment of dependence and management of OST

4.1 Key points

4.2 PHASE I: ASSESSING DEPENDENCE

4.3 PHASE II: INDUCTION PHASE

4.4 PHASE III: STABILISATION

4.5 PHASE IV: MAINTENANCE

4.6 PHASE V: DETOXIFICATION

drug use, as these can increase risks of fatal overdose by respiratory depression.

- » As a guide, the following is suggested, depending on clinical assessment and patient need:
 - Above 80 mgs: Twice weekly supervision
 - Above 120 mgs: Increased supervision should be considered.
- » No more than 6 days should be prescribed to take home, except for holidays.

4.6 PHASE V: DETOXIFICATION

This is the period during which dose reduction and discontinuation of OST takes place following stability of drug use. According to NICE (2007), detoxification should be a readily available treatment option for people who are opioid dependent and have expressed an informed choice to become abstinent. Requests for detoxification should have a defined time frame for response.¹⁷ Patients who do not successfully detoxify should be offered appropriate access back in OST or other treatment.

In order to obtain informed consent, staff should give detailed information to service users about detoxification and the associated risks, including:

- » The physical and psychological aspects of opioid withdrawal, including the duration and intensity of symptoms, and how these may be managed.
- » The use of non-pharmacological approaches to manage or cope with opioid withdrawal symptoms.
- » The loss of opioid tolerance following detoxification, and the ensuing increased

¹⁷ The Introduction of the Opioid Treatment Protocol recommends that the outcome should be reviewed for three and twelve month outcomes as part of a service audit process.

risk of overdose and death from illicit drug use that may be potentiated by the use of alcohol or benzodiazepines.

- » The importance of continued support, as well as psychosocial and appropriate pharmacological interventions, to maintain abstinence, treat comorbid mental health problems, and reduce the risk of adverse outcomes (including death).

Staff who are responsible for the delivery and monitoring of a care plan should:

- » Develop and agree the plan with the service user
- » Establish and sustain a respectful and supportive relationship with the service user
- » Help the service user to identify situations or states when he or she is vulnerable to drug use and to explore alternative coping strategies
- » Ensure that all service users have full access to a wide range of services
- » Ensure that maintaining the service user's engagement with services remains a major focus of the care plan
- » Review regularly the care plan of a service user receiving maintenance treatment to ascertain whether detoxification should be considered

1

2

3

4

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6

7

A

B



Chapter 4: Assessment of dependence and management of OST

4.1 Key points

4.2 PHASE I: ASSESSING DEPENDENCE

4.3 PHASE II: INDUCTION PHASE

4.4 PHASE III: STABILISATION

4.5 PHASE IV: MAINTENANCE

4.6 PHASE V: DETOXIFICATION

» Maintain effective collaboration with other care providers

» Discuss access to naloxone. See section on Dealing with overdose emergency; naloxone

For a range of useful tools and schedules to support community detoxification, see the Community Detoxification Protocols (ALDP, 2011).

Methadone or buprenorphine should be offered as the first-line treatment in opioid detoxification. Neither opioid medicine is more effective than the other in achieving good outcomes from detoxification. Detoxification should be carried out with the medicine on which the patient had stabilised.

4.6.1 Methadone detoxification

If the patient has been stabilised on methadone, the dose can be reduced at a comfortable and acceptable rate to that individual. This should be based on client assessment and on client direction; for example, this could be around 5 mg every one or two weeks. Patients often prefer a faster reduction at the beginning, although there is no evidence to indicate the superiority of a linear or exponential dose reduction.

4.6.2 Buprenorphine/buprenorphine-naloxone detoxification

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

4.6.3 Drug testing at detoxification phase

» Drug testing is one of a range of parameters used by clinicians within the detoxification phase. Other parameters include clinical review, patient self-report and collateral drug history.

» The recommendation is that at least one random drug test be taken per month, used in conjunction with other parameters.¹⁸

4.6.4 Frequency of supervision

» A reduction from daily supervised consumption can be considered,¹⁹ depending on clinical assessment and patient need.

» No more than 6 days should be prescribed to take home, except for holidays.

¹⁸ Note some residential services may require additional screening.

¹⁹ With the exception that OST administration in prison should be dispensed for supervised consumption only.

4.6.5 Symptomatic treatment of withdrawal

Prescribing symptomatically can reduce some of the physical effects of withdrawal (See Appendix 10 for drugs that may help symptoms in the end stages of detoxification). There is no systematic evidence that any of these medicines work to improve outcome but they may be useful for the clinician in situations where it is not possible to prescribe effective opioid substitution. Particular care is needed concerning the risks of polypharmacy and appropriate supervision and support should be paramount in such cases.

Lofexidine is a non-opioid alpha-adrenergic agonist and is not a controlled drug. It is an unlicensed medicine for use in opioid detoxification and is used predominantly within prisons and specialist treatment centres.

4.6.6 Relapse prevention

Addiction is a chronic relapsing condition and therefore relapse is common during treatment. For some patients, the period of relapse is short and they quickly regain stability again. This always requires careful re-evaluation and care planning. For some patients, this may require re-induction and stabilising.

1

2

3

4

5

6

7

A

B



Chapter 4: Assessment of dependence and management of OST

4.1 Key points

4.2 PHASE I: ASSESSING DEPENDENCE

4.3 PHASE II: INDUCTION PHASE

4.4 PHASE III: STABILISATION

4.5 PHASE IV: MAINTENANCE

4.6 PHASE V: DETOXIFICATION

Within the context of the person's care plan, it is important to put a relapse prevention programme in place to support the patient. This can include:

- » Identifying high-risk situations and triggers for craving
- » Developing strategies to limit exposure to high-risk situations
- » Developing skills to manage cravings and other painful emotions without using drugs or alcohol
- » Learning to cope with lapses
- » Learning how to recognise, challenge, and manage unhelpful or dysfunctional thoughts about drug/alcohol use
- » Developing an emergency plan for coping with high-risk situations when other skills are not working
- » Learning to recognise the ways in which an individual is 'setting oneself up' to use drugs/alcohol
- » Generating pleasurable sober activities and relationships
- » Improving quality of life and attaining a lifestyle balance

4.6.7 Naltrexone

Naltrexone is an opioid antagonist which, when taken regularly, blocks a former opiate user from experiencing the effects of opiates. It can be helpful following detoxification in enabling a patient to maintain abstinence. In Ireland, naltrexone is licensed only for oral use. A depot formulation is available but it is not licensed for opioid treatment. Naltrexone may be useful adjunct to psychosocial treatment for suitably motivated patients, but not generally recommended where psychological support cannot be secured. For under-18s, Naltrexone should be considered in motivated young people, where there is community support from both addiction specialists and family.

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3

4

5

6

7

A

B



Chapter 5: Drug Testing

5.1 Key points

5.2 Objectives of drug testing

5.3 Why and when drug testing can be useful

5.4 Choosing an appropriate drug test

5.5 Procedures for drug testing

5.6 Urine sample adulteration

5.7 Supervision of the provision of urine samples

5.8 Testing for Alcohol

5.9 Testing for Z-drugs

5.1 Key points

- » Drug testing may be used as an ongoing tool for monitoring illicit drug use and adherence with prescribed medications. It should always be used towards enhancing the treatment of the service user.
- » Most drug testing processes consist of two separate types of analysis: a screening test and a confirmation test.
- » The clinical situation will dictate the type of testing (screening or confirmatory) and frequency of testing:
- » Once a patient reaches a stable point with OST, a reduction in frequency of drug testing is recommended.
- » Drug testing should be randomised where possible
- » Direct observation of urine specimen collection is not required in routine clinical practice.
- » The use of oral fluid drug testing is an acceptable alternative to urine drug testing.
- » Drug testing results should be shared between treatment locations and agencies, with appropriate consent, to prevent the duplication of testing.
- » Addiction services, including Level 1 and Level 2 GPs, nationally, should have access to an appropriately accredited laboratory for drug testing/confirmatory analysis.
- » Biological fluids should be handled with appropriate standard and transmission-based precautions.
- » The recommendations for frequency of testing are to be viewed as a minimum standard for all patients receiving OST. In certain clinical situations, some patients may find that more regular testing may help them reach and maintain stability.
- » Stability and safer prescribing of OST is assessed on a range of criteria, drug screening being one of those. There are limitations to the value of drug testing, and clinicians need to assess stability across a range of parameters.

5.2 Objectives of drug testing

Drug testing should be viewed as an informative, supportive intervention in the management of OST. It should never be used as a reason for punitive action towards the service user. A combination of self-reporting and drug testing is more useful than either method alone.

A selection of appropriate drug testing methods can enhance the treatment of those using drugs. It is important that patients are treated with dignity and respect at all times when obtaining a sample for drug testing.

5.3 Why and when drug testing can be useful

- » To assist in confirming drug use, although testing does not confirm dependence or tolerance and should only be used in conjunction with clinical assessment
- » To verify self-reporting of drug use
- » To minimise possible licit and illicit drug interactions
- » To confirm recent OST consumption
- » To support prescribing decisions
- » As a protective factor in relation to minimising risk of overdose

1

2

3

4

5

6

7

A

B



Chapter 5: Drug Testing

5.1 Key points

5.2 Objectives of drug testing

5.3 Why and when drug testing can be useful

5.4 Choosing an appropriate drug test

5.5 Procedures for drug testing

5.6 Urine sample adulteration

5.7 Supervision of the provision of urine samples

5.8 Testing for Alcohol

5.9 Testing for Z-drugs

- » To monitor illicit drug use
 - » As a motivational tool to support recovery
- » To document periods of abstinence and evidence to support progress in treatment
- » To assist in contingency management interventions, e.g. deciding on takeaway doses
- » To re-evaluate treatment plans
- » To identify substance use disorders in pregnant women
- » To facilitate other agencies in assessing progress in treatment e.g. criminal justice and child welfare agencies. This is on the understanding that drug test results should not be considered in isolation in determining progress.
- » It may assist in detecting and monitoring emerging trends in substance use

The rationale for drug testing and the results of those tests should be clearly delineated to those responsible for service user care to ensure cost-effectiveness and maximise usefulness. The service user should be informed of the reasons for this measure.

Drug testing should be viewed as an informative measure, and not as a reason for punitive action towards the service user.

Repeated positive urine drug test results imply a treatment plan may not be working effectively and that another approach should be considered. Efforts to reduce a client's substance use by monitoring drug test results are most effective where open communication is practised between the person and the care team.

Drug testing to confirm drug use when a patient has already self-reported use is generally not cost-effective or regarded as necessary practice. A combination of self-reporting and drug testing is more useful than either alone.

5.4 Choosing an appropriate drug test

Most drug testing processes consist of two separate types of analysis: a drug screening and a confirmation test. In most clinical situations, the most practical and cost-effective option for screening purposes is the use of a randomised drug testing regime.

Many licit and illicit drugs can be misused, but not all can be targeted by routine screening. Testing regimens generally target commonly misused drugs or drug groups. Where more specific testing is required, confirmatory analysis should be used.

See Appendix 11 for different matrices for drug testing, and Appendix 12 for the

approximate durations of detectability of selected drugs in urine/oral fluid.

5.4.1 Drug Screen:

The screening test is less time consuming and is designed to easily identify negative results. An immunoassay system is used, either in the laboratory or using point of care tests (POCT). With these tests, a negative result can be reliably accepted as negative. However, although a positive result is reliable, the chance of a false positive cannot be ruled out due to possible cross reactions.

The most convenient drug screening test used in general practice is a urine POCT. This dipstick test provides immediate results. The advantages of this type of testing are that it is less time consuming than other tests and it is designed to easily identify negative results.

Cross reactivity: Care should be taken when interpreting immunoassay screening results, as some over-the-counter codeine-containing products, or prescribed opioid based medication, will give an opioid positive result.

If a patient has used ecstasy or New Psychoactive Substances (NPS), they may test positive for amphetamines.

1

2

3

4

5

6

7

A

B



Chapter 5: Drug Testing

5.1 Key points

5.2 Objectives of drug testing

5.3 Why and when drug testing can be useful

5.4 Choosing an appropriate drug test

5.5 Procedures for drug testing

5.6 Urine sample adulteration

5.7 Supervision of the provision of urine samples

5.8 Testing for Alcohol

5.9 Testing for Z-drugs

Routine Point of Care Tests (POCTs)

Presently most routine POCTs include the following:

- » Opioid
- » Methadone
- » Cocaine
- » Benzodiazepines
- » Amphetamines

Some POCTs can include the following add on screens

- » EDDP
- » Alcohol
- » PH
- » Creatinine
- » THC
- » 6-AM

Availability of these POCTs will determine their clinical utility and can assist with assessment, clinical review, and verification of self-report. If relying on POCT alone, clinicians

should ensure access to 6-AM²⁰ and EDDP²¹ tests.

The use of POCT should be guided by the **Guidelines for Safe and Effective Management and Use of Point of Care Testing in Primary and Community Care.**²² It is recommended that practitioners comply with these guidelines. Staff performing tests should also be trained in reading results.

Routine Laboratory Tests

- » Opioid
- » EDDP
- » Cocaine
- » Benzodiazepines
- » Amphetamine

20 A 6-AM (6 – acetyl morphine) is used in the pre-treatment assessment phase or if heroin use is suspected in the previous 24hrs, or if the patient disputes an opiate positive result.

21 EDDP is a methadone metabolite. Testing for EDDP shows that methadone has been ingested.

22 www.imb.ie/images/uploaded/documents/Guidelines_for_Safe_and_Effective_Management_and_Use_of_Point_of_Care_Testing_in_Primary_and_Community_Care.pdf
www.icgp.ie/go/library/catalogue/item/01147110-CDA5-40AC-883E5C8D06A6A9E8/
www.thepsi.ie/Libraries/Practice_Guidance/POCT_Guidelines_211209.sflb.ashx

- » Cannabis
- » Creatinine
- » 6-AM, Zopiclone and EtG screening are done on request

5.4.2 Confirmatory tests:

A positive screen can be confirmed with a confirmatory test, conducted by an accredited laboratory. However, this should only be done where a clinical decision substantially affects the patient. A confirmatory test is always laboratory based and uses either gas or liquid chromatography coupled to mass spectrometry. These methods will unambiguously identify drugs and metabolites present in a sample.

5.5 Procedures for drug testing

Collection procedures for drug testing should be conducted in ways that preserve dignity. A correctly collected specimen is essential for obtaining an accurate test result. Guidance on written procedures for the collection and storage of biological samples, their dispatch to a laboratory, and the subsequent discussion

1

2

3

4

5

6

7

A

B



Chapter 5: Drug Testing

5.1 Key points

5.2 Objectives of drug testing

5.3 Why and when drug testing can be useful

5.4 Choosing an appropriate drug test

5.5 Procedures for drug testing

5.6 Urine sample adulteration

5.7 Supervision of the provision of urine samples

5.8 Testing for Alcohol

5.9 Testing for Z-drugs

and management of reported results is referenced below.²³

The person responsible for specimen collection needs to ensure the following:

- » Confirming the identity of the service user
 - » Explaining clearly the collection procedure to the service user
 - » Ensuring that the collection container is appropriate for the specimen matrix
- 23 See S.I. No. 492/2001 Transportation of Dangerous Goods Regulations. Samples sent to the laboratory of the HSE National Drug Treatment Centre, must be designated either Infectious or Diagnostic and packaged according to UN guidelines. Infectious (UN Hazard Class 6.2 specifications) samples packaging consists of a primary receptacle (leak-proof, surrounded by absorbent material), which is inserted into a Secondary receptacle (leak-proof and shatter-proof). Both receptacles must be placed in an approved outer package, bearing UN hazard class 6.2 markings. Only Dangerous Goods Safety Advisor (DGSA) approved couriers, with specifically designated vehicles and certified drivers, can be used to transport Infectious samples. Diagnostic (UN Hazard Class 6.0 specifications) samples must have the basic triple packaging system and UN diagnostic class markings but are not subject to transportation by specially designated vehicles. See World Health Organization guidelines document www.who.int/csr/emc97_3.pdf. Also, each local hospital laboratory will have its own policy document on this. This is an example from Letterkenny General Hospital www.hse.ie/eng/services/list/3/hospitals/lgh/Specimen_Transport_Policy.pdf
- » Labelling the specimen properly
 - » Collecting a sufficient amount of the specimen
 - » Ensuring that the specimen collection process reduces the risk of substitution, dilution, or adulteration
 - » Storing the specimen according to the manufacturer's or laboratory's recommendations (e.g., appropriate temperature/protect from light) to maintain specimen integrity
 - » Preventing loss of or tampering with specimen by storing it in a secure area
 - » Accurately recording information; and complying with appropriate dispatch and transport procedures
 - » Following best practice in relation to disposal
 - » Compliance with standard and transmission-based precautions²⁴. Hand cleaning materials should be available to the patient after they have provided their sample.

24 See Standard Precautions Guidelines, HPSC (2009), <http://www.hpsc.ie/hpsc/A-Z/Respiratory/Influenza/SeasonalInfluenza/Infectioncontroladvice/File,3600,en.pdf>

5.6 Urine sample adulteration

A false negative can be achieved by specimen dilution, addition of chemicals (salt, soap, bleach) or direct substitution with another sample.

A false positive result can be achieved by direct addition of a drug to the sample or by substitution with one provided by a known drug user. In addition, pre-sample abstinence may produce a misleading negative result, while ingestion of drugs obtained licitly may mask those taken illicitly e.g. prescribed benzodiazepines masking the fact that there is illicit use also.

The following are suggested practical steps that should be considered in your practice to limit the opportunities to tamper with a urine specimen:

- » Using temperature and adulterant strips with the urine container
- » Checking the temperature strip on the urine containers as soon as collected
- » Prohibiting personal belongings in the bathroom
- » Ensuring that adulterants, such as soap, ammonia, or bleach are not readily available in the collection area when that patient provides specimens

1

2

3

4

5

6

7

A

B



Chapter 5: Drug Testing

5.1 Key points

5.2 Objectives of drug testing

5.3 Why and when drug testing can be useful

5.4 Choosing an appropriate drug test

5.5 Procedures for drug testing

5.6 Urine sample adulteration

5.7 Supervision of the provision of urine samples

5.8 Testing for Alcohol

5.9 Testing for Z-drugs

» Reducing unsupervised access to hot water and hand dryers to prevent patients from heating specimens brought from elsewhere

» Putting blue dye in the toilet

» Using bathrooms within eyesight of staff to preclude use by more than one person at a time

» Checking toilet before and after sample is given

» Testing for pH, creatinine, or specific gravity if you are concerned about the integrity of a sample

5.7 Supervision of the provision of urine samples

Direct observation of urine specimen collection is not required in routine clinical practice. If there are concerns about the integrity of a sample, an alternative test could be considered e.g. oral fluid testing.

If a supervised sample is required for legal purposes, it is important to ensure that the patient has provided informed consent and that an appropriate level of chain of custody procedures is applied.

When taking samples from under-18 year olds, the obligations under the Children First Guidelines must be taken into consideration in all aspects of their care.

5.8 Testing for Alcohol

Alcohol is associated with significant morbidity and mortality, particularly when used in combination with other substances. A patient's use of alcohol can be identified using their clinical history, examination, and by self-reporting questionnaires.

A range of biomarkers is available for detecting alcohol misuse. The most common and routine is breath alcohol which is measured using a breathalyser.

Ethyl glucuronide (EtG) is a direct metabolite of alcohol that can be detected in urine for up to 90 hours post ingestion and has the potential to become a useful marker of 'binge' drinking. Testing for this is only available in the laboratory.

5.9 Testing for Z-drugs

The proportion of people using these hypnotics has grown in recent years in Ireland and is of increasing concern in the drug using population.

If clinically indicated, specific drug tests for these drugs should be requested from the laboratory.

5.10 Testing for NPS

The use of NPS has increased significantly in recent years across the whole population but particularly in the drug using population. If clinically indicated specific drug screens for these tests should be requested from the laboratory.

1

2

3

4

5

6

7

A

B



Chapter 6: OST and associated health considerations

6.1 Key points

6.2 Responses to continued drug and alcohol misuse for patients in OST

6.3 Mental health

6.4 Viral Infections

6.5 Hepatitis A and B vaccinations

6.6 Health implications for continued drug and alcohol use when patients are on OST

6.7 Pain management for drug misusers

6.8 ECG Monitoring

6.9 Drug Related Deaths

6.1 Key points

- » OST should be provided with a range of other medical interventions.
- » Psychosocial interventions can also address common associated or co-occurring mental disorders, such as depression or anxiety.
- » Common mental health problems are frequent in people accessing addiction services. Interventions may need to be provided in addiction services, in conjunction with Community Mental Health Teams (CMHTs). Those with severe mental health problems should have care integrated with acute community-based secondary mental health services.
- » Reducing potential harm due to overdose, blood-borne viruses, and other infections should be a part of patient care.
- » All drug users should be offered testing and vaccination against hepatitis A and B, where indicated. This discussion should be documented in the patient's record.
- » All drug users should be offered testing and appropriate treatment for hepatitis C and HIV infections.
- » Retaining patients in high-quality treatment is protective against overdose. This protection may be enhanced by other interventions, including training drug users and their families and carers in the risks of overdose, its prevention, and how to respond in an emergency.
- » Drug users who are also using alcohol in a problematic way should be offered alcohol treatments.
- » Drug users who smoke tobacco should be offered smoking cessation interventions.

6.2 Responses to continued drug and alcohol misuse for patients in OST

There is good evidence for the effectiveness of psychological treatments for substance use. Interventions such as motivational interviewing and relapse prevention appear to be effective across a range of substances.

A combination of substitute prescribing and psychological treatment is frequently more effective than medication or psychological treatment alone, particularly for opiate, benzodiazepine, and alcohol use.

Where no substitute prescribing treatments are available, with substances such as cannabis and cocaine, there is evidence that psychological treatment alone can be effective in changing a person's substance-using behaviours.

Any form of psychological treatment can lead to better outcomes than no psychological treatment.

For cannabis users, MI, CBT, and family therapy appear to be the most effective.

1

2

3

4

5

6

7

A

B



Chapter 6: OST and associated health considerations

6.1 Key points

6.2 Responses to continued drug and alcohol misuse for patients in OST

6.3 Mental health

6.4 Viral Infections

6.5 Hepatitis A and B vaccinations

6.6 Health implications for continued drug and alcohol use when patients are on OST

6.7 Pain management for drug misusers

6.8 ECG Monitoring

6.9 Drug Related Deaths

Table 6: Responses to continued drug or alcohol misuse when patients are on OST (adapted from Drug misuse and dependence, UK guidelines on clinical management, 2007)

Scenario	Risks	Possible Reason	Responses to consider
Opiate misuse on top of OST	<ul style="list-style-type: none"> • Overdose • Blood-borne viruses and other infections if injecting • Continued offending and involvement in drug-misusing lifestyle • Impairing engagement 	<ul style="list-style-type: none"> • Inadequate dose • Medication unsuitable • Patient on reducing regimen • Patient using heroin and/or other opiates on effective dose of OST 	<ul style="list-style-type: none"> • Dose assessment, increase dose • Change medication regimen • Transfer patient to maintenance regimen • Review psychosocial interventions • Review contingency management, plus urine tests and supervised consumption • Provide harm reduction interventions • Address social functioning domains (including housing, employment and relationships) within a shared care approach
Crack cocaine and cocaine and/or other stimulants on top of OST	<ul style="list-style-type: none"> • Blood-borne viruses and infections if injecting • More chaotic drug misuse • Increased crime • Psychological problems • Overdose 	<ul style="list-style-type: none"> • Recreational use • Patient dependent on cocaine or crack cocaine 	<ul style="list-style-type: none"> • Review psychosocial interventions. • Review contingency management, plus urine tests and supervised consumption • Provide harm reduction interventions • Address social functioning domains (including housing, employment and relationships) within a shared care approach • For stimulant users, the strongest evidence for effective psychological treatment is for CBT approaches, including motivational interviewing, relapse prevention, community reinforcement approach, and contingency management; suggests a combination of approaches as being the most helpful

1

2

3

4

5

6

7

A

B



Chapter 6: OST and associated health considerations

6.1 Key points

6.2 Responses to continued drug and alcohol misuse for patients in OST

6.3 Mental health

6.4 Viral Infections

6.5 Hepatitis A and B vaccinations

6.6 Health implications for continued drug and alcohol use when patients are on OST

6.7 Pain management for drug misusers

6.8 ECG Monitoring

6.9 Drug Related Deaths

Scenario	Risks	Possible Reason	Responses to consider
Alcohol* or benzodiazepine misuse with OST	<ul style="list-style-type: none"> Alteration of methadone metabolism Deterioration of hepatic functioning in those with Hepatitis C Street drinking with public disorder Presentation Overdose or 'near misses' Drug Interactions Violent and aggressive behaviour 	• Problematic use*	<ul style="list-style-type: none"> Alcohol/benzodiazepine detoxification and/or reduction regimen For alcohol consider a breathalyser test Consider increased supervised consumption of opioid prescriptions Review key working Review psychosocial interventions (brief intervention in line with the SAOR model)
		• Patient dependent*	<ul style="list-style-type: none"> Alcohol/benzodiazepine detoxification and/or reduction regimen For alcohol consider a breathalyser test Increased supervised consumption of opioid prescriptions May need to transfer to specialist addiction service Review key work and psychosocial interventions For benzodiazepine users, a CBT approach appears to be effective in reducing drug use. For alcohol users, CBT (including motivational enhancement therapy), 12 step, and family therapy approaches appear to be the most effective

*For alcohol, AUDIT is the recommended tool for screening for levels of alcohol risk.

6.3 Mental health

There is a high rate of psychiatric disorders among individuals misusing or dependant on drugs and alcohol.

- » A range of problems are seen, including anxiety, mood disorders, and personality disorders.
- » The coexistence of mental health and drug use problems is common, generally referred to as 'dual diagnosis' or 'comorbidity'. Patients with comorbidity generally have poorer prognosis.

- » Comorbidity can be associated with negative factors, such as higher rates of relapse, increased hospitalisation, suicide, poverty, homelessness, and criminality.
- » The emergence of NPS use in recent years has increased the number of individuals presenting with mental health difficulties to services. A particular concern is the association between certain NPS and suicide (cathinone drugs).

- » It is important these patients receive appropriate assessment of needs and risk and treatments that are evidence based.
- » The Mental Health Act of 2001 specifically mentions that addiction to drugs or intoxicants is not a reason for involuntary admission to psychiatric care.
- » Patients with significant mental health issues should be prioritised for addiction treatment.

Chapter 6: OST and associated health considerations

6.1 Key points

6.2 Responses to continued drug and alcohol misuse for patients in OST

6.3 Mental health

6.4 Viral Infections

6.5 Hepatitis A and B vaccinations

6.6 Health implications for continued drug and alcohol use when patients are on OST

6.7 Pain management for drug misusers

6.8 ECG Monitoring

6.9 Drug Related Deaths

6.3.1 Treatment for mental health problems

Practitioners in mental health and addiction services should be competent to manage patients with comorbidities. Substance use is associated with comorbid psychiatric disorders. Substance use may also contribute to and exacerbate mental illness. A multidisciplinary approach, with specialist practitioners and psychiatrists, and the availability of structured psychological interventions, is advised. Caution should be used when prescribing benzodiazepines to treat comorbid psychiatric disorders (see Appendix 13: Guiding principles for working with clients with co-occurring disorders).

Depression:

- » Depression is common and should be assessed and monitored closely.
- » A validated measure, e.g. the Hospital Anxiety and Depression Scale (HADS), can be used to inform assessment and monitoring.
- » Treatment can consist of psychological or pharmacological interventions or both.
- » Management of mild to moderate depression is the same as for non-drug-using patients; sleep hygiene, individual facilitated self-help, cognitive behavioural therapy (CBT), structured physical activity

programme, counselling, group-based peer support, antidepressants, referral for further assessment.

- » Management of failure to respond to first-line treatment or moderate to severe depression is with high intensity psychological interventions such as CBT or interpersonal therapy, pharmacological treatment, combined or collaborative care.
- » The choice of antidepressant depends on patient choice and patient preference, SSRIs, e.g. sertraline, or SNRIs, e.g. venlafaxine, being appropriate choices.
- » Citalopram and escitalopram are contraindicated for use with methadone due to the increase risk of QT prolongation.
- » Tricyclics (especially Doxepin) should be avoided, as there is a high incidence of abuse.
- » The management of drug dependant patients with severe mental health issues is challenging in primary care. Refer to specialist mental health services if depression is severe or if the patient has failed to respond.
- » If there is risk to life or severe self-neglect, then inpatient mental health care may be needed.

Anxiety:

- » Anxiety disorders, such as Generalised Anxiety Disorder, Panic disorder, Agoraphobia, Social Phobia Obsessive Compulsive Disorder, and Post-traumatic Stress Disorder are common.
- » Identify and assess the level of anxiety.
- » A validated measure relevant to the disorder, e.g. 7-item Generalised Anxiety Disorder (GAD-7), can be used for assessment and monitoring.
- » For management of mild anxiety, offer low-intensity psychological interventions; individual non-facilitated and facilitated self-help, psychoeducational groups, self – help groups, trauma-focused CBT.
- » Management of failure to respond or severe anxiety is with high-intensity psychological interventions such as CBT, applied relaxation, or medications such as SSRIs or SNRIs, combined or collaborative care.
- » Caution should be used with prescribing benzodiazepines and/or pregabalin because of their abuse potential.
- » Refer to mental health services if anxiety is severe or refractory.

Psychosis:

- » Psychosis is characterised by a loss of connectedness with reality, e.g. the presence of delusions and hallucinations.

1

2

3

4

5

6

7

A

B



Chapter 6: OST and associated health considerations

6.1 Key points

6.2 Responses to continued drug and alcohol misuse for patients in OST

6.3 Mental health

6.4 Viral Infections

6.5 Hepatitis A and B vaccinations

6.6 Health implications for continued drug and alcohol use when patients are on OST

6.7 Pain management for drug misusers

6.8 ECG Monitoring

6.9 Drug Related Deaths

- » It is important to distinguish between substance-induced and substance-related psychosis.
- » It is advisable to allow three to four weeks of abstinence before making a diagnosis of a psychiatric disorder.
- » Stimulants such as cocaine, ecstasy, and amphetamines are significant causes of psychosis and paranoia, however any psychoactive drug used to excess can cause these symptoms.
- » Use of NPS has also been implicated in the development of psychosis in individuals.
- » The main forms of psychosis that are not substance-induced are schizophrenia and bipolar disorder.
- » Substance use, particularly with NPS, with these disorders is common and can precipitate an acute episode.
- » The occurrence of substance induced psychosis in some individuals may indicate an 'at-risk' mental state, and they are at risk of developing schizophrenia.

If it is clinically indicated that psychosis is substance-related, and not substance-induced, consider referral for specialist psychiatric assessment.

Personality Disorders

- » Personality Disorders are long-standing and maladaptive patterns of perceiving and responding to other people and stressful circumstances.
- » The two subtypes most researched are Emotionally Unstable Personality Disorder and Dissocial Personality Disorder.
- » High-risk behaviour can persist, despite successful opiate treatment.
- » Patients with Personality Disorders can be offered the same range of treatment to those without Personality Disorders.
- » Management includes the use of limit setting and therapeutic contracts. Scheduling of brief, structured, and frequent visits may be helpful.
- » There is no specific pharmacological treatment for Personality Disorders.
- » Collaborative care planning with other service providers can be indicated.

6.4 Viral Infections

6.4.1 Hepatitis A

- » Commonly transmitted by fecal-oral contamination.

- » Usually self-limiting and requires no treatment, unless occurring with another disease e.g. Hepatitis B or C.
- » Based on current evidence, it is recommended that injecting drug users are vaccinated against Hepatitis A.
- » The combined Hepatitis A and B vaccines may improve uptake.
- » Hepatitis A (acute) infection is a notifiable disease. See www.hpsc.ie/hpsc/NotifiableDiseases

6.4.2 Hepatitis B

- » May present with flu-like illness or may be asymptomatic in early stages.
- » May be discovered by abnormal liver function test results and subsequent positive Hepatitis B blood test.
- » Initial assessment of any drug user should include history of Hepatitis B vaccination and results of screening for Hepatitis B.
- » Vaccination for Hepatitis B should be carried out for all those at risk and records of these vaccinations should be kept.
- » Hepatitis B (acute and chronic) infection is a notifiable disease. See www.hpsc.ie/hpsc/NotifiableDiseases

1

2

3

4

5

6

7

A

B



Chapter 6: OST and associated health considerations

6.1 Key points

6.2 Responses to continued drug and alcohol misuse for patients in OST

6.3 Mental health

6.4 Viral Infections

6.5 Hepatitis A and B vaccinations

6.6 Health implications for continued drug and alcohol use when patients are on OST

6.7 Pain management for drug misusers

6.8 ECG Monitoring

6.9 Drug Related Deaths

6.4.3 Hepatitis C

- » Most patients are asymptomatic during early stages of infection, but others can suffer from nausea, fever, vomiting, or jaundice.
- » 20-30% of those infected will spontaneously clear the virus, 70-80% may become chronically infected.
- » Recent developments in non interferin based treatments has dramatically improved treatment outcomes. All chronically infected Hepatitis C patients should be referred for consideration for these new treatments.
- » Chronic infection can lead to cirrhosis, liver failure, and/or hepatocellular carcinoma.
- » When a patient tests positive for Hepatitis C antibody, further blood tests should be carried out. It is recommended that Hep C antigen and liver function tests should be done in primary care and community drug services. Patients who are antigen positive should be referred to specialist services for PCR blood testing, Fibro scanning, and consideration for treatment.
- » Counselling prior to screening for Hepatitis C is no longer routine.
- » All patients who are at risk of contracting Hepatitis C should be given information and advice on the disease and how it is transmitted.

- » It is recommended that all drug users are screened for Hepatitis C, even if they are not intravenous drug users.
- » Early detection and early referral of all active Hepatitis C cases to secondary care is now recommended.
- » Patients who continue to inject drugs or misuse alcohol should not be excluded from treatment because of these behaviours.

- » Risks of concurrent alcohol use should be explained to all Hepatitis C positive patients. Alcohol has been shown to be a significant risk factor in the development of cirrhosis in patients who are chronically infected with Hepatitis C.
- » Hepatitis C infection is a notifiable disease. See www.hpsc.ie/hpsc/NotifiableDiseases

Disease progression in Hepatitis C infection

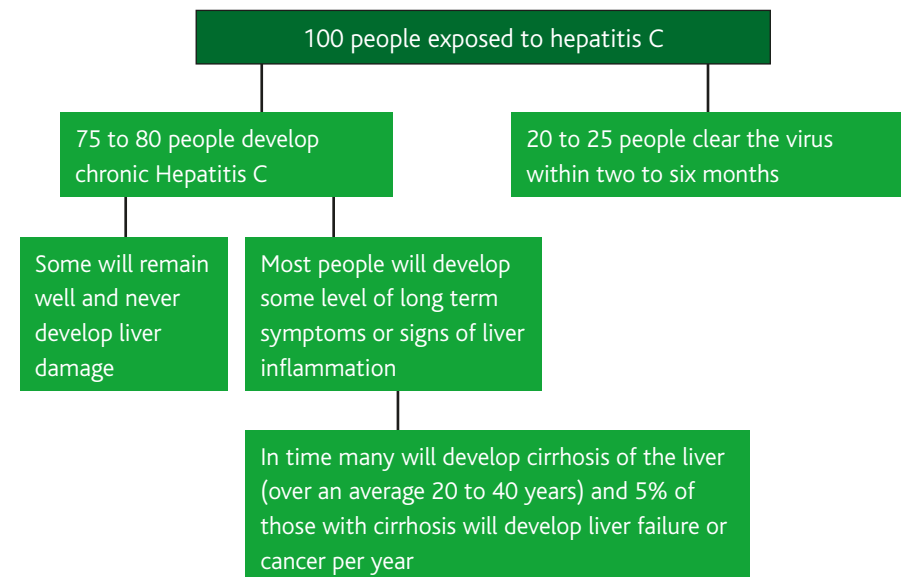


Figure 2: Disease progression in Hepatitis C infection (Source: RCGP Hep C guidance)

Chapter 6: OST and associated health considerations

6.1 Key points

6.2 Responses to continued drug and alcohol misuse for patients in OST

6.3 Mental health

6.4 Viral Infections

6.5 Hepatitis A and B vaccinations

6.6 Health implications for continued drug and alcohol use when patients are on OST

6.7 Pain management for drug misusers

6.8 ECG Monitoring

6.9 Drug Related Deaths

6.4.4 HIV

- » All service users should be offered education and prevention advice on HIV transmission, safe injecting, and safe sexual practises.
- » Among people who inject drugs, HIV is passed by sharing equipment used for intravenous drug use, as well as through unsafe sexual practices.
- » Increased risk of HIV transmission in injecting drug users has been associated with injecting synthetic cathinones and homelessness.
- » Some newly infected people experience flu-like symptoms, develop a rash, and/or lymphadenopathy; others may have no symptoms.
- » All drug users entering OST should be offered a HIV anti-body blood test. Patients should be regularly reviewed for HIV risk behaviour and repeat tests offered, as clinically appropriate.
- » On site point of care and salivary antibody testing may be considered for screening at risk or hard to reach populations. All reactive test results must be confirmed using a laboratory-based confirmatory test, as a small number of people who are not HIV infected will produce a positive (reactive) result. The importance for confirmatory testing at an approved HIV testing laboratory needs to be emphasized to rule

out the possibility of a false-positive result in the rapid HIV test and to confirm a true positive result.

- » PCR testing may be considered if a clinician has concerns about more recent infection
- » All service users who are HIV infected should be referred to specialist hospital based services for ongoing monitoring of CD4/ viral load and antiretroviral therapy.
- » For chaotic /non-adherent service users, directly observed therapy may be considered.
- » Changes in drug use patterns may increase HIV transmission risks in certain categories of drug users. The Health Protection Surveillance Centre (www.hpsc.ie) identifies high risk populations and targets areas for intervention.
- » HIV infection is a notifiable disease. See www.hpsc.ie/hpsc/NotifiableDiseases

6.5 Hepatitis A and B vaccinations (Department of Health Immunisation Guidelines for Ireland 2012) see summary tables Appendix 15

- » Hepatitis A and B can be given as combined or separate vaccines.
- » Hepatitis A, if given on its own, is a single dose, with a booster at 6-12 months. This results in immunity beyond 10 years.

» Immunity against Hepatitis A is the same whether gained by combined Hepatitis A and B vaccine or Hepatitis A vaccine alone.

- » Immunity against Hepatitis A is the same whether gained by routine or accelerated schedule.
- » The Hepatitis B vaccine requires a series of doses following the routine schedule (0, 1, 6 months), or an accelerated schedule (0, 7, 21 days, 12 months).
- » If offering Hepatitis B vaccination on its own, it is recommended that individuals at risk of infection are offered a single booster once at 5 yrs. Measuring Hepatitis B immunity is not required before or after this booster.
- » The combined Hepatitis A and B vaccine requires a series of doses following the routine schedule (0, 1, 6 months), or an accelerated schedule (0, 7, 21 days, 12 months).

» Testing for immunity after vaccination is recommended only for persons whose subsequent clinical management or occupational risk depends on knowledge of their immune status.

» Such persons include immunocompromised people and sex or needle-sharing partners of HBsAg-positive persons.

1

2

3

4

5

6

7

A

B



Chapter 6: OST and associated health considerations

6.1 Key points

6.2 Responses to continued drug and alcohol misuse for patients in OST

6.3 Mental health

6.4 Viral Infections

6.5 Hepatitis A and B vaccinations

6.6 Health implications for continued drug and alcohol use when patients are on OST

6.7 Pain management for drug misusers

6.8 ECG Monitoring

6.9 Drug Related Deaths

» Testing should be performed 2 months after the last dose of vaccine.

» About 10% of patients fail to respond adequately to three doses of the Hepatitis B vaccine. This is more common in those over 40 years of age, obese people, and in smokers. Poor response is also reported in alcoholics and in advanced liver disease.

» Ideally, after the vaccination course, Anti-HBs levels of >100mIU/ml would be achieved, levels >10mIU/ml are generally accepted as enough to protect against infection.

» Both the Hepatitis B and Hepatitis A and B combined vaccines are inactivated and so are considered safe in pregnancy and for patients with HIV. These groups may not mount the same immune response, and may need further boosters.

» It is recommended that vaccination should be offered to the children and sexual partners of those at high risk.

» It is important that vaccination does not encourage relaxation of other measures designed to prevent exposure to blood borne viruses, for example, condom use and needle exchange.

» All health workers should be vaccinated for Hepatitis A and B.

6.6 Health implications and interventions for continued alcohol and drug use when patients are on OST

6.6.1 Alcohol

Problematic alcohol use is a significant risk factor for drug users on OST due to:

» It being a significant cause of death due to alcohol overdose, inhalation of vomit, hypoglycaemia, and accidents or violence

» It increases the dropout rates from treatment

» It increases risk of hepatic cancer in people with Hepatitis C

» One third of patients receiving methadone have been identified as having a current drink problem.

The National Treatment Outcomes Research Study (Comiskey *et al.*, 2009) found 24% of the cohort at the start of the study were drinking above Department of Health recommended limits, and 25% were doing so at the five-year follow-up. Some, 8%, were drinking at harmful levels.

About one-third of patients receiving methadone have been identified as having a current drink problem, and a further one-sixth

have a history of a drinking problem. It follows that clinicians working with drug users require:

» An awareness that alcohol misuse is not separate from misuse of other drugs

» Competence at detecting problem drinking

» The ability to give harm reduction and educational messages regarding misuse of alcohol

» The ability to manage alcohol misuse emerging alongside pharmacotherapies, such as substitute prescribing

It may be clinically helpful to think of different patterns of drinking associated with drug misuse:

» Drinking that is substantially independent of other drug misuse

» Drinking that is interchangeable with the use of other psychoactive drugs.

» Drinking and other other drug misuse, as a supplement to a substitute prescription

Assessment of the cumulative effects of high-risk behaviours and polydrug use requires repeat assessment by an experienced clinician. Opiate users who are chronically intoxicated with alcohol are difficult to manage. Some strategies to deal with the problems are outlined in the section on responding to failure to benefit from treatment (section

1

2

3

4

5

6

7

A

B



Chapter 6: OST and associated health considerations

6.1 Key points

6.2 Responses to continued drug and alcohol misuse for patients in OST

6.3 Mental health

6.4 Viral Infections

6.5 Hepatitis A and B vaccinations

6.6 Health implications for continued drug and alcohol use when patients are on OST

6.7 Pain management for drug misusers

6.8 ECG Monitoring

6.9 Drug Related Deaths

5.5). As the risks of prescribing opioids, in conjunction with high levels of alcohol use, need to be balanced against the benefits of retaining the patient in treatment, specialist competencies are required.

Interventions:

- » An alcohol screen and appropriate intervention in line with the HSE National Screening and Brief Intervention (SAOR) Programme; the level of brief intervention is dependent on the score someone receives. See <http://www.hse.ie/eng/services/Publications/topics/alcohol/alcoholscreening.html> for the SAOR Guideline Framework, alcohol screening tools, and support materials.
- » The standard interventions for problem alcohol use and dependence apply for patients on OST (see Table 6).
- » Consider a care plan towards alcohol detoxification, either in-patient or out-patient, psychological interventions, pharmacology to prevent relapse, and supplements to prevent vitamin deficiencies problems.
- » Minimise polypharmacy, particularly with benzodiazepines.
- » Provide posters with information on supports, such as Narcotics Anonymous, Alcoholics Anonymous, SMART Recovery etc.

6.6.2 Benzodiazepines and Z-compounds

Doctors should familiarize themselves with the recommendations of the Benzodiazepine Best Practice Guidelines, published by the Department of Health and Children in 2002.²⁵ These commonly prescribed drugs do cause tolerance and dependence. Initiation should be avoided in substance misusers. For a range of useful tools and schedules to support community detoxification, see the Community Detoxification Guidelines (ALDP, 2015).

They are often taken in large quantities:

- » To enhance other drug effects
- » To help manage withdrawals from other drugs
- » As a form of self-medication for anxiety & mood problems

Actions:

- » Identify those who qualify as having a dependence on benzodiazepines.
- » Assess if they also may have anxiety or mood symptoms.
- » Avoid double prescribing, by liaising with their community GP.

²⁵ www.drugs.ie/resourcesfiles/reports/DOHC_Benzo_committee.pdf

- » Prescribing to attenuate benzodiazepine withdrawal symptoms should only occur when there is evidence of dependence.
- » Clear treatment goals should be agreed and documented.
- » Regular patient review, and dispensing and supervision should follow a schedule similar to that for other drugs of dependence, including daily dispensing and supervised consumption.
- » Aim to convert other BDZ and sedative hypnotics into an appropriate dose of diazepam.
- » Aim for the lowest dose of diazepam that will prevent withdrawal symptoms.
- » To minimize diversion, prescribe in 2mg doses.
- » Only very rarely should doses of more than 30mg diazepam per day be prescribed.
- » Patients that are likely to need in excess of this dose should be considered for referral for inpatient medically assisted detoxification, in either St. Michaels, Beaumont or Cuan Dara, IPU Cherry Orchard Hospital.
- » Aim to prescribe a reducing regimen for a limited period of time, reducing slowly, at a rate of 2-2.5mg every fortnight.

1

2

3

4

5

6

7

A

B



Chapter 6: OST and associated health considerations

6.1 Key points

6.2 Responses to continued drug and alcohol misuse for patients in OST

6.3 Mental health

6.4 Viral Infections

6.5 Hepatitis A and B vaccinations

6.6 Health implications for continued drug and alcohol use when patients are on OST

6.7 Pain management for drug misusers

6.8 ECG Monitoring

6.9 Drug Related Deaths

- » OST dose should be kept stable throughout the benzodiazepine reduction period.
- » Consider adjunctive therapies where available.
- » Not to take extra benzodiazepines while prescribed a benzodiazepine detoxification programme.
- » Benzodiazepine withdrawal symptoms include anxiety, agitation, insomnia, tension, sweating, and sensory and perceptual distortions.
- » That concurrent use of benzodiazepines and other opioids, including methadone and heroin, may increase the risk of sedation, respiratory depression, risk of overdose, and death.
- » That benzodiazepine use is associated with decreased reaction time and impaired motor co-ordination that may lead to accidents and injuries.
- » That any prescription above 30 mg diazepam daily, or consumption above the doses recommended in the SmPC and BNF for the individual medications, constitutes misuse for driver licensing purposes.

Patients should be advised to:

- » Reduce their use of benzodiazepines to an equivalent dose of diazepam 10mg TDS/ QDS daily i.e. between 30 and 40mg of diazepam daily as an outpatient.

Benzodiazepine agonist drug	Half Life of Parent Drug (hours)*	Speed of onset	Equivalence to diazepam 5mg**	Use
Chlordiazepoxide	5-30	Slow	15mg	Anxiety
Diazepam	20-100	Rapid	5mg	Anxiety/Insomnia
Loprazolam	4-15	Slow	0.5mg (to 1mg)	Insomnia
Lorazepam	10-20	Intermediate	0.5mg ***	Anxiety/Insomnia
Lormetazepam	11	Intermediate	0.5 (to 1mg)	Insomnia
Nitrazepam	18-25	Rapid	5mg	Insomnia
Oxazepam	4-15	Slow	15mg	Anxiety
Temazepam	8-22	Intermediate	10mg	Insomnia
Zaleplon	1	Rapid	10mg	Insomnia
Zolpidem	2	Rapid	10mg	Insomnia
Zopiclone	5-6	Rapid	3.75mg	Insomnia

*Some variation between individuals

**Equivalence as BNF and Clinical guidelines

***Approximately equivalent oral dosage from other sources

1

2

3

4

5

6

7

A

B



Chapter 6: OST and associated health considerations

6.1 Key points

6.2 Responses to continued drug and alcohol misuse for patients in OST

6.3 Mental health

6.4 Viral Infections

6.5 Hepatitis A and B vaccinations

6.6 Health implications for continued drug and alcohol use when patients are on OST

6.7 Pain management for drug misusers

6.8 ECG Monitoring

6.9 Drug Related Deaths

Anxiety symptoms (can mimic symptoms the drug was first taken for and also appear on rebound as drug stopped)		Distorted perceptions (usually a sign of drug withdrawal, rather than anxiety)	Major incidents (occurs especially when high doses are stopped abruptly)
Psychological	Physical		
» Anxiety	» Agitation	» Hypersensitivity to sound, light, touch, taste, etc.	» Fits (1-2% of patients, esp. if stopping high dose abruptly)
» Panic attacks	» Tremor	» Abnormal body sensation, e.g. itching, widespread pain & stiffness, blurred vision, paraesthesia, muscle twitching, tinnitus, burning sensations, etc.	» Delirium (rare)
» Insomnia	» Headache	» Feeling self or world to be abnormal	» Transient hallucinations (visual, tactile, auditory) or illusions (rare)
» Poor memory	» Weakness	» Depersonalisation	» Psychosis (very rare)
» Depression	» Dizziness		
» Paranoia	» Nausea		
» Intrusive memories	» Vomiting		
» Cravings	» Diarrhoea		
» Nightmares	» Constipation		
» Excitability	» Palpitations		
» Agoraphobia	» Rashes		
» Social phobia	» Tingling, numbness, altered sensation		
» Obsessions	» Fatigue		
» Rage, aggression	» Flu-like symptoms		
» Irritability			

(Guidance for the use and reduction of misuse of benzodiazepines and other hypnotics and anxiolytics in general practice, 2014)

6.6.3 Stimulants (cocaine & amphetamines)

- » The mainstay of treatment is psychological. There are no substitute pharmacological interventions recommended.
- » Give safe injecting advice where appropriate.
- » Consider careful management in patients who use cocaine while on OST, such as no take home doses.
- » Observe for significant psychiatric symptoms, as withdrawal may be associated with significant depression, and suicidal risk.
- » Be cautious when prescribing SSRIs, as toxic reactions have been described while cocaine or amphetamines continue to be taken.
- » Treatment of young people may require: full mental health assessment, treatment and careful monitoring, with close liaison with CAMHS or other mental health team.

1

2

3

4

5

6

7

A

B



Chapter 6: OST and associated health considerations

6.1 Key points

6.2 Responses to continued drug and alcohol misuse for patients in OST

6.3 Mental health

6.4 Viral Infections

6.5 Hepatitis A and B vaccinations

6.6 Health implications for continued drug and alcohol use when patients are on OST

6.7 Pain management for drug misusers

6.8 ECG Monitoring

6.9 Drug Related Deaths

6.6.4 Cannabis

- » Withdrawal may precipitate sleep disturbance, irritability, cravings, weight loss, vivid dreams etc. and these may require brief symptomatic management
- » Prescribing benzodiazepines should be avoided.
- » Cannabis can exacerbate existing mental health problems and if there is any evidence of psychosis, a full mental health assessment is required.
- » Psychosocial interventions are recommended for young cannabis misusers.

6.6.5 Tobacco

Most patients in drug treatment smoke and this is often the only drug dependence that is not addressed. This is despite smoking-related diseases being highly prevalent in drug misusers, with a likelihood of causing premature death. Smoking may act as a cue for the misuse of other drugs that are consumed in the same way. Therefore, smoking may increase the risk of relapse into drug misuse.

Smoking cessation in drug treatment

Evidence suggests smoking cessation may be associated with improved drug treatment outcomes. Similar processes apply to smoking cessation treatment as to treatment for other types of drugs, such as coping with cravings and preventing relapse. Despite this, most drug treatment services do not offer smoking cessation. This may be because staff have not been appropriately trained, or believe it may interfere with drug treatment or are tobacco smokers themselves, or it may result from a lack of evidence and clinical experience of using smoking cessation treatments in this patient group. However, societal attitudes are changing and the smoking bans introduced across Ireland in 2004, and in the UK three years later, may increase the demand for treatment for tobacco dependence among drug misusers.

Treatment options

There is a large evidence base for the effectiveness of smoking cessation treatment in the general population and in prisons, with the best outcomes from a combination of behavioural support and pharmacological interventions, such as nicotine replacement therapies, bupropion, and varenicline. In the absence of evidence to the contrary, it seems likely that drug misusers will respond to the same treatments as the general population,

although they may need more intensive options to achieve the same results.

Given the high rates of smoking and the low quit rates in drug misusers, it may be reasonable to consider harm reduction approaches to smoking, such as replacing cigarettes with clean nicotine in the form of patches for some of the day. This may be particularly useful in alleviating the symptoms of tobacco withdrawal while a patient is in a residential or inpatient drug treatment facility.

Clinicians should encourage patients to stop or reduce their smoking and refer them to smoking cessation services. See www.quit.ie.

6.7 Pain management for drug misusers

The most common causes of pain are back pain, arthritis, and headache; all increasing in prevalence with age. Acute pain commonly occurs in drug users, as they have a higher risk of physical illness and injury.

Pharmacological intervention is only one aspect of pain management and non-pharmacological interventions such as CBT should be considered for drug users.

1

2

3

4

5

6

7

A

B

Chapter 6: OST and associated health considerations

6.1 Key points

6.2 Responses to continued drug and alcohol misuse for patients in OST

6.3 Mental health

6.4 Viral Infections

6.5 Hepatitis A and B vaccinations

6.6 Health implications for continued drug and alcohol use when patients are on OST

6.7 Pain management for drug misusers

6.8 ECG Monitoring

6.9 Drug Related Deaths

Acute pain

- » Requires full analgesic management in patients who are dependent on opioids.
- » These patients may have a lower tolerance of pain and a higher tolerance of opioid analgesic effects.
- » For mild-moderate pain, non-opioid analgesia, education, and advice are first line responses.
- » For more severe pain, if opioid analgesia is indicated, treatment depends on whether patient is taking full opioid agonists (methadone), partial agonists (buprenorphine), or opioid antagonists (naltrexone).
- » If the patient is dependent on full agonists (methadone), the opioid pain relief should be in addition to the usual opioid treatment dose and the amount of pain relief medication titrated against pain whilst monitoring respiratory function.
- » Sub-therapeutic doses should be avoided.
- » If the patient is dependent on a partial agonist (buprenorphine), specialist advice should be sought.
- » Opiate antagonists (naltrexone) will render opioid analgesia ineffective.

- » All patients and their carers should be informed of and understand the effects of OST and opioid blockade on pain management.

Chronic pain

- » Studies show opioid dependent patients who develop chronic pain report lower pain thresholds than controls.
- » Doctors need to exclude physical comorbidities and mood disorders.
- » It frequently requires multi-disciplinary team assessment by medical, primary care (physiotherapy, occupational therapy, psychology), psychiatric, and pain service.
- » Ideally, there would be jointly agreed treatment plan, a single prescriber, dispensing arrangements to minimise over use and diversion, regular reviews, and a plan for managing non-compliance or if outcomes are not met.
- » Aim for acceptable balance between improved function and minimal side-effects.
- » Pain from terminal illness should be managed by palliative care team.

Pain and Substance Misuse: Improving the patient Experience, British Pain Society, 2006

6.8 ECG Monitoring

Methadone can prolong QTc interval, and increase the risk of cardiac arrhythmias. The risk increases with increasing doses. The current guidance is not uniform, and clinicians should consider identifying those with significant risk factors for QT prolongation, and performing a baseline ECG:

- » Patients on a dose over 100mg methadone.
- » Patients being prescribed other known QT prolonging medicines.
- » Patients with a personal or family history of significant cardiac disease.
- » Patients experiencing unexplained syncope or generalized seizures.

6.9 Drug Related Deaths

The main causes of drug related deaths are: overdose, suicide, accidents and physical health complications of drug misuse. Concurrent use of benzodiazepines, alcohol, and other sedating drugs substantially increases the risk of death from methadone toxicity. One study found evidence of polydrug use in 92% of methadone-related deaths.

1

2

3

4

5

6

7

A

B



Chapter 6: OST and associated health considerations

6.1 Key points

6.2 Responses to continued drug and alcohol misuse for patients in OST

6.3 Mental health

6.4 Viral Infections

6.5 Hepatitis A and B vaccinations

6.6 Health implications for continued drug and alcohol use when patients are on OST

6.7 Pain management for drug misusers

6.8 ECG Monitoring

6.9 Drug Related Deaths

6.9.1 Overdose

- » The induction period for OST and the early part of treatment are both associated with a high risk of overdose, as tolerance can be difficult to assess.
- » Similarly, the period after leaving treatment, either after detoxification or with the sudden cessation of treatment, are associated with an increased risk of death.
- » The risk of overdose is especially high following release from prison if tolerance has been reduced, they have a history of intravenous drug use, and/or a long history of opioid dependence or polydrug use.
- » Those who are out of treatment are approximately three times more likely to die than those who are stable in treatment (Farrell and Barry, 2010).

6.9.2 Reducing drug-related deaths

- » Be aware of those most at risk.
- » Provide easy and timely access to treatment.
- » Retain people in treatment.
- » Provide education and training to drug misusers and their families, on the risks of overdose and how to respond effectively.
- » Advise on the dangers of combining drugs, especially alcohol and benzodiazepines.
- » Educate new patients on the risks of loss of tolerance.
- » Use appropriate supervised consumption in the early stages of OST.
- » Confirm satisfactory home storage arrangement and document this, especially when children are in the home.
- » Conduct or arrange a mental health assessment for anyone with a suicidal risk.
- » Liaise effectively with the prison regarding transfer of care.
- » Have an emergency protocol in place that covers the management of drug overdoses.

6.9.3 Dealing with overdose emergency; naloxone

- » Treat opiate overdose with standard resuscitation techniques and naloxone.
- » Naloxone is given 0.4-2.0 mg IV/IM/SC, and this can be repeated every 3-4 minutes up to a maximum of 10 mg.
- » The half-life of naloxone is much shorter than methadone or buprenorphine.
- » Patients should be helped to understand that they are at risk of life-threatening sedation when naloxone wears off.
- » This should be made clear to patients, especially in emergency departments and other situations where the patient may leave suddenly.

1

2

3

4

5

6

7

A

B



Chapter 7: Specific treatment situations and populations

7.1 Key points

7.2 Hidden Harm

7.3 Criminal justice system

7.4 Opiate dependent patients in hospital

7.5 Pregnancy and neonatal care

7.6 Young people

7.7 Older current and ex-drug users

7.8 Palliative care and life-limiting conditions

7.1 Key points

- » Effective, safe and responsive services for service users involve working together and with others in teams in primary care, in secondary care, or across both.
- » Interventions must be carried out by trained and competent people with a clear understanding of the impact of problematic drug use.
- » Appropriate communication and transfer of information between professionals is vital to ensure seamless care. In line with the HSE Consent Policy.
- » Assessment and evidence-based care provided by liaison or multidisciplinary team is appropriate in many cases.
- » Quality of treatment should be consistent, across the criminal justice system including prisons.
- » Drug users in hospitals will require interventions that facilitate their medical treatment and, if possible, improve their engagement with drug misuse treatment.
- » Clinicians working with pregnant women should aim to support the woman in achieving drug stability in order to reduce the risk of neo natal abstinence syndrome (NAS).
- » Young people are likely to require different interventions compared to adults, and healthcare professionals will require specific competencies to deliver these interventions.
- » Information sharing, governance, policies and practice should include guidance for clinicians working with the parents of under-18-year-old service users.
- » Older drug users are likely to have increased drug-related and non-drug-related health needs. Drug users in pain will have needs for pharmacological and other interventions similar to non-drug users.

7.2 Hidden Harm

Parental problematic substance use can and does cause serious harm to children at every age from conception to adulthood e.g., emotional and physical neglect, development of serious emotional and social problems, elevated risk of Foetal Alcohol Spectrum Disorders, and vulnerability to the development of substance use problems themselves in later life. This may add to potential intergenerational problems connected to substance misuse.

Two key features of this experience are:

- » Children are often not known to services
- » They may suffer harm in a number of ways through physical and emotional neglect, including exposure to harm and poor parenting

Not all parents who use substances experience difficulties with parenting and not all children exposed to parental substance use are affected adversely, either in the short or longer term.

Any issues raised through the assessment of family and child welfare (see Table 7) need to be managed in accordance with the Children First Guidelines: National Guidance For The Protection And Welfare Of Children (Department of Children and Youth Affairs, 2011) and its supporting document, Child

1

2

3

4

5

6

7

A

B



Chapter 7: Specific treatment situations and populations

7.1 Key points

7.2 Hidden Harm

7.3 Criminal justice system

7.4 Opiate dependent patients in hospital

7.5 Pregnancy and neonatal care

7.6 Young people

7.7 Older current and ex-drug users

7.8 Palliative care and life-limiting conditions

protection and welfare practice handbook (Health Service Executive, 2011). See Appendix 14.

Table 7: Assessment of Family and Child Welfare

- » Effect of drug use on functioning e.g. intoxication, agitation
- » Effect of drug-seeking behaviour e.g. leaving children unsupervised, contact with unsuitable characters
- » Impact of parent's physical and mental health on parenting
- » How drug use is funded e.g. sex working, diversion of family income
- » Emotional availability to children
- » Effects on family routines e.g. getting children to school on time
- » Other support networks e.g. family support
- » Ability to access professional support
- » Storage of illicit drugs, prescribed medication, and drug-using paraphernalia. With consent, information should be gathered from other professionals, informing the patient and preferably with their consent

7.3 Criminal justice system

7.3.1 Garda custody

Accurate assessment by the designated doctor of drug misuse in detainees, including the degree and severity of dependence and of the need for medical intervention is essential, as intoxication and withdrawal can put detainees at risk of medical, psychiatric and legal complications.

To ensure the continuity of pharmacological treatment for drug users taken into custody, the Garda station must have access to a level 2 GP prescriber to:

- » Contact the CTL to confirm if the detainee is receiving OST. The CTL is available 9-5 Monday to Friday, telephone 01 648 8638.
- » If the person is in receipt of OST, contact the relevant Drug Treatment Clinic or GP/Community Pharmacy to confirm details of the patient's prescription and last received doses of OST and other medications.
- » If the person is not currently in receipt of OST, it should be requisitioned from a pharmacy by the medical practitioner under whose care the methadone will be provided to the patient, using the standard methadone prescription form.

The Irish College of General Practitioners (ICGP) has published a protocol for managing OST in Garda stations (ICGP, 2015). It is important that doctors attending to patients in Garda stations confirm the last dose and date of dispensing. This information is accessible through the dispensing location, the CTL, and the patient.

7.3.2 Drug Treatment Court

The Drug Treatment Court (DTC) programme provides an alternative to incarceration to people who have been found guilty of offences before the District Court, who are struggling with substance abuse.

- » Referral occurs where someone pleads guilty or has been found guilty of an offence before the District Court, which would involve serving time in prison.
- » The judge responsible for handing down the sentence will refer the person to the DTC programme, if there is a view in the Court that this could work.
- » It is eligible to people over the age of 18 who have an address in the County of Dublin.
- » It operates from the Chancery Street Courthouse.

1

2

3

4

5

6

7

A

B



Chapter 7: Specific treatment situations and populations

7.1 Key points

7.2 Hidden Harm

7.3 Criminal justice system

7.4 Opiate dependent patients in hospital

7.5 Pregnancy and neonatal care

7.6 Young people

7.7 Older current and ex-drug users

7.8 Palliative care and life-limiting conditions

It consists of a multi-disciplinary team who supports the DTC Judge. Participants attend daily at the City of Dublin Education and Training Board (CDETb) centre where they receive educational training for the purposes of obtaining FETAC qualifications. The CDETb staff also work with the participants on improving all aspects of their life and provide day to day support with recovery efforts. These efforts are underpinned by the DTC Liaison Nurse, who is employed by the HSE and who helps develop a treatment plan for each participant, tailored to their needs.

7.3.3 Probation orders

Conditions for drug and alcohol treatment can be included as conditions of a probation order or as part of a case management plan agreed with client/offender before coming out of prison on a post-sentence supervision order (which is the part of the sentence served in the community).

7.3.4 Prison

As with drug misuse management in other settings, there is a need to integrate prescribing practice with psychological, medical, and social interventions Irish Prison Service Drug Treatment Services Review, Farrell, 2009; Amato *et al.*, 2004). Integration with mental health and primary healthcare

services is also very important in order to address the high levels of complex needs within the prison population.

Prison can present opportunities, as well as challenges, to address a wide range of clinical needs of drug users. It is Irish Prison Service (IPS) policy to offer viral screening, vaccination, and appropriate referral to specialist services. STI, HIV and Hepatitis C in-reach services have been developed in prisons where high need has been identified. See the IPS Drug Treatment Clinical Policy (2008).

» The prevalence rates for drug use in Irish prisons greatly exceed those of the general population (Drummond *et al*, 2014). In 2015, 1,467 patients were in receipt of methadone during the period (with 497 individuals receiving methadone at the end of December 2015).

» Any patient recorded on the CTL will have this treatment continued in prison. Clinicians need to liaise with community services and Gardaí to verify prescriptions and consumption and use appropriate drug screens to verify consumption of opioids.

» Prisoners with addiction problems, not already established on OST in the community, will be assessed for opioid dependence with a view to providing appropriate drug treatment.

» Initiation of methadone in prison is carried out in collaboration with community services to ensure that there is a treatment place available on release from prison.

» The CTL must be notified if a patient is initiated on methadone, completes a methadone programme, or is discharged from a programme while in prison.

» On committal to prison, community drug services should communicate in writing with prison healthcare staff outlining the current care plan for the patient. Similarly, on release from prison it is the responsibility of designated healthcare staff in each prison to ensure the community treatment service is informed in the form of a discharge letter as soon as possible.

Although clinicians should regard drug misuse management in prisons as equivalent to any other setting, there are some particular differences that may need to be taken into account:

» The effects of incarceration itself on the individual; stress and anxiety.

» Lower availability of drugs, leading to intermittent intoxication and withdrawal.

» Less injecting behaviour, but when it does occur there can be a higher risk due to scarcity of injecting equipment.

1

2

3

4

5

6

7

A

B



Chapter 7: Specific treatment situations and populations

7.1 Key points

7.2 Hidden Harm

7.3 Criminal justice system

7.4 Opiate dependent patients in hospital

7.5 Pregnancy and neonatal care

7.6 Young people

7.7 Older current and ex-drug users

7.8 Palliative care and life-limiting conditions

» High volume and frequency of movement of prison population.

» Risk of overdose on release due to diminished opioid tolerance.

» Correlation between drug withdrawal and suicide in first week in prison.

» High value of drugs in relation to limited income of prisoners.

» The particular needs of prisoners in custody for very short periods of time.

» Efforts should be maximised to ensure continuation of community treatment on release even in circumstances of unplanned release.

7.3.5 Discharge from prison setting

» The principle objective in preparing a drug-misusing prisoner for release should be to prevent overdose; this is done by working to prevent relapse, facilitating continuation of treatment in the community, and linking in with supports and aftercare.

» Post-release community drug treatment should be planned where possible; this means close liaison with community services and GP before discharge.

» » The prison should contact the appropriate liaison pharmacist if a change of treatment location is required.

» There needs to be contingency plans for when unanticipated release of prisoner on OST from prison takes place.

» Re-induction onto OST prior to release can be considered for patients who are about to leave prison and have an identifiable risk of overdose who were not maintained on OST during their prison sentence if a community treatment place can be sourced.

7.3.6 Phases of OST within the prison setting; detoxification

In addition to the guidance provided under sections 3.11-3.15 (Phase I: Assessing dependence, Phase II: Induction, Phase III: Stabilisation, Phase IV: Maintenance, Phase V: Detoxification), the following clinical considerations for the prison setting should be taken into account.

Detoxification within the prison setting

» As in all treatment settings, treatment exits should be negotiable and revisited.

» As in all other environments, treatment should not be discontinued punitively.

» Polydrug use is common and in cases of co-dependence on any combination of alcohol, opiates, and benzodiazepines, more than one reduction regime may be needed.

» Detoxification from more than one drug should not take place concurrently, with alcohol commonly the initial priority.

» There is potential for rapid onset of withdrawal effects of opiates in prison and increased risk of suicide among drug users during early days of custody.

» Prisoners withdrawing from stimulant drugs should be treated according to clinical indications and should be observed for signs of psychological distress.

7.4 Opiate dependent patients in hospital

» Hospitals are exempt by the Methadone Protocol. However, all hospitals should have appropriate policies and standard operating procedures for the provision of in-patient OST services.

» The objective of drug treatment in hospital is to stabilise drug misuse as quickly as possible and treat the drug related or non-drug related condition.

» On occasion, patients may wish to take the opportunity of a hospital admission to reduce their drug doses or even to detoxify fully. This may occasionally be useful, but, if unplanned, is likely to result in relapse on leaving hospital, which in turn exposes the patient to overdose risks.

1

2

3

4

5

6

7

A

B



Chapter 7: Specific treatment situations and populations

7.1 Key points

7.2 Hidden Harm

7.3 Criminal justice system

7.4 Opiate dependent patients in hospital

7.5 Pregnancy and neonatal care

7.6 Young people

7.7 Older current and ex-drug users

7.8 Palliative care and life-limiting conditions

» Transfer of care on admission and discharge requires coordinated response by all professional staff.

» Planned admissions to hospital are preferable.

Substitute opioids or other controlled drugs should only be prescribed following an adequate assessment. The aims of this assessment are:

» To enable treatment of emergency or acute problem or enable elective procedure to take place.

» Confirm the patient is taking drugs; history, examination and urine analysis.

» Identify the degree of dependence; opioid withdrawal signs may be observed.

» Identify complications of drug misuse and evaluate risk behaviour; blood borne virus tests, nutrition, alcohol intake.

» Consider psychiatric comorbidity.

For patients currently being prescribed methadone or buprenorphine, good communication between hospital and community is essential for safe patient care. Prescribing in these cases should be a relatively straightforward matter of continuing the usual dose of OST while in hospital. The OST dose needs to be independently verified

through the CTL, the community pharmacist, and the patient's methadone prescriber.

For patients not on OST, or where there is uncertainty about recent compliance, particular care must be exercised in initiating OST.

Initial dosing schedule for opiate dependent patients admitted to hospital:

» Only prescribe following assessment, as described above.

» Polydrug and alcohol misusers may develop multiple withdrawal syndromes, so these may need to be differentiated to prioritise treatment.

» Methadone may initially mask alcohol or benzodiazepine withdrawal symptoms.

» Exercise particular care in cases of respiratory disease, head injury, and liver diseases.

» Exercise care when prescribing additional drugs such as sedatives.

» When it is appropriate to initiate opioid substitution in hospital to manage risk of withdrawal, methadone is usually preferred over buprenorphine.

» Induction should follow the protocols previously described for induction (see

section 3.10). However, close supervision in hospital may allow for a modified protocol.

» Signs of intoxication, such as drowsiness, slurred speech, or constricted pupils indicate a need to discontinue the drug or reduce the dose.

» Hospitals should contact community drug treatment services before prescribing buprenorphine products to ensure continuity after discharge as approval from PCRS is required before buprenorphine products can be reimbursed in a community setting for the treatment of opioid dependence (see section 3.3.2).

7.4.1 Other drugs of misuse

Opioid dependant patients in hospital may commonly be taking other drugs and misusing alcohol.

» The misuse of benzodiazepines or alcohol may lead to associated withdrawal symptoms and seizures.

» Benzodiazepine prescribing should only be initiated once dependence has been established by history taking and by noting symptoms of withdrawal.

» In the inpatient setting, it is appropriate to provide a slow withdrawal regimen over one to four weeks, with a starting dose of diazepam of no more than 30mg daily,

1

2

3

4

5

6

7

A

B



Chapter 7: Specific treatment situations and populations

7.1 Key points

7.2 Hidden Harm

7.3 Criminal justice system

7.4 Opiate dependent patients in hospital

7.5 Pregnancy and neonatal care

7.6 Young people

7.7 Older current and ex-drug users

7.8 Palliative care and life-limiting conditions

given in divided doses. For a range of useful tools and schedules, see the Community Detoxification Guidelines (ALDP, 2015).

- » Patients may also require concurrent detoxification from alcohol.
- » Routine prescribing of benzodiazepines as hypnotics and as anxiolytics should be avoided while in hospital.

7.4.2 Discharge from hospital

For drug misusers not previously in treatment, attendance at the emergency department or hospital admission may present a window of opportunity to put them in touch with other services.

On discharge, the following information should be given:

- » General health promotion advice.
- » Contacts for further help, such as needle exchange, drug treatment services, or self-help groups.
- » Advice on preventing overdose.
- » Advice on reducing the risk of blood-borne viruses and Hepatitis B vaccination.
- » Advice of loss of tolerance in hospital

If the patient was admitted on an opioid prescription from the community, this should

be continued on discharge and prescribing responsibility transferred back to the GP or HSE addiction clinic. Planned discharge is best done in collaboration with local drug treatment service, the GP, and the community pharmacy. See section 3.8, Referral procedure, for change of treatment location.

On the day of discharge confirm the following for the community services:

- » Whether that day's dose has been given and how much was given.
- » Any other drugs that the patient is being prescribed.
- » Patients should receive their dose on the day of discharge and contact should be made with their GP and community pharmacy to confirm that they have had that day's dose.
- » Arrangements should be made in advance of discharge to ensure the patient has a place in a community pharmacy to receive their methadone and a place with a methadone prescribing GP.

7.5 Pregnancy and neonatal care

Women who are pregnant or who may become pregnant are high priority for interventions to reduce drug use. Women may be more prepared to change drug using

behaviour if they are pregnant. Substitute prescribing can occur at any time in pregnancy and carries a lower risk than continuing illicit drug use. It allows engagement and identification of health and social needs, and also offers opportunity for interventions and advice to improve outcomes.

All women with problematic substance use should be made aware of the benefits of antenatal care and advised to attend early in pregnancy. Research suggests that women who misuse substances have better outcomes, as do their infants, if they take up antenatal care early and they use services consistently throughout pregnancy. However, pregnant women, with substance misuse problems, can be subjected to social disapproval and judgemental attitudes. Discriminatory professional practice deters women from seeking help.

Drug using women of child bearing age should be offered pregnancy test, as amenorrhoea is common in female opiate users, and symptoms of opiate withdrawal may mimic early pregnancy.

If a pregnancy test is positive, a referral to a crisis pregnancy agency may be appropriate. Referral also may be appropriate to the Drug Liaison Midwife service connected to the three Dublin Maternity hospitals.

1

2

3

4

5

6

7

A

B



Chapter 7: Specific treatment situations and populations

7.1 Key points

7.2 Hidden Harm

7.3 Criminal justice system

7.4 Opiate dependent patients in hospital

7.5 Pregnancy and neonatal care

7.6 Young people

7.7 Older current and ex-drug users

7.8 Palliative care and life-limiting conditions

Drug misusing women are often at risk of domestic violence and at high risk of antenatal and postnatal mental health problems. See the HSE Information Booklet 'Substance Misuse in Pregnancy' (2009).²⁶

7.5.1 Antenatal care

- » The objectives of management are to achieve pharmacological, social, medical, and psychological stability.
- » The dangers of sudden benzodiazepine or opiate detoxification should be highlighted.
- » Efforts should be made to engage drug misusing partners in ANC and treatment.
- » Shared ANC with a GP may not be appropriate due to the complex needs and high risk pregnancy; ideally, a referral should be made to specialist maternity services.
- » Specialist Drug Liaison Midwives are employed by Addiction Services and are attached to the main Dublin Maternity Hospitals. For contact details, See the HSE Information Booklet 'Substance Misuse in Pregnancy' (2009).²⁷
- » Where such a specialist service is not available, emphasis should be placed on arranging continuity of care, with an open channel of communication between all relevant parties.

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²⁶ Available to download at www.drugs.ie

» Agencies should consider holding pre-birth case conferences early in the pregnancy if the child could be considered to be at risk when born to identify risk, goals, and the plan for discharge.

7.5.2 Prescribing for pregnant drug users

- » Opiate dependent pregnant women should not be required to reduce or come off OST in pregnancy. Such a detoxification may be inappropriate, as it may lead to unnecessary risks with the pregnancy.
- » The main objective is to achieve and maintain stability for the duration of pregnancy and after.
- » In particular, third trimester detoxification and dose reduction should not be encouraged, as there is evidence that even mild maternal withdrawal can be associated with foetal distress and stillbirth.
- » For those who continue to request dose reductions and detoxification, this should be commenced in the second trimester, with small frequent reductions e.g. 2-3mg methadone every 3-5 days, as long as there is no illicit drug use and no evidence of maternal withdrawal symptoms.
- » The metabolism of methadone is increased in the third trimester of pregnancy, therefore it may occasionally be necessary to increase methadone dose.

» If illicit opiate use continues, all efforts should be made to stabilise the patient on a prescribed opiate, which may involve increasing the dose.

» This may require referral to inpatient stabilisation services e.g. Cuan Dara in Cherry Orchard Hospital, and St Michael's Ward in Beaumont Hospital.

7.5.3 Effects of drugs on the foetus and baby

Evidence has shown that the effects of different drugs can be broadly similar, non-specific, and multifactorial e.g. intrauterine growth retardation, pre-term delivery, increased rates of low birth-weight, and increased perinatal mortality rate.

Opioids:

» Heroin use can lead to increased rates of small for gestational age babies and pre-term delivery.

Methadone:

- » There is an increased rate of Sudden Infant Deaths (SIDS) in methadone using women (with smoking as a recognised risk factor).
- » The relationship between methadone dose and neonatal withdrawal is controversial; a recent study in two Dublin maternity hospitals showed that incidence and duration of neonatal abstinence syndrome

1

2

3

4

5

6

7

A

B



Chapter 7: Specific treatment situations and populations

7.1 Key points

7.2 Hidden Harm

7.3 Criminal justice system

7.4 Opiate dependent patients in hospital

7.5 Pregnancy and neonatal care

7.6 Young people

7.7 Older current and ex-drug users

7.8 Palliative care and life-limiting conditions

were not affected by methadone dose and so should not be used as an incentive for patients to reduce their methadone dose during pregnancy. However, there are growing concerns about the effects of methadone on the developing visual system of the foetus and increased incidence of Pierre Robin syndrome in these babies. This needs further investigation.

Buprenorphine:

» Buprenorphine is not licensed for use in pregnancy, however, research on women already taking this medication when they become pregnant does not demonstrate any adverse effects on the pregnancy or neonatal outcomes.

Cocaine:

» Cocaine use can lead to higher rates of early pregnancy loss, third trimester placental abruption, increased rates of stillbirth, increased neonatal deaths, and Sudden Infant Deaths (SIDS).

» Cocaine users should be advised to stop altogether, as there is no drug for substitution prescribing. See Table 6: Responses to continued drug or alcohol misuse when patients are on OST. For stimulant users, the strongest evidence for effective psychological treatment is for CBT approaches, including motivational interviewing, relapse prevention, community reinforcement approach, and contingency

management. A combination of approaches is considered to be most effective.

Benzodiazepines:

» Health risks of benzodiazepines in pregnancy have not been clearly established. Regular benzodiazepine use in pregnancy may be associated with neonatal abstinence syndrome.

» The aim is to stabilise the patient on diazepam and then try gradual reduction if tolerated without restarting illicit use.

» A woman on methadone should have her dose maintained while trying to reduce benzodiazepine use.

» Women should be informed of SIDS precautions and safe sleeping practices.

Nicotine:

» Smokers have an increased incidence of threatened and spontaneous miscarriage, premature birth, low birth weight, perinatal death, SIDS etc.

» Smoking cessation programmes are recommended for all pregnant women.

Alcohol:

» Alcohol has known teratogenic effects.

» Foetal alcohol spectrum disorder is the name used to cover all alcohol related birth defects.

» The only certain way to avoid the risk of this is to abstain from drinking alcohol during pregnancy. See Table 6: Responses to continued drug or alcohol misuse when patients are on OST.

» Pregnant women who drink alcohol at hazardous or harmful levels have high rates of comorbidity and social problems.

» Pregnant women using alcohol should be offered brief and extended interventions to reduce alcohol intake.

7.5.4 Early neonatal care and withdrawals

New-born babies should not be removed from their mothers unless there is a clinical reason to do so. Practices, such as skin-to-skin contact and breast feeding, should be encouraged. Neonatal withdrawal or neonatal abstinence syndrome can be associated with being on methadone maintenance therapy, even when a woman has been stable throughout her pregnancy.

1

2

3

4

5

6

7

A

B



Chapter 7: Specific treatment situations and populations

7.1 Key points

7.2 Hidden Harm

7.3 Criminal justice system

7.4 Opiate dependent patients in hospital

7.5 Pregnancy and neonatal care

7.6 Young people

7.7 Older current and ex-drug users

7.8 Palliative care and life-limiting conditions

Women should be educated about neonatal abstinence syndrome early in the antenatal period.

Many babies will not need a paediatric review, but it is important to have access to skilled neonatal paediatric care.

Signs of withdrawal from opioids tend to be vague and multiple and tend to occur 24–72 hours after delivery. Symptoms include high-pitched cry, rapid breathing, ineffective sucking, excessive wakefulness, hyper tonicity, and convulsions. Babies should not be discharged from hospital until 120 hours post-delivery. Neonatal withdrawal can be delayed for up to seven to ten days if a mother was taking methadone and benzodiazepines in pregnancy. There is a need to see the baby regularly in first two weeks to check for delayed signs of withdrawals.

Continuing support is required, including parenting advice and training, mental health advice, and intervention, where needed. There is a need to discuss SIDS and contraception with the woman.

7.5.5 Breast feeding

Taking methadone is not a contraindication to breast feeding. Breast feeding should be encouraged, unless the mother is HIV positive, using alcohol, cocaine or amphetamine type drugs. In addition, consideration should be given if the mother's drug use is considered unstable regarding risks associated with falling asleep when breast feeding.

7.6 Young people

A minority of people under-18 years use illegal drugs occasionally, and most of this is short term or occasional cannabis use. Drug dependence, especially opiate or stimulant dependence, and injecting drug use are uncommon. Young people with psychosocial problems, young offenders, young people with mental health problems, and those excluded from school are most likely to misuse drugs and alcohol.

Drug treatment goals are initially focused on reduction of immediate harm, addressing psychosocial and interpersonal factors which perpetuate substance use and then to try to move towards abstinence. Family Therapy has been found to be more effective than other treatments in engaging and retaining adolescents in treatment and reducing their drug use.

There is often potential for rapid improvements for those with a shorter history of substance use.

Although the evidence base for treatment in this group is not extensive, evidence and clinical experience suggests young people's drug treatment is different from that of adults and should be provided separately (NICE, 2007b).

Structured treatment by specialist multidisciplinary substance misuse treatment services, in collaboration with other children's agencies is indicated for those with significant or complex substance misuse problems. This may occasionally involve pharmacological interventions.

Pharmacological treatment is required for a minority of young people who are physically dependent on alcohol, benzodiazepines, or opiates. Many of the medication options are 'off license' for this age group. **See Guidance for the pharmacological management of substance misuse among young people (Department of Health UK, 2009).**

1

2

3

4

5

6

7

A

B



Chapter 7: Specific treatment situations and populations

7.1 Key points

7.2 Hidden Harm

7.3 Criminal justice system

7.4 Opiate dependent patients in hospital

7.5 Pregnancy and neonatal care

7.6 Young people

7.7 Older current and ex-drug users

7.8 Palliative care and life-limiting conditions

Policy and clinical governance issues are also different for this group, including:

- » Consideration of the young person's ability to consent to treatment and competence (or capacity to consent)
- » Involvement of those with parental responsibility
- » Confidentiality and information sharing
- » Child protection needs
- » Competence of clinician and multi-disciplinary team in working with this group
- » Whether and how to involve other professionals
- » Prescribing and drug licensing
- » Different legal, statutory, and policy framework for young people and families

In Ireland, anyone over-16 years old can consent to medical, dental or surgical procedures. However, the 1937 Constitution gives parents very substantial rights and other legislation makes it very clear that people aged 16–17 years are regarded very differently in law from those aged 18 years or over. Therefore, even if a 16-year-old does consent to an intervention, a doctor needs to document his or her assessment of this young person's competence to give it. Every effort

should also be made to get parents involved in all treatment decisions for 16-to-17-year-olds.

The Child Care Act 1991, the Children Act 2001, and the Mental Health Act 2001 define a child as a service user under the age of 18, "other than a service user who is or who has married".

A person with parental responsibility (or the courts) can consent on behalf of a child who lacks capacity to consent for themselves. Parents cannot override the competent consent of their child to investigations or treatments that are in their best interests. Legal advice should be sought if a competent child refuses treatment necessary to save life or avoid serious deterioration in health.

As per section 1.9, duties of confidentiality apply to children and young people just as much as to adults. In addition to the reasons for non consensual disclosure (see section 1.4), information can be shared about a child or young person without consent when it is deemed to be in their best interest in situations where they do not have the capacity to make a decision about disclosure.

In addition to the guidance provided under sections 3.11-3.15 (Phase I: Assessing dependence, Phase II: Induction, Phase III: Stabilisation, Phase IV: Maintenance, Phase V: Detoxification), the following clinical considerations for under-18 should be taken into account.

7.6.1 Methadone induction for under-18s

- » Induction onto methadone carries the same potential hazards as with adult patients, with iatrogenic overdose being the greatest concern.
- » Inpatient units may be useful for methadone stabilisation and commencement of therapy in those with unclear tolerance, comorbid problems, multiple drug use, poor family and social support, and for assessment of all other domains of functioning.
- » Care should be taken on assessment of tolerance and dependence in young people, as it is more uncertain in this group.
- » If the extent of physical dependence is unclear, consider withholding the initial starting dose of opiate until objective opiate withdrawal symptoms are witnessed.

1

2

3

4

5

6

7

A

B



Chapter 7: Specific treatment situations and populations

7.1 Key points

7.2 Hidden Harm

7.3 Criminal justice system

7.4 Opiate dependent patients in hospital

7.5 Pregnancy and neonatal care

7.6 Young people

7.7 Older current and ex-drug users

7.8 Palliative care and life-limiting conditions

- » Dose induction is similar to that in adults, although care must be taken in assessing tolerance in relation to body mass.
- » Induction onto methadone is generally commenced at doses under 30mg a day and lower if tolerance is unclear.
- » Regular clinical review and dose titration in response to progress are good practice.

7.6.2 Buprenorphine/buprenorphine-naloxone induction for under-18s

- » Buprenorphine/buprenorphine-naloxone induction should normally be commenced at 2 mg, and then titrated according to response.
- » All doses of buprenorphine must be carefully titrated and adjusted for height, weight and age.

7.6.3 Stabilisation for under-18s

Anecdotal evidence suggests stabilisation on to substitute medication with retention in treatment is greater if the young person's parents are involved and supportive. Treatment in day care settings may initially allow greater compliance and encourage greater retention, particularly if parental support is less. In addition to opiate substitute medication, a care plan should include individual psychological work to support drug

cessation and should also include very proactive case management of the care plan by the multidisciplinary team, with a nominated team member as the designated key worker.

7.6.4 Maintenance for under-18s

For under-18s, the maintenance phase should be short-term and should include individual psychological work to support drug cessation and a proactive case management of the care plan by the multi-disciplinary team and named keyworker.

7.6.5 Detoxification for under-18s

- » Some opiate dependant adolescents who have resilient personalities and good support may be suitable for detoxification.
- » Where physical dependence is not substantial, a symptomatic detoxification regime can be considered.
- » For those young people, who make a clear decision for immediate detoxification without a period of substitution treatment, lofexidine is an appropriate medication.
- » As with adult detoxification, young people who have been stabilised on OST, would usually undergo detoxification using the same medication.

7.6.6 Under-18s and benzodiazepine use

- » Most often characterised by episodic bingeing rather than daily use in young people.
- » Benzodiazepine maintenance prescribing is not recommended for this group.
- » If detoxification is required, it should be gradual and the length and severity of dependence should be taken into account.
- » Diazepam doses of 10mgs TDS are sufficient as a starting dose, even when previous reported use was higher.
- » Benzodiazepine dependence and withdrawal can be associated with self-harming and suicide, so monitoring of mental state is important.

7.6.7 Under-18s and co-morbid disorders

- » Psychological treatments are a mainstay of treatment but pharmacology may be required in certain cases e.g. ADHD or depression.
- » Treatment should be in conjunction with other professionals, including CAMHS.
- » See the NICE guidelines on ADHD, adolescent depression, and early onset psychoses.

1

2

3

4

5

6

7

A

B



Chapter 7: Specific treatment situations and populations

7.1 Key points

7.2 Hidden Harm

7.3 Criminal justice system

7.4 Opiate dependent patients in hospital

7.5 Pregnancy and neonatal care

7.6 Young people

7.7 Older current and ex-drug users

7.8 Palliative care and life-limiting conditions

7.7 Older current and ex-drug users

Evidence suggests that drug use continues throughout the lifespan and younger drug users mature out of their drug use. While there is little documented evidence about older drug users, the number of older heroin users accessing treatment is increasing and there are patients in their 40's, 50's, and 60's receiving OST. Prevalence of over 40's accessing OST was 42% in 2015 (compared with 31% in 2013).

Older opiate users are likely to suffer from negative social consequences of long term of drug use such as unemployment, social exclusion, marginalisation, and homelessness. Dental deterioration is common. Older drug users may seem hostile or suspicious of change due to adverse past experiences; an understanding of their lifestyle difficulties is necessary to manage these attitudes constructively.

Older opiate users need all the usual screening and monitoring that a non-drug using patient would be offered, this should be appropriate to their age and general health. They may have special health needs caused either by complications of long history of drug (and alcohol) misuse, or by the problems associated with OST.

Complications	Examples
Related to long history of drug and alcohol misuse	Hepatic damage due to Hepatitis B, Hepatitis C and excess alcohol
	HIV infection
	Chronic airway disease
	Chronic lung damage
	Increased cardiovascular disease risk
Poly-pharmacy	Risk of drug interactions between methadone and medications used to treat other diseases
Normal ageing process	Hypertension
	Diabetes
	Chronic airway disease
	Loss of cognitive function

1

2

3

4

5

6

7

A

B



Chapter 7: Specific treatment situations and populations

7.1 Key points

7.2 Hidden Harm

7.3 Criminal justice system

7.4 Opiate dependent patients in hospital

7.5 Pregnancy and neonatal care

7.6 Young people

7.7 Older current and ex-drug users

7.8 Palliative care and life-limiting conditions

7.8 Palliative care and life-limiting conditions

Patients on OST are at risk of developing life-limiting illness associated with drug abuse, for example, Hepatitis C, which may lead to cirrhosis and liver cancer. They may also develop life-limiting AIDS, but this is less common with antiretroviral treatment.

Patients with a history of drug use may also engage in other behaviour which increases their risk of developing cancer e.g. tobacco related lung and head and neck cancers, cervical cancer. The problems that patients on OST with life-limiting illnesses have are similar to those outlined for older people on OST.

Patients with life limiting conditions may have palliative care needs which are addressed by their main health care team, or they may have complex palliative care needs, requiring referral to specialist palliative care services. Patients with life limiting conditions who have pain should be referred to specialist palliative care, as their pain may be difficult to manage. All health care staff caring for people with palliative care need competency in dealing with those needs.²⁷

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²⁷ See the HSE Palliative Care Competence Framework (2014)

1

2

3

4

5

6

7

A

B



Appendix 1: Clinical Governance

Appendix 1: Clinical Governance

The HSE places an important emphasis on quality and patient safety by developing an infrastructure for integrated quality, safety, and risk management in order to achieve excellence in clinical governance. Formalised governance arrangements ensure everyone working in the health and personal social services is aware of their responsibilities, authority, and accountability and they work towards achieving improved patient outcomes. Effective governance recognises the interdependencies between corporate and clinical governance across services and integrates them to deliver high quality, safe and reliable healthcare.



The guiding principles of clinical governance are:

Patient First: Based on a partnership of care between patients, families, carers and healthcare providers in achieving safe, easily accessible, timely and high quality service across the continuum of care

Safety: Identification and control of risks to achieve effective, efficient, and positive outcomes for patients and staff

Personal Responsibility: Where individuals, whether members of healthcare teams, patients or members of the public, take personal responsibility for their own and others' health needs. Where each employee has a current job description, setting out the purpose, responsibilities, accountabilities, and standards required.

Defined authority: The scope given to staff at each level of the organisation to carry out their responsibilities. The individual's authority to act, the resources available and the boundaries of the role are confirmed by their direct line manager.

Clear Accountability: A system whereby individuals, functions, or committees agree accountability to a single individual.

Leadership: Motivating people towards a common goal and driving sustainable change to ensure safe, high-quality delivery of clinical and social care.

Inter-disciplinary working: Work processes that respect and support the unique contribution of each individual working member of a team in the provision of clinical and social care. Inter-disciplinary working focuses on the interdependence between individuals and groups in delivering services. This requires proactive collaboration between all members.

Supporting Performance: In a continuous process, managing performance in a supportive way, taking performance account of clinical professionalism and autonomy in the organisational setting. Supporting a director/manager in managing the service and employees, thereby contributing to the capability and the capacity of the individual and organisation, with measurement of the patients and staff experience being central in performance measurement, as set out in the National Charter (HSE, 2010).

Open culture: A culture of trust, openness, respect, and caring where achievements are recognised.

Open discussion: of adverse events are embedded in everyday practice and communicated openly to patients. Staff willingly report adverse events and errors, so there can be a focus on learning, research, improvement, and appropriate action taken where there have been failings in the delivery of care.

Continuous quality improvement: A learning environment and system that seeks to improve the provision of services improvement with an emphasis on maintaining quality in the future and not just controlling processes. Once specific expectations and the means to measure them have been established, implementation aims at preventing future failures and involves the setting of goals, education, and the measurement of results so that the improvement is ongoing

1

2

3

4

5

6

7

A

B



Appendix 1: Clinical Governance

Relevant clinical governance frameworks

Members of some professions involved in drug treatment services are bound by their own governance frameworks:

- » **Doctors:** The Medical Council is responsible for protecting the public by promoting and better ensuring high standards of professional conduct and professional education, training and competence among doctors. Doctors are legally obliged to enrol in professional competence schemes operated by postgraduate training bodies. The Irish College of General Practitioners (ICGP) also provides guidance for GPs.
- » **Nurses:** The Nursing and Midwifery Board of Ireland, the regulatory body for the nursing profession, fulfils a range of functions, including:
 - **Non-Medical Prescribing/Nurse Prescribing:** The term non-medical prescribing refers to the prescribing of medication by health professionals other than doctors and dentists. Currently, only nurses/midwives are allowed to prescribe under strictly limited circumstances. The Introduction of the Opiate Treatment Protocol specifically recommends that "Nurse prescribing of controlled drugs should be explored and if possible developed further in line with international practice" (Farrell and Barry, 2010, p.36).
 - **Pharmacists:** The PSI is an independent statutory body responsible for the effective regulation of pharmacy services and supervising compliance with the Pharmacy Act 2007. All pharmacists are legally obliged to undertake Continuing Professional Development (CPD), which includes maintaining appropriate experience in the practice of pharmacy, keeping abreast of continuing education and professional developments, and undertaking appropriate CPD to their area of practice.

- **Psychologists:** The Psychological Society of Ireland maintains the standards of practice in Psychology, set by its members.²⁸
- **Psychiatrists:** The College of Psychiatrists of Ireland is the sole body recognised by the Medical Council and the HSE for Competence Assurance and Training in Psychiatry.²⁹
- **Counsellors:** Individual counsellors and psychotherapists must be accredited members of one of the various counselling and psychotherapy representative bodies e.g. The Irish Association of Alcohol and Addiction Counsellors and/or the Irish Association for Counselling and Psychotherapy.

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28 <http://www.psihq.ie/overview-of-psi>
29 <http://www.irishpsychiatry.ie/Home.aspx>

1

2

3

4

5

6

7

A

B



Appendix 2: Assessment Templates

Example 1: Addiction Assessment Form (ICGP, 2011)

PSYCHIATRIC EVALUATION:					
During the past 3 months you have felt:					
Sad	Yes/ No	Hopeless	Yes/No		
Anxious	Yes/ No	Do you think life is worth living	Yes/ No		
Frightened	Yes/No	Do you think about suicide	Yes/No		
Guilty	Yes/No	<i>If yes, have you planned to take your life</i>	Yes/No		
No Interest	Yes/No	<i>If yes, have you attempted to take your life</i>	Yes/		
Worthless	Yes/No	No			
URINE INVESTIGATION					
DATE OF SAMPLE		Methadone	Cocaine	Amphetamines	Tricyclic
Opiates	Benzodiazepine				
PATIENTS GOALS & AIMS					
Motivation on a scale of 1-5					
MANAGEMENT PLAN					
Refer to Central Services	Yes/No				
Treatment	Yes/No				
<i>If yes, *Stabilisation</i>					
Detox in Patient	<input type="checkbox"/>				
Detox out Patient	<input type="checkbox"/>				
Slow reduction	<input type="checkbox"/>				
Maintenance	<input type="checkbox"/>				

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Appendix 2: Assessment Templates

Example 2: Initial assessment used by Cork Kerry Substance Misuse Services, 2015

Service User Consent & Confidentiality Form

This consent & confidentiality form is designed to give you an understanding of:

What happens to the information you give

Who has access to the information you give

_____ Male / Female

[Clients Name: Block Capitals]

Date of Birth _____

1. I understand that by signing / marking this form below, I give consent to the recording of my personal information which is ordinarily confidential to the Service. Consent does allow that information to be discussed as a team.
2. I understand that I have the right to withdraw consent for the sharing of information at any time, except where there is a professional obligation for confidentiality to be extended (e.g. Child Protection, risk to self, risk to others, Court order).
3. I understand that the information I provide is ordinarily not disclosed to people outside the Service without further written consent from myself or from my legal guardian, if I am under 18 years of age.
4. I understand that my information / records are retained in electronic [computer] and, or paper form, and are the property of the service provider.
5. I understand that I have the right to access any information held in that record.
6. I understand that consent applies to the duration of this current assessment and, the service provided following on from this assessment.
7. I understand that attending this service requires appropriate behaviour.
8. I also understand that selected information from my records' is also retained by the Health Research Board without the use of my name.

9. All requests for a report for an external agency regarding my attendance at or my treatment with this service must be requested in writing with 10 working days advance notice. Such reports may require some additional consent.

Please note: In the event of the team becoming aware of information that would indicate that you, or someone in your care, or any other person, may be at risk, then staff of this Service have a professional responsibility to report that concern to a relevant authority.

I CONFIRM THAT THE ABOVE CONDITIONS HAVE BEEN EXPLAINED TO ME AND THAT I FULLY UNDERSTAND AND AGREE TO THEM.

Signature of Client: _____ Date: ____/____/____
DD/MM/YYYY

Signature of Staff: _____ Date: ____/____/____
DD/MM/YYYY

Consent Specific to Homeless Services Computer System(s)

Signed _____ Date _____
(Service User)

Signed _____ Date _____
(Assessor)

Name of organisation: _____

Project Worker: _____

Contact telephone number: _____

1

2

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4

5

6

7

A

B



Appendix 2: Assessment Templates

Additional Consent(s) Given

Additional Consent(s)

For sharing my information with persons named below

I give consent to communicate with the below named people / service provider

Signed: _____ Date: _____
[Client]

Witnessed: _____ Date: _____

Additional Consent(s) Withdrawn

Withdrawal of Additional Consent(s)

For sharing my information with the persons named below

I withdraw consent to communicate with the below named people / service provider

Signed: _____ Date: _____
[Client]

Witnessed: _____ Date: _____

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Appendix 2: Assessment Templates

Initial Assessment Form

General information

Name of Client:		Male[HRB4]	Female[HRB4]
Date of Birth[HRB6]		Age[HRB5]	

What is the reason for your referral/access to this service? [HRB14]

Alcohol Use Illicit Drug Use Licit Drug Use Other Homelessness

TICK ALL APPROPRIATE BOXES

If 'Other

 selected above give details _____

** It is of the utmost importance to the care plan that where relevant the appropriate annex are fully completed **

Current / Last / Most Recent Address: _____

Phone Number _____ Mobile Number _____

Agree to contact at above address: Yes No On mobile: Yes No

Living With [HRB7a] Alone Parents/ Family Friends Partner(alone)
 Partner & Children Alone & Children Foster Care
 Other Not Known

Living Where [HRB7b] Stable accommodation
 Institution (prison, clinic)

Homeless

Other unstable accommodation

Not known

Accommodation type: _____

Nationality[HRB10] _____

Ethnicity: [HRB10a] White Irish

White Irish traveller

Any other white background

Black African Background

Any other Black Background

Chinese Background

Any other Asian Background

Other

Do not wish to answer this question

Age left Primary or Secondary School [HRB12a] _____

Highest Primary or Secondary Education level reached [HRB12b] _____

Employment Status [HRB11] _____ Occupation _____

Source of Income _____ Amount of Income _____

What days do you work _____

What hours do you work _____

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7

A

B



Appendix 2: Assessment Templates

G.P Name: _____ G.P aware of Drug Use: Yes No

GP Address: _____

Medical Card: Yes No Applying for

(Homeless Service Only) Medical Card Number _____ Valid until _____

Substance use in family: Yes No

Details _____

No. of children _____ Age Range: _____

(Homeless Service Only) No. of current dependent Children _____

Child Care/Welfare/Protection Concerns: _____

Living with Substance Users/Gamblers/other addictions: Yes No

Details _____

Current links with Agencies/External Professionals Involved: Yes No

Other services involved in care plan to date _____

Next Of Kin

Name of next of kin / emergency contact: _____

Relationship of next of kin / emergency contact _____

Next of Kin/Family aware of substance use: Yes No

Enter contact details of Next of Kin _____

Specific to Drug & Alcohol Services

Substance use, gambling, eating dx, histories [HRB14, 24a, 24b-28e]

Drugs used	Route of transmission	Frequency	Quantity	Duration of Use	Age 1st used	Date Last Used
Alcohol						
Cannabis						
Hallucinogens						
Benzodiazepines, Hypnotics & Sedatives						
Prescribed						
Street						
Heroin						
Methadone						

1

2

3

4

5

6

7

A

B



Appendix 2: Assessment Templates

Drugs used	Route of transmission	Frequency	Quantity	Duration of Use	Age 1st used	Date Last Used
Other Opiates						
Cocaine						
Amphetamine						
Ecstasy						
Over the counter Drugs Any other drugs: [i.e. Solvents / Gas Head-shop / Steroids' Others.....]						
Drug of Choice: Past Present First Drug taken						

Drugs used	Route of transmission	Frequency	Quantity	Duration of Use	Age 1st used	Date Last Used
Gambling	Forms of	Frequency	Amount	Duration	Age 1st	Last Gambled
Eating Disorders						

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7

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Appendix 2: Assessment Templates

Risk Management

Ever injected [HRB29b] Yes No

Age first injected [HRB29c] _____

Ever shared [HRB30] Yes No

Injected in last month [HRB29a] Yes No

Shared in last month Yes No

If using I.V. needles how are they obtained _____

If using IV needles how are they disposed _____

HIV test Yes No Date Estimated _____

HBV test Yes No Date Estimated _____

HCV test Yes No Date Estimated _____

Last vaccination date: (Location) _____
Date Estimated _____

Type of vaccination _____

Place of vaccination _____

Any History of STI's Yes No

Unprotected Risk: Yes No

Justice / Legal _____

Supports habit with: _____

Most serious charge: _____

Current charge Yes No

History of Assault Yes No

Details of convictions/Probation?

Harm Reduction Advise Given

Needle Exchange time and places Yes No

Safer sex Yes No

Drug Interactions' Yes No

Other (give details) _____

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Appendix 2: Assessment Templates

Previous Treatment

Ever Treated for Substance Use/Gambling [HRB22] Yes No

Number of previous treatments _____

Treatment Type(s) _____

Longest time Drug/Gambling Free: _____

Date Free From:

Date Free To:

Previous Treatment(s) Agency _____

Reason for leaving _____

Current methadone treatment?[HRB 21a, 21b] Yes No

Other Current Treatments/Medications Yes No

Details: _____

Previous methadone maintenance Yes No

Any services currently involved in care provision Yes No

Other Relevant History

Any known Allergies [Medical or Any Other]

Past / Recent relevant medical history:

Currently Prescribed Medications

Any history of seizures Yes No

If 'Yes' give details _____

Ever seen by a Psychiatrist/Psychologist/Counsellor/Occupational Therapist:

Yes No

If 'Yes' give details

Any Occupational Therapy or Other diagnosis _____

History of Overdoses Yes No

Accidental Overdose _____

Deliberate Overdose _____

History of Self Harm Yes No

History of Domestic Violence Yes No

History of suicidal thought Yes No

1

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4

5

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7

A

B



Appendix 2: Assessment Templates

Details _____

Treatment requested by Service User Yes No

Specify: _____

Assessors Actions required following initial assessment not requiring comprehensive assessment

- Children First / Child protection / Social work referral
- Direct provision treatment[HRB 18a-1]
- Progress to opiate substitution protocols [HRB 18a-2]
- Refer on to other treatment provider[HRB 18a-3]]
- Psychiatric assessment or review [HRB 18a-4]
- Medical assessment [HRB 18a-6]
- Nursing viral screening or review[HRB 18a-6]
- Harm reduction psycho-educational group[HRB 18a-6]
- other / Involving placement on a list [HRB 18a-6]
- Referral to HAT / Homeless Action Teams
- Key working toward another services provider _____
- Other _____

Assessors' comments & Initial Care Plan

Initial assessment completed by:

Signature _____ Date ___/___/___

Comprehensive assessment needed: Yes No

Comprehensive assessment arranged Yes No

Common assessment needed: Yes No

Common assessment arranged Yes No

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Appendix 2: Assessment Templates

“Annex A”

Housing information relevant to primary homeless services

Can you outline the main reasons for you becoming homeless on this occasion?	
Have you been homeless before?	
If yes, please give brief details	
Have you ever slept rough?	
If so when and for how long?	
Are you registered with a Local Authority	
If so please specify which Local Authority	
Do you have any outstanding rent arrears with a Local Authority	
Have you ever received a deposit from C.W.O towards private rented accommodation	
Address of property/properties deposit was given for	
*Date of receipt of deposit- approx	

*Are you currently entitled to receive a deposit from Social welfare office	
Have you ever lived independently	
Have you ever been in state care under age of 18 years? If so please specify type e.g. residential or foster care.	
What are the main reasons for you becoming homeless? e.g. relationship, drug, alcohol issues, discharge from prison/hospital or other.	
If you were evicted from accommodation could you outline the reason for the eviction	
What difficulties would you say you have experienced in attempting to maintain accommodation in the past	

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Appendix 2: Assessment Templates

Name: _____ Client No: _____ DOB: _____

Southeast Regional Substance Misuse Services

Insert Service Name Here

Comprehensive Assessment Medical – GP & Liaison Nurse Domain

Consent for Medical – GP & Liaison Nurse Assessment Checklist

- You've explained to service user the purpose of the Medical Assessment, processes and he/she fully understands the assessment process.
- You've explained to the service of and the *insert service name* Confidentiality & Information Sharing Policy:
- This information is confidential within the Substance Misuse Team for the purpose of working together to promote service users wellbeing and provision of a high quality service, clinical care and care plan.
 - This information will not be shared without first discussing the need for sharing and getting agreement from service user to share.
- You've reminded the Service User of their right to have a member of my family/concern person present with during this assessment and wish to include:
- Name of family member/CP:** _____ in my assessment. Declined this option
- You've reminded the service user of their right to change their mind at any time during the assessment and remove consent.
- Service User agrees** to participate in the Medical Assessment with the substance misuse service.
- Service User states they are not** under pressure to take this Medical Assessment.

A witness should sign below if the client is unable to sign but has indicated his or her consent. Young people/children may also like a parent to sign here (see notes).

Signature _____ Date _____

Name (PRINT) _____

Confirmation of consent

On behalf of the *Insert Service Name here*, I have confirmed with the client that s/he has no further questions and wishes the procedure to go ahead.

Staff Signature: _____ Date _____

Name: _____ Client No: _____ DOB: _____

Southeast Regional Substance Misuse Services

Insert Service Name Here

Comprehensive Assessment Medical – GP & Liaison Nurse Domain

1.0 Client & Referral Details (Demographics)

1.1 Date of Assessment: _____D____M____Y		1.1a Assessor's Name:	
1.2 Name:	Last: _____	1.2a Client Number	
	First: _____		
1.3 Address:			
1.4 Phone No. (Landline) _____ (Mobile) _____		1.4a Which is best to contact you? Tick one Landline <input type="checkbox"/> Mobile <input type="checkbox"/>	
1.5 GP Name:		Medical Card No: <input type="text"/>	
1.6 Gender: Male <input type="checkbox"/> Female <input type="checkbox"/>	1.7 Date of Birth: _____D____M____Y		
1.8 Next of Kin:		1.8a Phone Number:	
1.9 Date of Referral: _____D____M____Y	1.9a Reason for referral: <input type="checkbox"/> Alcohol <input type="checkbox"/> Drugs <input type="checkbox"/> Poly Drugs <input type="checkbox"/> Other		1.9b Priority Status: A: Pregnancy <input type="checkbox"/> B: Under-age <input type="checkbox"/> C: Femoral Injectors: (<i>Grain/Neck</i>) <input type="checkbox"/> D: Self Harm <input type="checkbox"/>
1.9c Other Reason for referral/Comments:			
Allergies:			

- 1
- 2
- 3
- 4
- 5
- 6
- 7
- A
- B



Appendix 2: Assessment Templates

Name:

Client No:

DOB:

2.0 Level of Problematic Substance Use & Severity of Dependency

2.1 Initial Assessment Screening Result and Dependency Severity Score (DSS)		
a. Date of AUDIT Screening ____/____/____Y	Score: _____	Extent of problem: <input type="checkbox"/> Hazardous Drinker <input type="checkbox"/> Harmful Drinker <input type="checkbox"/> Dependent Drinker
b. Date of DUDIT Screening ____/____/____Y	Score: _____	Extent of problem: Male 6+ = <input type="checkbox"/> Harmful Misuse Female 2+ = <input type="checkbox"/> Harmful Misuse Both genders 25+ = <input type="checkbox"/> Heavily Dependent *
c. Date of CUDIT - R Screening ____/____/____Y	Score: _____	Extent of problem: <input type="checkbox"/> Low risk <input type="checkbox"/> Hazardous Use <input type="checkbox"/> High Use – Most likely Dependent *
d. Date of the Leeds Dependency Questionnaire (LDQ) ____/____/____Y	Score: _____	Dependency Severity: <input type="checkbox"/> Low <input type="checkbox"/> Medium <input type="checkbox"/> High

3.0 Current Substance Use

3.1 Substance Use History			
What substances do you use or have you used, including alcohol. Refer to Initial Assessment (2.7b) for first substance of choice and include to this domain.			
Substance Type/Age at first use/order of choice	Route of Administration	Use in last 30 days (tick one)	
a. Alcohol Specify Type _____ <input type="checkbox"/>	<input type="checkbox"/> Inject <input type="checkbox"/> Smoke <input type="checkbox"/> Eat/Drink <input type="checkbox"/> Sniff/snort <input type="checkbox"/> Sublingual <input type="checkbox"/> Rectal <input type="checkbox"/> Topical <input type="checkbox"/> Not known	<input type="checkbox"/> Once a week or less <input type="checkbox"/> 2-6 days a week <input type="checkbox"/> Daily <input type="checkbox"/> No use <input type="checkbox"/> Not know	
b. Cannabis Specify Type _____ <input type="checkbox"/>	<input type="checkbox"/> Inject <input type="checkbox"/> Smoke <input type="checkbox"/> Eat/Drink <input type="checkbox"/> Sniff/snort <input type="checkbox"/> Sublingual <input type="checkbox"/> Rectal <input type="checkbox"/> Topical <input type="checkbox"/> Not known	<input type="checkbox"/> Once a week or less <input type="checkbox"/> 2-6 days a week <input type="checkbox"/> Daily <input type="checkbox"/> No use <input type="checkbox"/> Not know	
c. Amphetamine Specify Type _____ <input type="checkbox"/>	<input type="checkbox"/> Inject <input type="checkbox"/> Smoke <input type="checkbox"/> Eat/Drink <input type="checkbox"/> Sniff/snort <input type="checkbox"/> Sublingual <input type="checkbox"/> Rectal <input type="checkbox"/> Topical <input type="checkbox"/> Not known	<input type="checkbox"/> Once a week or less <input type="checkbox"/> 2-6 days a week <input type="checkbox"/> Daily <input type="checkbox"/> No use <input type="checkbox"/> Not know	

Rev515RN/RRC

Page 3

Name:

Client No:

DOB:

d. Benzodiazepines Specify Type _____ <input type="checkbox"/>	<input type="checkbox"/> Inject <input type="checkbox"/> Smoke <input type="checkbox"/> Eat/Drink <input type="checkbox"/> Sniff/snort <input type="checkbox"/> Sublingual <input type="checkbox"/> Rectal <input type="checkbox"/> Topical <input type="checkbox"/> Not known	<input type="checkbox"/> Once a week or less <input type="checkbox"/> 2-6 days a week <input type="checkbox"/> Daily <input type="checkbox"/> No use <input type="checkbox"/> Not know
d. Opioids Specify Type _____ <input type="checkbox"/>	<input type="checkbox"/> Inject <input type="checkbox"/> Smoke <input type="checkbox"/> Eat/Drink <input type="checkbox"/> Sniff/snort <input type="checkbox"/> Sublingual <input type="checkbox"/> Rectal <input type="checkbox"/> Topical <input type="checkbox"/> Not known	<input type="checkbox"/> Once a week or less <input type="checkbox"/> 2-6 days a week <input type="checkbox"/> Daily <input type="checkbox"/> No use <input type="checkbox"/> Not know
e. Hallucinogens Specify Type _____ <input type="checkbox"/>	<input type="checkbox"/> Inject <input type="checkbox"/> Smoke <input type="checkbox"/> Eat/Drink <input type="checkbox"/> Sniff/snort <input type="checkbox"/> Sublingual <input type="checkbox"/> Rectal <input type="checkbox"/> Topical <input type="checkbox"/> Not known	<input type="checkbox"/> Once a week or less <input type="checkbox"/> 2-6 days a week <input type="checkbox"/> Daily <input type="checkbox"/> No use <input type="checkbox"/> Not know
f. Cocaine Specify Type _____ <input type="checkbox"/>	<input type="checkbox"/> Inject <input type="checkbox"/> Smoke <input type="checkbox"/> Eat/Drink <input type="checkbox"/> Sniff/snort <input type="checkbox"/> Sublingual <input type="checkbox"/> Rectal <input type="checkbox"/> Topical <input type="checkbox"/> Not known	<input type="checkbox"/> Once a week or less <input type="checkbox"/> 2-6 days a week <input type="checkbox"/> Daily <input type="checkbox"/> No use <input type="checkbox"/> Not know
g. Inhalants Specify Type _____ <input type="checkbox"/>	<input type="checkbox"/> Inject <input type="checkbox"/> Smoke <input type="checkbox"/> Eat/Drink <input type="checkbox"/> Sniff/snort <input type="checkbox"/> Sublingual <input type="checkbox"/> Rectal <input type="checkbox"/> Topical <input type="checkbox"/> Not known	<input type="checkbox"/> Once a week or less <input type="checkbox"/> 2-6 days a week <input type="checkbox"/> Daily <input type="checkbox"/> No use <input type="checkbox"/> Not know
h. Tobacco Products Specify Type _____ <input type="checkbox"/>	<input type="checkbox"/> Inject <input type="checkbox"/> Smoke <input type="checkbox"/> Eat/Drink <input type="checkbox"/> Sniff/snort <input type="checkbox"/> Sublingual <input type="checkbox"/> Rectal <input type="checkbox"/> Topical <input type="checkbox"/> Not known	<input type="checkbox"/> Once a week or less <input type="checkbox"/> 2-6 days a week <input type="checkbox"/> Daily <input type="checkbox"/> No use <input type="checkbox"/> Not know
3.2 Injecting History		
Please review Initial Assessment for Injecting History (2.9 – 2.10b) which includes information related to potential abscess sites. Follow-up on the injecting questions in order to give the service user the opportunity to verify information from Initial Assessment and/or to provide new information.		
3.2a Have you ever injected? <input type="checkbox"/> Yes <input type="checkbox"/> No	3.2b Have you injected in the last 30 days? <input type="checkbox"/> Yes <input type="checkbox"/> No OR <input type="checkbox"/> Injected in the last year but not last 30 days <input type="checkbox"/> Injected but not in the last 12 months	3.2c Have you Shared injecting Equipment: (tick one) <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, have you shared in: <input type="checkbox"/> last 30 days <input type="checkbox"/> last 12 months <input type="checkbox"/> more than 12 months ago
3.3. Prescribed Medication		
If a CA- Alcohol & Drug History has been completed please review this assessment to avoid duplication		

Rev515RN/RRC

Page 4



1

2

3

4

5

6

7

A

B

Appendix 2: Assessment Templates

Name: _____ Client No: _____ DOB: _____

Please list all your current medication and/or recent prescribed medication including both complementary and over the counter medications

a. Medication Type:		Reason:	
Commenced: ____/____/____	Completed: ____/____/____	Dosage, Frequency & Route:	
Dispensing Pharmacy ☺:	Frequency Dispensed ☺:	If not taken as prescribed How... ☺:	
Reason for non-compliance☺:			
Where are you getting this medication? <input type="checkbox"/> GP <input type="checkbox"/> Chemist <input type="checkbox"/> Family member <input type="checkbox"/> Friends <input type="checkbox"/> Internet <input type="checkbox"/> Other specify:			
b. Medication Type:		Reason:	
Commenced: ____/____/____	Completed: ____/____/____	Dosage, Frequency & Route :	
Dispensing Pharmacy ☺:	Frequency Dispensed ☺:	If not taken as prescribed How... ☺:	
Reason for non-compliance☺:			
Where are you getting this medication? <input type="checkbox"/> GP <input type="checkbox"/> Chemist <input type="checkbox"/> Family member <input type="checkbox"/> Friends <input type="checkbox"/> Internet <input type="checkbox"/> Other specify:			
c. Medication Type:		Reason:	
Commenced: ____/____/____	Completed: ____/____/____	Dosage, Frequency & Route:	
Dispensing Pharmacy ☺:	Frequency Dispensed ☺:	If not taken as prescribed How... ☺:	
Reason for non-compliance☺:			
Where are you getting this medication? <input type="checkbox"/> GP <input type="checkbox"/> Chemist <input type="checkbox"/> Family member <input type="checkbox"/> Friends <input type="checkbox"/> Internet <input type="checkbox"/> Other specify:			
d. Medication Type:		Reason:	
Commenced: ____/____/____	Completed: ____/____/____	Dosage, Frequency & Dose:	
Dispensing Pharmacy ☺:	Frequency Dispensed ☺:	If not taken as prescribed How... ☺:	
Reason for non-compliance☺:			
Where are you getting this medication? <input type="checkbox"/> GP <input type="checkbox"/> Chemist <input type="checkbox"/> Family member <input type="checkbox"/> Friends <input type="checkbox"/> Internet <input type="checkbox"/> Other specify:			

Name: _____ Client No: _____ DOB: _____

3.4 When was the last time you misused substances?	
Alcohol	
<input type="checkbox"/> Today	<input type="checkbox"/> Within last 24 hours <input type="checkbox"/> 1-2 days ago <input type="checkbox"/> Within the week
3.5 Are signs of intoxication/affected present? <input type="checkbox"/> YES <input type="checkbox"/> No	
3.5a If yes, what are the observed (O) and/or self-reported (SR) physical signs below:	
<input type="checkbox"/> Smell O/SR	<input type="checkbox"/> Enlarged pupils O/SR
<input type="checkbox"/> Slurred or loud speech O/SR	<input type="checkbox"/> Loss of Balance O/SR
<input type="checkbox"/> Nausea or vomiting O/SR	<input type="checkbox"/> Quick Mood Changes (aggression) O/SR
3.6 Are signs of withdrawal present? <input type="checkbox"/> YES <input type="checkbox"/> No	
3.6a If yes, what are the observed (O) and/or self-reported (SR) physical signs below:	
<input type="checkbox"/> Hand tremors O/SR	<input type="checkbox"/> Sweating O/SR
<input type="checkbox"/> Nausea O/SR	<input type="checkbox"/> Visual hallucinations O/SR
<input type="checkbox"/> Seizures (fits) O/SR	
y If signs are present for withdrawal, complete Withdrawal Screening for Alcohol – CIWA-R	
Drugs	
<input type="checkbox"/> Today	<input type="checkbox"/> Within last 24 hours <input type="checkbox"/> 1-2 days ago <input type="checkbox"/> Within the week
3.7 Are signs of intoxication/affected present? <input type="checkbox"/> YES <input type="checkbox"/> No	
3.8 Are signs of intoxication/affected present? <input type="checkbox"/> YES <input type="checkbox"/> No	
3.8a If yes, what are the observed (O) and/or self-reported (SR) physical signs below:	
<input type="checkbox"/> Small Pupils O/SR	<input type="checkbox"/> Running Nose O/SR
<input type="checkbox"/> Slurred Speech O/SR	<input type="checkbox"/> Glassy Eyed O/SR
<input type="checkbox"/> Goofing off O/SR	<input type="checkbox"/> Hyperactivity O/SR
3.9 Are signs of withdrawal present? <input type="checkbox"/> YES <input type="checkbox"/> No	
3.9a If yes, what are the observed (O) and/or self-reported (SR) physical signs below:	
<input type="checkbox"/> Anxiety or Jumpiness O/SR	<input type="checkbox"/> Sweating O/SR
<input type="checkbox"/> Trembling O/SR	<input type="checkbox"/> Irritability O/SR
<input type="checkbox"/> Headaches O/SR	
y If signs are present for withdrawal, complete Withdrawal Screening for Opiate – COWS	
Notes:	

- 1
- 2
- 3
- 4
- 5
- 6
- 7
- A
- B



Appendix 2: Assessment Templates

Name: _____ Client No: _____ DOB: _____

4.1 Current or Past Medical Key Areas of Need	
List needs identified from this section of Medical Assessment	
\$ _____	Prioritise <input type="checkbox"/>
\$ _____	<input type="checkbox"/>
\$ _____	<input type="checkbox"/>
\$ _____	<input type="checkbox"/>
\$ _____	<input type="checkbox"/>

5.0 General Medical History – Mental Health

(Before completing this section, ensure you have review of Section 4.0 Psychological & Mental Health Domain of the Initial Assessment)

5.1 Insert from Initial Assessment **Patient Health Questionnaire -4 (PHQ-4)**: Score:

5.1a *If the score is 6 or more, a Hospital Anxiety Depression Scale was a required action post Initial Assessment. Has this been completed at time of this medical assessment?* YES NO

If yes: HAD Baseline Score: _____ / Date: _____

If no: Complete the HAD as identified in Initial Assessment and ensure this item is care planned.

5.1a The **Patient Health Questionnaire -4 (PHQ-4)** has been included within this medical assessment in the event a re-screen is required.

Patient Health Questionnaire – 4(PHQ-4) (Ultra-Brief Screening for Depression & Anxiety) <small>(Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues)</small>				
Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several Days	More than Half of the Days	Nearly Every Day
1 Feeling nervous, anxious or on edge	0	1	2	3
2 Not be able to stop or control worrying	0	1	2	3
3 Little interest or pleasure in doing things	0	1	2	3
4 Feeling down, depressed or hopeless	0	1	2	3
Sub Total				

Scoring guidance - Score range 0-12: score of **6 or more** is an indication of an

Name: _____ Client No: _____ DOB: _____

underlying depression & anxiety.	Total		
----------------------------------	-------	--	--

5.2 *If it was identified in the initial assessment (Q4.1, Q4.1a, Q4.1b, Q4.2 & Q4.2a) that service user has a previously been under the care of mental health services, Follow-up on the questions in order to give the service user the opportunity to verify information from Initial Assessment and/or to provide new information. Such as more information in relation to when/where?*

Previously been under the care of Mental Health Services? YES NO When/ Where?

5.3 Previous Hospital Admissions? YES NO When/ Where?

5.4 Insert Initial Assessment **Short Screening Self-Harm** Results: *Follow-up on the questions in order to give the service user the opportunity to verify information from Initial Assessment and/or to provide new information.*

In the last 12 months have you ever:			
Wanted to harm your-self?	<input type="checkbox"/> Never	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Often
Wanted to end your life?	<input type="checkbox"/> Never	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Often

5.4a Are you currently having self-harm or suicidal thoughts? Yes No

5.4b *If the answer to 5.4 was Often and/or 5.4a yes, a full Suicide Risk Assessment was a required action post Initial Assessment. Has this risk assessment been completed at time of this medical assessment?* YES NO

If yes: Risk Assessment Suicide Baseline Score: _____ Date: _____

CURRENT Risk	<input type="checkbox"/> (0-23) Low Risk Provide Support	<input type="checkbox"/> (24-50) Moderate Risk Intervention required	<input type="checkbox"/> (51 -75) High Risk Immediate intervention required
Risk Level 12 month ago	<input type="checkbox"/> (0-23) Low Risk Explore factors, triggers and what helped	<input type="checkbox"/> (24-50) Moderate Risk Explore factors, triggers and similarities patterns and interventions & supports which were useful	<input type="checkbox"/> (51 -75) High Risk EXPLORE & identified the successful interventions

If no: Complete the risk assessment as identified in Initial Assessment and ensure this item is care planned.

5.4c The **Short Screening Self-Harm** has been included within this medical assessment in the event a re-screen is required due to new information resulting in a possible baseline change.

In the last 12 months have you ever:			
Wanted to harm your-self?	<input type="checkbox"/> Never	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Often
Wanted to end your life?	<input type="checkbox"/> Never	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Often

- 1
- 2
- 3
- 4
- 5
- 6
- 7
- A
- B



Appendix 2: Assessment Templates

Name: _____ Client No: _____ DOB: _____

5.4d Are you currently having self-harm or suicidal thoughts? <input type="checkbox"/> Yes <input type="checkbox"/> No		
5.5 Have you ever self-harmed? <input type="checkbox"/> YES <input type="checkbox"/> NO	5.5a In the past (>3/12) <input type="checkbox"/> YES <input type="checkbox"/> NO	5.5b How many times? <input type="text"/>
<i>If yes and not already commenced, complete a full risk assessment.</i>	5.5c Recently (<3/12) <input type="checkbox"/> YES <input type="checkbox"/> NO	5.5d How many times? <input type="text"/>
	5.5e Notes:	
5.6 Have you ever taken an Overdose? <input type="checkbox"/> YES <input type="checkbox"/> NO	5.6a In the past (>3/12) <input type="checkbox"/> YES <input type="checkbox"/> NO	5.6b How many times? <input type="text"/>
<i>Please mention whether deliberate &/or accidental</i>	5.6c Recently (<3/12) <input type="checkbox"/> YES <input type="checkbox"/> NO	5.6d How many times? <input type="text"/>
	5.6e Notes:	
5.7 Have you ever attempted suicide? <input type="checkbox"/> YES <input type="checkbox"/> NO	5.7a In the past (>3/12) <input type="checkbox"/> YES <input type="checkbox"/> NO	5.7b How many times? <input type="text"/>
<i>If yes and not already commenced, complete a full risk assessment.</i>	5.7c Recently (<3/12) <input type="checkbox"/> YES <input type="checkbox"/> NO	5.7d How many times? <input type="text"/>
	5.7e Notes:	
5.8 <i>If it was identified in the initial assessment (Q7.4) that service user has learning difficulties, Follow-up on the questions in order to give the service user the opportunity to verify information from Initial Assessment and/or to provide new information.</i>		
Learning Disability Identified: <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe		
5.8a When diagnosed? <input type="text"/>		

Name: _____ Client No: _____ DOB: _____

5.9 Do you suffer from Depressive Episodes? <input type="checkbox"/> YES <input type="checkbox"/> NO	5.9a In the Past:	
<i>If yes and not already commenced, complete the Becks Inventory</i>	5.9b Currently:	
	5.10 Do you suffer from Recurrent Depressive Disorder? <input type="checkbox"/> YES <input type="checkbox"/> NO When Diagnosed?	
5.11 Do you suffer from Schizophrenia? <input type="checkbox"/> YES <input type="checkbox"/> NO When Diagnosed?		
5.12 Do you suffer from Panic Attacks or an Anxiety Disorder? <input type="checkbox"/> YES <input type="checkbox"/> NO When Diagnosed? <i>(This relates to Past & Present) If yes and not already commenced, complete the HAD Scale</i>		
5.13 Do you have ADHD or a Conduct Disorder? <input type="checkbox"/> YES <input type="checkbox"/> NO When Diagnosed?		
5.14 OTHER RELEVANT INFORMATION:		
5.15 Mental Health Key Areas of Need List needs identified from this section of Medical Assessment		
\$ _____		Prioritise <input type="text"/>
\$ _____		<input type="text"/>

- 1
- 2
- 3
- 4
- 5
- 6
- 7
- A
- B



Appendix 2: Assessment Templates

Name: _____ Client No: _____ DOB: _____

6.0 BBV Screening History: (Y= Yes, N=No, DK = Don't know)

Screening	Screened	Aware of Results	Vaccinations	How Many	Previous Tx or Referred
Hep A	<input type="checkbox"/> Y Date..... Where..... <input type="checkbox"/> N <input type="checkbox"/> DK <input type="checkbox"/> Does not want to disclose	<input type="checkbox"/> Y P / N Date..... Where..... <input type="checkbox"/> N <input type="checkbox"/> DK <input type="checkbox"/> Does not want to disclose	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK		<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK Date: Where.....
Hep B	<input type="checkbox"/> Y Date..... Where..... <input type="checkbox"/> N <input type="checkbox"/> DK <input type="checkbox"/> Does not want to disclose	<input type="checkbox"/> Y P / N Date..... Where..... <input type="checkbox"/> N <input type="checkbox"/> DK <input type="checkbox"/> Does not want to disclose	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK		<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK Date: Where.....

Name: _____ Client No: _____ DOB: _____

Hep C	<input type="checkbox"/> Y Date..... Where..... <input type="checkbox"/> N <input type="checkbox"/> DK <input type="checkbox"/> Does not want to disclose	<input type="checkbox"/> Y P / N Date..... Where..... <input type="checkbox"/> N <input type="checkbox"/> DK			<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK Date: Where.....
HIV	<input type="checkbox"/> Y Date..... Where..... <input type="checkbox"/> N <input type="checkbox"/> DK <input type="checkbox"/> Does not want to disclose	<input type="checkbox"/> Y P / N Date..... Where..... <input type="checkbox"/> N <input type="checkbox"/> DK			<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK Date: Where.....

If Client has not been screened	Screening offered Y / N	Accepted Y / N	Consent Signed Y / N
<input type="checkbox"/> Is Hb Titre required? Y / N	Hb Titre offered Y / N	Accepted Y / N	Consent Signed Y / N

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Appendix 2: Assessment Templates

Name: _____ Client No: _____ DOB: _____

6.1 BBV Screening Key Areas of Need	
List needs identified from this section of Medical Assessment	
\$ _____	Prioritise <input type="checkbox"/>
\$ _____	<input type="checkbox"/>
\$ _____	<input type="checkbox"/>
\$ _____	<input type="checkbox"/>
\$ _____	<input type="checkbox"/>

7.0 Clinical Observations

Presentation:		Hair:	
Skin: Colour/ Rashes / Bruising / Sclerosed veins/Abscesses/Needle marks/Self-harm			
Oral / Dental:		Tattoos / Piercings:	
Diet/Appetite			
Possible Eating Disorder: Y/N Is an EAT 24 assessment required? Y/N Weight loss (MUST): Y/N			
Blood Pressure	Pulse	Temperature	Allergies
Height	Weight	BMI < 20, is a MUST assessment required? Y/N	BSL (If Diabetic)

Rev515RN/RRC

Page 16

Name: _____ Client No: _____ DOB: _____

Hearing	Sight / Pupils Normal Constricted Dilated	Elimination / Bowel Normal Constipated Diarrhoea / Loose Haemorrhoids <u>Elimination / Bladder</u> Normal Anuria Poyuria Dysuria	If Pregnant - / 40 EDD..... First antenatal apt Y/N Date:.....
Contraception: Y/N If Yes, Type: Prescribed by Whom:		Menstrual Cycle: Regular / Irregular / Amenorrhoea First day of Last Period..... Pregnancy Test Y/N Result...P / N When: _____ Referred to: _____ Date:	
Urinalysis: Y/N Result:		Breathalysed: Y/N Result:	
Bloods: Y/N Haematology / Biochemistry		Bloods: Y/N Serology / BBV Screening / Hb Titre	
Examination Notes / Doctor:			
Any Relevant Comments: ☆ ☆ ☆ ☆			

Rev515RN/RRC

Page 17

1

2

3

4

5

6

7

A

B



Appendix 2: Assessment Templates

Name: _____ Client No: _____ DOB: _____

7.1 Clinical Observations Key Areas of Need	
List needs identified from this section of Medical Assessment	
	Prioritise
§ _____	<input type="checkbox"/>
§ _____	<input type="checkbox"/>
§ _____	<input type="checkbox"/>
§ _____	<input type="checkbox"/>
§ _____	<input type="checkbox"/>

8.0 Outcomes, Priorities & Conclusion with Service User

8.1. Comprehensive Medical Domain Outcome Priorities & Conclusion with Service User	
Have you discussed the outcome of the AOD Domain with the service user and agreed identified needs below?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
Medical/LN Care Plan Goals Identified – Priorities/Motivation	
§ _____	<input type="checkbox"/>
§ _____	<input type="checkbox"/>
§ _____	<input type="checkbox"/>
§ _____	<input type="checkbox"/>
§ _____	<input type="checkbox"/>

Name: _____ Client No: _____ DOB: _____

§ _____		
8.1a. Have risks screenings identified where full comprehensive risk assessments are required? <input type="checkbox"/> Yes <input type="checkbox"/> Not at this time If yes, list the identified comprehensive risk assessment(s) required?		

8.2. List of possible services required & onward referrals needed. If a referral is required, have discussed with service user the reason why this would be helpful <input type="checkbox"/>		
Service Type	Reason for referral	§ Consent given to refer
		<input type="checkbox"/> Yes <input type="checkbox"/> Declined
		<input type="checkbox"/> Yes <input type="checkbox"/> Declined
		<input type="checkbox"/> Yes <input type="checkbox"/> Declined
		<input type="checkbox"/> Yes <input type="checkbox"/> Declined
§ You and the service user completed and signed a consent form(s) for referral(s) and release of Medical Domain Outcome, if appropriate.		
We have discussed a follow up plan from this service on any agreed referrals as part of this assessment process?		
<input type="checkbox"/> Yes <input type="checkbox"/> Declined		
Have you discussed with the service user follow up information to be provided back to the referring agency and have agreed the information to be feedback?		
<input type="checkbox"/> Yes <input type="checkbox"/> Declined		
Have you offered the service user a debrief session? <input type="checkbox"/> Yes <input type="checkbox"/> Declined		



Appendix 2: Assessment Templates

Name:

Client No:

DOB:

Signature of Service User: _____	Date: _____
Print Assessors Name: _____, Liaison Nurse	
Signature Assessor : _____	Date: _____
(Substance Misuse Service Only)	
Clinic Doctor: _____	Date: _____



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Appendix 3: Care plan templates

The following template structures are taken from the National Drugs Rehabilitation framework (2010). It is intended that there be one shared care plan for each service user, which will be monitored and reviewed by the case manager.

Care plan template (service user and key worker)

Date Objective set	Objective and Timescale	How will progress be measured	Work to be done to achieve objective	Referred to	Name of worker & agency	Outcome	Comment: Reasons achieved or not
10/1/10	Stop illicit drug use within 8 weeks	1. Self-report 2. Attend Drug awareness course 3. Urinalysis	1:1 with counsellor concerning motivational interviewing and CBT analysis of triggers Attend next drug awareness course	Counsellor Crumlin	Michael Boggs Crumlin	Attending 1:1 and successfully engaged with counselling activities Completed drug awareness course 12/6/08 Applied for next treatment course 28/2/2010	Intends to apply for a training course

Care plan template (for shared care plan).

This shared care plan can be split into separate sections, with various key workers taking responsibility for the implementation and review of these. Each row is completed and monitored by an individual key worker; the case manager oversees the entire plan.

	Date Objective set	Objective and Timescale	How will progress be measured	Work to be done to achieve objective	Referred to	Name of worker & agency	Outcome	Comment: Reasons achieved or not
Key Worker 1 completes and monitors ...	10/1/10	Stop illicit drug use within 8 weeks	1. Self-report 2. Attend Drug awareness course 3. Urinalysis	1:1 with counsellor concerning motivational interviewing and CBT analysis of triggers Attend next drug awareness course	Counsellor Crumlin	Michael Boggs Crumlin	Attending 1:1 and successfully engaged with counselling activities Completed drug awareness course 12/6/08 Applied for next treatment course 28/2/2010	Intends to apply for a training course
Key Worker 2 completes and monitors ...	10/2/10	Improve level of reading and writing over 12 weeks	1. Self-report 2. VEC Teacher-report	Attend all literacy classes in programme	Teacher with help from friend	Joan Smyth, Crumlin VEC Centre & Kevin O'Toole	Improvement. Can read newspaper and display competence to a level appropriate to children leaving primary school	Applying for Junior Cert in English
Key Worker 3 completes and monitors ...	25/1/10	Address identified health risks associated with illicit drug misuse within 2 weeks.	1. Self-report and 2. Nurse confirmation	Attend 1:1 with nurse. Attend health education course.	Nurse	Doris Murphy Recovery Project	Attended 1:1 sessions. Received leaflets ✓	No health education course as yet. On waiting list for Medical Flag Contact clinician prior to major session

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Appendix 5: Recommendations re appropriate patient cohort for buprenorphine / naloxone

Recommendations re appropriate patient cohort of the Expert Group on the Regulatory Framework for products containing buprenorphine / naloxone and buprenorphine-only for the treatment of opioid dependence

3.3 In the interests of public health, and based on a clinical assessment, buprenorphine / naloxone may be most appropriate for use in the following cohorts of patients or in the following circumstances:

3.3.1 Patients currently receiving treatment with buprenorphine / naloxone who should be maintained on buprenorphine / naloxone.

3.3.2 Patients with a specific medical need for whom methadone is contraindicated or not suitable, such as:

- patients with prolonged QT intervals,
- male patients with feminisation syndrome,
- patients on neuroleptic medications which also affect QT interval
- patients on high dose methadone treatment, who are also being treated with medicines which inhibit CYP450 enzymes (such as antiretroviral agents e.g. efavirinz or the anti-infective rifampicin etc.) and therefore are at greater risk of drug interactions or
- patients diagnosed with HIV in order to facilitate alternative HIV treatment options.

3.3.3 Methadone-naïve patients or patients, including young patients, where detoxification is a primary goal of treatment, provided the prescriber is of the opinion that detoxification is a realistic goal for the patient.

3.3.4 Patients being treated for codeine and other pharmaceutical opioid dependencies.

3.3.5 Patients where, having regard to all of the patient's circumstances, the prescriber is satisfied that there is clear evidence that the patient has been stable, socially, domestically and from a family perspective, for at least a period of six months, and particularly where the patient is in stable employment or education, and that the patient demonstrates a commitment to compliance with the treatment programme.

3.4 Buprenorphine / naloxone may not be suitable for the following categories of patients:

- patients who are not stabilised on methadone,
- patients who are poly-drug users,
- patients who are problem benzodiazepine users, and
- Patients with a history of non-compliance with treatment regimes

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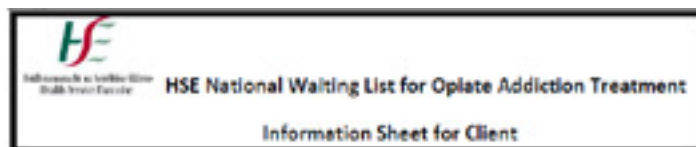
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Appendix 7: National Waiting List Information Sheet



The National Waiting List (NWL) has been designed to ensure an equitable service for all clients who present for treatment for Opiate addiction. The NWL will provide information about waiting times and assist with service planning and development within the HSE Addiction Services.

All information on the NWL is treated in the strictest confidence in compliance with Data Protection legislation

Name of Client: _____ Male:
Write Name in Capital Place tick box

Date of Birth: / / Female:
DD/MM/YYYY

I have been advised and I understand that my details will be placed on the HSE National Waiting List for treatment when the following validation processes are complete:

- (a) to establish that my name is not already on a waiting list
- (b) to establish that I am not currently in receipt of treatment

I have been advised and I understand that my details will be dealt with in a confidential manner and will be kept safe and secure and that I can request my details to be removed from the NWL at any time.

I have been advised and I understand that my details will be removed from the National Waiting List, when:

- I commence treatment
- I no longer require treatment, when offered treatment
- I cannot be located by the addiction service

I have been advised and I understand that I should keep in regular contact with the Addiction Service with regard to my status on the NWL.

Signature of Client: _____ Date: / /
DD/MM/YYYY

I have explained the above to the client. A copy has been given to the client. The client has been given the opportunity to ask and verify any queries.

Signature of Staff: _____ Date: / /
DD/MM/YYYY

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Appendix 8: Central Treatment List Entry Form

CENTRAL TREATMENT LIST - ENTRY FORM.

On receipt of completed form, the patient will be entered on the Central Patient Treatment List. The list may be checked by telephoning 01 4555618. All information on this form should be filled in BLOCK LETTERS. THIS FORM SHOULD BE FILLED IN FULL. Treatment card cannot be processed without PATIENT SIGNATURE & PHOTOGRAPHS. COMPLETED FORMS TO BE RETURNED TO: CENTRAL TREATMENT LIST, NATIONAL DRUG TREATMENT CENTRE, MCCAERTHY CENTRE, 30/31 PEARNE STREET, DUBLIN 2

PATIENT DETAILS

SURNAME: _____

FIRST NAME: _____

ADDRESS: _____

DATE OF BIRTH: DAY MONTH YEAR

PATIENT GMS NO:

INSERT PHOTO

TREATMENT DETAILS

COMMENCEMENT DATE: DAY MONTH YEAR DATE DUE TO FINISH: DAY MONTH YEAR

(TICK WHERE APPROPRIATE) DETOXIFICATION: MAINTENANCE: STABILISATION: (OFFICE USE ONLY)

DISPENSING REQUIREMENTS: _____

DOCTOR/AGENCY NAME: _____

ADDRESS: _____ STAMP MAY BE USED

TELEPHONE NO: _____

DOCTOR GMS NO:

PHARMACY NAME: _____

ADDRESS: _____ STAMP MAY BE USED

TELEPHONE NO: _____

PHARMACY GMS NO:

PLEASE CENTRE PATIENT SIGNATURE
 PATIENT SIGNATURE: _____

FOR OFFICIAL USE ONLY
 PH:

For office use Only:

Initial Date Received		Processed by	
Date Cross checked with Suboxone List			
If Applicable:			
GP Co-ordinator		Liaison Pharmacist	
Date request sent to GP Co-ordinator		Date request sent to Liaison Pharmacist	
Date approved by GP Co-ordinator		Date approved by Liaison Pharmacist	
Checked			

- 1
- 2
- 3
- 4
- 5
- 6
- 7
- A
- B

Appendix 9: Drug to drug interactions with methadone

		Increase Methadone effects	Decrease Methadone Effects
Anti-infection	Antibacterial	Ciprofloxacin Clarithromycin Erythromycin	Fusidic Acid Rifampicin
	Antifungal	Fluconazole Ketoconazole	
	Antiretroviral	Delaviridine	Abacavir Amprenavir Efarvirenz Lopinavir/Ritonavir Nelfinavir Nevirapine Ritonavir
Cardiac	Ca++ channel blocker	Verapamil	
Corticosteroid			Dexamethasone
Gastrointestinal		Cimetidine Omeprazole	
Neurologic	Anti-alcohol	Disulfiram	
	Anticonvulsant		Carbamazepine Phenytoin
	Migraine	Dihydroergotamine	
Opioids			Buprenorphine Naloxane Naltrexone Pentazocine

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Appendix 9: Drug to drug interactions with methadone.19

		Increase Methadone effects	Decrease Methadone Effects
Psychiatric	Antianxiety	Diazepam	
	Antidepressant	Fluoxetine Fluvoxamine Moclobemide Nefazodone Paroxetine	
	Barbiturate		Amobarbital Butalbital Pentobarbital Phenobarbital Secobarbital
Urologic	Diuretics		Spironolactone
	Urinary acidifiers		Vitamin C (in large doses)
	Urinary alkalisers	Sodium Bicarbonate Potassium Citrate)	
Herbal drugs		Cat's Claw Chamomile Echinacea Goldenseal	St. John's Wort
Food		Grapefruit Juice	
Addictive drugs		Alcohol (Acute Use)	Alcohol (Chronic Use) Cocaine Heroin Tobacco

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Appendix 10: Drugs that may help symptoms in the end stages of detoxification (RCGP, 2010, p.19)

Symptom	Drug
Muscle cramps	Quinine sulphate normally 200 to 300 mg at night
Gastrointestinal spasm/stomach cramps	Hyoscine butylbromide (Buscopan) 10 to 20 mg qds pm
Diarrhoea	Loperamide hydrochloride (Imodium) 4mg stat, then 2 mg after each loose stool (maximum of 10mg in 24 hours)
Nausea	Metoclopramide hydrochloride 10 mg tds Note: Domperidone is not suitable due to increased risk of QT interval prolongation in patients receiving Methadone.
Anxiety	Propranolol 10 mg pm
Bone pain and headaches	Paracetamol 1 g qds, or Non-steroidal anti-inflammatory drug (NSAID) such as ibuprofen 400 mg tds after food
Sedation	Trazodone 100 to 150 mg nocte, or Diazepam 2 to 10 mg pm day and 10 mg nocte for 3 to 5 days

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Appendix 11: Different Matrices for Drug Testing, adapted from TAP 32 (SAMHSA, 2012)

MATRIX	ADVANTAGES	DISADVANTAGES
Urine	<ul style="list-style-type: none"> Available in sufficient quantities Higher concentrations of parent drugs and/or metabolites than in blood Availability of point-of-care tests (POCTs) Well-researched testing techniques 	<ul style="list-style-type: none"> Short to intermediate window of detection Easier to adulterate or substitute May require supervised collection in certain clinical/legal situations
Oral Fluid	<ul style="list-style-type: none"> Non-invasive specimen collection Easy to collect Reduced risk of adulteration Directly observed specimen collection Parent drug rather than metabolite can be the target of the assay Able to detect same-day use, in some cases Detect residual drug in the mouth 	<ul style="list-style-type: none"> Limited specimen volume Possibility of contamination from residual drug in mouth that cannot be correlated with blood concentrations Short window of detection In certain circumstances, a period of observation of 10-15 minutes is required before sampling
Hair	<ul style="list-style-type: none"> Longest window of detection May be able to detect changes in drug use over time (from 7–10 days after drug use to 3 months, depending on length of hair tested) Directly observed specimen collection Non-invasive specimen collection Easy storage and transport Difficult to adulterate or substitute Readily available sample, depending on length of hair tested 	<ul style="list-style-type: none"> Cannot detect use within the previous 7–10 days Difficult to interpret results Few laboratories available to perform testing Difficult to detect low-level use (e.g., single-use episode) May be biased in respect of hair colour Specimen can be removed by shaving
Sweat	<ul style="list-style-type: none"> Detects recent use (fewer than 24 hours with a sweat swipe) or allows for cumulative testing with the sweat patch (worn for up to 7–14 days) Non-invasive specimen collection Difficult to adulterate Requires little training to collect specimen 	<ul style="list-style-type: none"> Few facilities and limited expertise for testing Risk of accidental or deliberate removal of the sweat patch collection device Unknown effects of variable sweat excretion among individuals Only a single sweat collection patch available so multiple analyses cannot be done if needed

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Appendix 11: Different Matrices for Drug Testing, adapted from TAP 32 (SAMHSA, 2012)

Blood	<p>Generally detects recent use</p> <p>Established laboratory test method</p>	<p>Expensive</p> <p>Limited window of detection</p> <p>Invasive specimen collection (venipuncture)</p> <p>Risk of infection</p> <p>Requires training to collect specimen</p> <p>May not be an option for individual with poor venous access</p>
Breath	<p>Well-established method for alcohol testing</p> <p>Readily available</p>	<p>Used for alcohol</p> <p>Short window of detection</p> <p>May be difficult to obtain adequate sample especially with patients who are very intoxicated or uncooperative</p>

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Appendix 12: Approximate Durations of Detectability of Selected Drugs in Urine/Oral Fluid

Drug or its metabolite(s)	Duration of detection in urine	Duration of detection in oral fluid
Amphetamines including methyl amphetamine and MDMA	2 days	Between 24 and 48 hours for most drugs
Benzodiazepines:		
» Ultra-short-acting (half-life 2h) (e.g. midazolam)	12 hours	
» Short-acting (half-life 2-6h) (e.g. triazolam)	24 hours	
» Intermediate-acting (half-life 6-24h) (e.g. temazepam, chlordiazepoxide)	2-5 days	
» Long-acting (half-life 24h) (e.g. diazepam, nitrazepam)	7 days or more	
Buprenorphine/buprenorphine - naloxone and metabolites	8 days	
Cocaine metabolite	2-3 days	
Methadone (maintenance dosing)	7-9 days	
Codeine, Dihydrocodeine, Morphine	48 hours	
Propoxyphene		
Heroin is detected in urine as the metabolite 6 acetyl morphine (6am)	24 hours	
Cannabinoids		
» Single use	3-4 days	
» Moderate use (three times a week)	5-6 days	
» Heavy use (daily)	20 days	
» Chronic heavy use (> three times a day)	Up to 45 days	

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Appendix 13: Guiding principles for working with clients with Co-Occurring Disorders (COD) (SAMSHA TIP 42)

1. Employ a Recovery Perspective

- » Recovery is a long-term process of internal change, including steps forward and sometimes steps backward. Recovery recognizes that internal changes proceed through various stages.
- » Develop a treatment plan that provides for continuity of care over time.
- » Recognize that treatment may occur in different settings over time (e.g., residential, outpatient) and that much of the recovery process occurs outside of or following treatment.
- » Devise treatment interventions that are specific to the tasks and challenges faced at each stage of the co-occurring disorder recovery process.
- » Use sensible, step-wise approaches in developing and using treatment protocols. Consider markers unique to the individual's culture.

2. Adopt a Multi-problem Viewpoint

- » People with COD generally have an array of mental health, medical, substance abuse, family, housing, and social problems.
- » Services should be comprehensive to address these problems.
- » Engagement, stabilisation, treatment, and continuing care are treatment phases that can enable the clinician to offer stage-appropriate treatment protocols.

3. Address Specific Personal and Social Problems Early in Treatment

- » Approaches may incorporate case management and intensive case management to help clients find housing or handle legal and family matters.
- » Often, solving such problems is an important first step toward achieving service user engagement in continuing treatment.

4. Plan for the Client's Cognitive and Functional Impairments

- » In relatively short, highly structured treatment sessions that focus on practical life problems, present interventions compatible with the client's cognitive and functional impairments.
- » Careful assessment of such impairments such as alcohol related brain injury and a coordinated treatment plan consistent with the assessment are essential.

5. Use Support Systems

- » The mutual self-help movement, the family, the faith community, and other resources that exist within the client's community can play an invaluable role in recovery. This can be particularly true for clients with COD, as many have not enjoyed a consistently supportive environment.
- » Personal responsibility, self-management, and helping one another are the basic tenets of mutual self-help approaches.
- » Mutual self-help principles, highly valued in the substance abuse treatment field, are now widely recognized as important components in the treatment of COD.

The client with COD who successfully completes treatment must face the fragility of recovery, the toxicity of the past environment, and the negative impact of previous associates who may encourage drug or alcohol use and illicit or maladaptive behaviours. There is a need for groups and activities that support change. In this context, it is important that these clients receive support from families and significant others. There is also the need to help the client reintegrate into the community through such resources as religion, recreation, and social organizations.

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Appendix 14: Roles and responsibilities of Mental Health and Addiction Services under Children First National Guidelines (Department of Children and Youth Affairs, 2011, p.25)

- » Professionals who are treating a person with a mental health or addiction problem must consider the welfare and safety of any children in that person's family and/or children in regular contact with the person
- » Where there are concerns, these must be discussed and reported to the HSE Children and Family Services, as outlined in the standard reporting procedure
- » Professionals in the adult mental health and addiction services may find themselves assessing people who have a history of abusing or neglecting children. In such cases, the potential risk to any child with whom this person may have contact must be considered and communicated to the HSE Children and Family Services and to any other service involved in providing treatment or other assistance to the family

Where work with a family involves both the victim and the perpetrator of abuse, it is essential that efforts are coordinated and that information is shared between professionals. The child's needs must remain paramount. All decisions taken in relation to parents/carers with a mental health or addiction problem of relevance to the child's protection and welfare, such as a discharge back to their family or termination of treatment, must be communicated to the relevant HSE personnel.

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Appendix 15: Summary Tables of Vaccinations for Hepatitis A and B

Hepatitis B				
		Dose	Volume	Schedules (months unless stated)
Age 16 years and older	Engerix B	20mg	1ml	0,1,6 0,1,2,12 ¹ 0,7,21 DAYS ² + 12 months
	HBVAXPRO 10	10mg	1ml	0,1,6 0,1,2,12 ¹
Hepatitis A and B				
		Dose HAV/ HBV	Volume	Schedules (months unless stated)
Age 16 years and older	Twinrix	720IU/ 20mg	1ml	0,1,6 0,7,21 DAYS ² + 12

1: When rapid protection is required **2:** When very rapid protection is required

Anti-HBs Level	Action Required
0 or <10 mIU/ml	Non responder Test for anti-HBc* If anti-HBc negative, repeat full course of hepatitis B vaccine (use a different brand) Recheck anti-HBs remains <10 mIU/ml, person is susceptible to HBV
10-99 mIU/ml	Low response If low level anti-HBs confirmed by 2 different assays, give booster dose if at increased risk (see page 12) There is no need to retest for anti-HBs
100 mIU/ml or greater	Good response No need for further vaccine or anti-HBs Investigations

*For those who are performing exposure-prone procedures, HBsAg testing should also be carried out.

HBsAg	HBeAg	Anti-HBe	Anti-HBcIgM	Anti-HBc total	Anti-HBs	Interpretation
Neg	Neg	Neg	Neg	Neg	Neg	Susceptible to HBV
POS	POS	Neg	POS/Neg	POS/Neg	Neg	Acute HBV infection
Neg	Neg	Neg	POS	POS ¹	Neg	Recent HBV infection (HBsAg window)
POS	POS	Neg	Weak POS/Neg	POS	Neg	Chronic HBV infection ²
POS	Neg	POS/Neg	Weak POS/Neg	POS	Neg	HBeAg neg chronic HBV infection ³
Neg	Neg	POS/Neg	Neg	POS	POS/Neg	Resolved HBV infection
Neg	Neg	Neg	Neg	Neg	POS	Response to hepatitis B vaccine

Notes

- 1 Anti-HBc detected in two assays
- 2 Follow up sample required to confirm chronic HBV infection
- 3 Follow up sample required and also HBV DNA viral investigations may be required



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