ISLE OF WIGHT

YOUNG PEOPLES SUBSTANCE MISUSE SERVICES

SUBSTITUTE PRESCRIBING

Policy and Procedure

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Contents:

1. Preparation for and management of prescribing – tasks to be completed for all young people on any detoxification programme

This document has been developed by young peoples substance misuse services in accordance with SCODA policy guidelines for drug intervention 'Young People and Drugs' (1999) and the Department of Health 'Drug Misuse and Dependence: Guidelines on Clinical Management' (1999), to specifically identify and address the needs of young people in relation to substitute prescribing.

A drug treatment intervention should always be based on an assessment of the individual and be provided within the structure of a care plan.

Health Advisory Service - 2001 – The Substance of Young Needs Review 2001.

SCODA & The Children's Legal Centre -1999 – Young People and Drugs: Policy guidance for drug interventions.

SCODA – 2000 – Assessing Young People's Drug Taking: Guidance for drug services.

Department of Health – 1999 – Drug Misuse and Dependence: Guidelines on Clinical Management.

Misuse of Drugs Regulations – 2001.

Nursing and Midwifery Council – 2004 – Guidelines for the Administration of Medicines.

NHS Code of Practice on Confidentiality - 2003

Purpose

To ensure safe practices in specialist substitute prescribing for young people with a problem drug use.

To ensure that young people prescribing is kept separate from adult specialist services to reduce their exposure to adults with problematic drug use and inherent risks.

Scope

All staff working in specialist prescribing who are independent and supplementary prescribers and aims to include the provision of a period of stabilisation for problematic drug users with a view to reducing harm and/or eliminating their illicit drug use by:

- Encouraging reduction in illicit, problematic and intravenous use of substances.
- Encouraging motivation to change.
- Monitoring achievements and progress through the programme.

1.1 Multi-disciplinary intervention plans

1.1.1 Any detoxification programme needs to be carried out in the context of a well-formulated plan of patient care that considers a range of interventions for the young person and their family. Prior to commencing any prescribing programme, consideration must be given to the availability of resources that will enable the young person to progress. For example, where accommodation is not available or the young person is found to be residing with either adult entrenched and/or misusing peers, the clinician should consider delaying the onset of prescribing until these urgent factors have been addressed.

1.1.2 The patient intervention plan should include assessment, competency and consent to treatment, a description of the detoxification regime, how the regime will be monitored and suggestions for aftercare.

1.1.3 The plan should be agreed by the young person, clinical lead nurse practitioner, the parent/carer where appropriate and external agency case manager where required.

1.2 Assessment

1.2.1 All patients should have a recorded comprehensive assessment of their substance misuse that should be available to the clinician and a time booked for a pre-clinic case discussion between the worker and clinical staff to look at issues highlighted within the assessment and to consider possible treatment plans prior to the young person's first appointment. Furthermore, 2 x drug screenings should have been undertaken as part of this assessment and the results should be made available to the clinician alongside the assessment.

1.2.2 This assessment should include recorded information on the young person's drug and alcohol taking history; history of other relevant areas including family and care history; developmental history; education/employment history; mental health, general physical health, especially serious illness and accidents, hospital admissions, contact with the criminal justice system or other statutory agencies.

1.2.3 A medical examination should be carried out by the doctor, chaperoned by a practitioner of the opposite gender.

1.2.4 Urinalysis, blood testing and chest x-ray should be carried out where relevant.

1.2.5 Hepatitis and HIV status should be addressed during the assessment and access to testing or vaccination should be encouraged where appropriate.

1.2.6 Sexual health should also have been addressed during the assessment and services such as pregnancy testing can be accessed via the clinical lead nurse where appropriate.

1.3 Consent and competency

1.3.1 For those under 16 years, a doctor should record whether she/he finds the patient to be "Fraser" competent. Thereby you should record on the medical

file whether the young person has the capacity to understand the proposed treatment and its possible effects and side effects.

1.3.2 Where the patient is deemed competent, the effects and side effects of the treatment and the licensing status of any proposed medication should be explained to the patient, and a signature confirming this explanation recorded; permission should be sought to discuss their treatment with their parents.

1.3.3 Where the patient is not deemed competent then the effects and side effects of the treatment and the licensing status of any proposed medication should be explained to the patients and their parents and a signature from a parent or legal guardian recorded.

1.3.4 Detoxification regime (please refer to individual regimes for detoxification from different drugs)

1.3.5 The detoxification regime should be agreed with the young person and with the parent or guardian where appropriate.

1.3.6 A record should be kept in the patient's notes of the agreed regime, and a copy given to the patients.

Consumption of all prescribed substitute medication will be supervised (see section 1.4 Monitoring for full details) and this should be fully explained to and understood by the young person before commencement of any detoxification regime.

The young person should be made aware of what actions may be taken by the team if the young person fails to comply with the regime.

1.4 Monitoring

A plan for monitoring the young person's response should be agreed, and then the plan recorded in the notes. A copy of the treatment plan should be given to the young person and a further copy given to the caseworker to be placed on the main case file. The patient and those residing with them should be made aware of overdose risks and what to do if an emergency should occur.

If the young person is going to access a pharmacy service for daily supervised pick up purposes, you must discuss with the client the terms of the pharmacy contract and ensure that they sign the contract and abide by the expectations of the service level agreement with designated pharmacists.

If it is not in the young person's best interests to access this provision, supervision must still occur and can only be undertaken by either appropriately trained under 19's service personnel or by an agreed parental/carer figure who has attended clinical appointments and received appropriate education and guidance on the medication being prescribed, it's effects and side-effects, when it should and shouldn't be taken, how to supervise it's consumption and what to do in an emergency. This can only occur as part of the agreed treatment plan, which must be agreed with and signed by the young person and their parent/carer where appropriate.

For chaotic young people, the provision of 7 day per week supervision for an initial 2 – 3 week period may be a requirement to enable treatment to commence.

Agreement must be sought on a case-by-case basis from the Get Sorted service manager in circumstances where this is necessary.

Clinical review meetings are to be held at regular intervals, usually between one to three weeks. They will be co-ordinated by the clinical lead nurse practitioner and will involve the U19 Doctor (as the responsible medical officer), caseworker, young person and their parent/carer if appropriate.

Caseworkers should allow time before these meetings to update clinical staff on the young person's progress and circumstances to date before the young person joins the appointment. This will allow time for reflection and review to ensure that the professionals' response is appropriate and not an emotive 'knee-jerk' response.

Should caseworkers need to share information or discuss a change of circumstances with clinical staff outside of these meetings, they must liaise with Clinical Lead Nurse prescriber who will then contact the Under 19's Service Doctor if appropriate. If the Lead Nurse is not available, practitioners should contact the service doctor directly.

Withdrawal of substitute prescribing will occur when a young person continues to use illicit and/or non-prescribed drugs/medication and/or alcohol. Recommencement of prescribing services will then only be considered following full reassessment of the young person and the risks involved.
The ultimate responsibility for the provision of substitute prescribing lies with the Under 19's service Doctor as the responsible medical officer who may on evaluation, decide that the risks of prescribing are greater than the risks of not prescribing. In this situation, the Doctor will fully document his decision and will review it when necessary.

To ensure young people are clinically reviewed effectively, caseworkers must ensure that they do not arrange other appointments for the young person which clash with their time with the Doctor.

Medical records should be kept up to date on each patient seen and medical files should be accessible in the case of an emergency.

1.5 Aftercare

If the regime is not completed a plan for aftercare should still be formulated. An emphasis should be placed on securing the continued engagement of the client even if they have declined services at that time. This will be the role of the clinical nurse prescribing lead although advice may be sought from the Get Sorted Doctor by the casework practitioners regarding this vulnerable group.

When a successful regime is nearing completion, a plan for aftercare should also be formulated. The young person, parent, carer when appropriate and involved professionals should be involved in the construction of this plan. The agreed aftercare plan should be recorded.

1.6 Communication with the G.P.

The patient's G.P. should be informed of each stage of the intervention plan, and asked not to initiate the prescription of opiates, benzodiazepines or other sedatives.

Where the GP is already prescribing such medication, this should be reviewed before commencing detoxification, and agreement reached over what other drugs will still be prescribed, and who will prescribe them.

If prescribing is occurring that does not reflect the guidance set out in the young person's chapter of the Guidelines on Clinical Management – Drug Misuse and Dependence (1999), the Get Sorted Doctor should advise the patient's GP to transfer the prescribing responsibility to the Get Sorted Substance Misuse Service.

A summary should be sent to the GP at the beginning and the end of treatment, and the GP should also be made aware as soon as possible of any problems.

1.7 Pregnancy

If a young woman presenting to the service is, or becomes pregnant, the clinical management of the case will be in full accordance with the "Guidelines for Clinical Practice – Substance Misuse in Pregnancy". This is a locally agreed policy between substance misuse, midwifery and children and families' services.

1.8 Additional Information

CRITERIA FOR ADMISSION TO THE PROGRAMME

1. The client has a credible history of substance use.

2. The client is registered with a GP.

3. The client provides a substance positive urine sample

4. A referral into the area who is currently prescribed a substance for the treatment of illicit drug use or

5. A referral by an out of district agency currently prescribing a substitute for the client. The client needs to be registered with a GP in this area.

6. The client is willing to consent to and accept the terms and conditions of treatment.

Note

A young person under the age of 16 years may consent to his/ her treatment is they are deemed competent under the Fraser competency guidelines, following a specific assessment. When a child under 16 years is not deemed to be competent to consent to treatment, consent must be provided by a holder of parental responsibility. Those aged 16/17 years are competent to consent to their own treatment. The more complex or intensive the treatment, the higher the test for competence.

REFERRAL SOURCES

Referrals will be accepted from:-

- The client/ family/ carer
- GP
- Statutory/ Non-statutory agencies

METHODS OF REFERRAL

Referral will be accepted by initial common assessment, referral letter, telephone and by self-presentation.

Referrals into the area of people who are currently prescribed substances for their treatment of illicit drug use will be accepted by a formal transfer letter from the previous prescriber and/or drugs worker.

PROCESS

- The process through the programme will follow the stages:-
- Initial common assessment
- Health assessment
- Urinalysis
- Case Discussion at the Team Review
- Medical assessment by Substance Misuse Team Doctor
- A letter will be sent to clients GP.

Young people are less likely to be heavily dependent and therefore drugs may be prescribed at lower doses than for heavily dependent adults. Wherever possible, substitute prescribing should be titrated to the individual.

If it is agreed that the client meets the criteria, a programme of care including type of medication/ dosage will be decided and the following process will take place:

- Allocation of key worker/ care worker
- Full explanation of the treatment programme with the client and their carer where appropriate
- Contract/ consent drawn up with the client and pharmacy collection point agreed.
- Prescription generation form is completed
- Any doctor who prescribes medication for a young person should keep his/ her GP fully informed; prescribing further medication without this information could be dangerous.

PRESCRIPTIONS

Collections

- It will be normal practice to deliver this programme in accordance with SCODA policy guidelines for drug intervention 'Young People and Drugs' (1999), with daily supervised consumption for the following reasons:
- To enable monitoring of the clients medication and dosage.
- To reduce the risk of fatality by overdose.
- To reduce leakage to other sources.
- In certain circumstances, the parent/ carer may take the responsibility for the collection, storage and administration of the substitute.

During pharmacy closures such as Sunday or bank holidays, alternative arrangements will be sought. Parents and carers will be encouraged in the involvement of storage and administration of medicine.

CONTACT ARRANGEMENTS

- Minimum contact will be weekly with the key worker or allocated co-worker for monitoring.
- The key worker will be available to the client for focussed work on specific issues which may be problematic.
- Group work will be an available option if appropriate.

MONITORING ARRANGEMENTS

Non-compliance of the monitoring process will be discussed as soon as possible at the team review.

Weekly self-reporting of illicit or problematic use of substances.

Weekly urinalysis and, if appropriate, body checks for intravenous sites. (If the individual is under 16 years of age, this must be in the presence of an appropriate adult).

Care plans should be subject to regular review, taking place at least every three months where competence can be reassessed, any new needs identified, new goals set and care plans reappraised.

TEMPORARY PRESCRIPTION CHANGES

Changes in prescribing must be assessed by the key worker, discussed at the team review in the presence of the team doctor and will be based on the clients stability, progress and good clinical practice.

QUALITY

This programme must be underpinned by a number of policies which include:

- Admission/ discharge
- Key worker
- Team review
- Prescribing protocol

BREACH OF CONDITIONS OF TREATMENT

If a client is in breach of their terms and conditions of treatment, a letter will be sent to remind them of their agreement. In the event of the client continuing to breach these terms, the clients case will be discussed at the team review as soon as possible. If a breach involves their prescription, urgent review by the prescribing doctor may be sought.

DISCHARGE

All clients will be given information about support networks on discharge from the programme.

Note: Special arrangements will be made for women who are pregnant.

- Clients reaching the age of 18 will be transferred to their local Adult Service, as soon as they are allocated a new key worker in that area.

or
- moved out of the area

or
- completed on planned reduction of their prescription

or
- the team decided to stop the prescription following breach of contract

2. Guidelines for prescribing Buprenorphine

2.1 Background

Buprenorphine is used in clients with opiate dependence, and is licensed for use in detoxification and maintenance.

It is a mixed opiate agonist/antagonist - this means it produces some of the effects of opiates, whilst blocking the effects of opiates that are taken. As it has some of the effects of opiates, it relieves withdrawal, and is said to produce a particularly gradual and smooth withdrawal.

It is taken sublingually (by dissolving under the tongue)

Fatal respiratory depression is rare with Buprenorphine, so it is relatively safe in over dose. However, it can prove fatal if taken with Benzodiazepines.

Buprenorphine does have the potential for misuse.

2.2 Detoxification

a) Which patients?
Buprenorphine may be particularly suitable for young, well-motivated patients with a short history of opiate dependency, lower levels of opiate dependence, and little previous treatment.

It could also be considered for patients with longer histories of opiate use who have experienced problems with methadone detoxification.

Buprenorphine is contraindicated in respiratory, hepatic of renal insufficiency; pregnancy or breast-feeding; acute alcoholism or delirium tremens.

It should not be used in those who have had a previous adverse reaction.

For children under 16 years, Buprenorphine is not licensed for use in detoxification programmes. However, it is licensed for use in other conditions, although it is given at lower doses than would be usual in detoxification regimes. If a young person under sixteen is assessed as needing and being suitable for detoxification using Buprenorphine, then the licensing issues should be explained to the young person (as outlined in the general guidelines for detoxification)

Buprenorphine may be the preferred treatment option for use by the Under 19's service as the safest substitute and the 'clear headedness' it provides enables the engagement of therapeutic work and the re-integration with education, training and employment.

b) **Interactions**

Buprenorphine can enhance the CNS depressive effects of other opiates; barbiturates; antidepressants including MAOIs; neuroleptics; antitussives; benzodiazepines. It should not be taken with alcohol.

c) **Dosage and Administration**

The patient should be warned that they might feel unsettled during the first few days of treatment with Buprenorphine (see 'Side Effects') BNF (2006) and 2.3.

Buprenorphine treatment can be started 6 to 8 hours after the last use of heroin or other short acting opiates.

For those using Methadone, the Methadone should be reduced to the lowest dose possible and not more than 30mg daily. The first dose of Buprenorphine is taken no less than 24 hours after the last dose of Methadone and preferably greater than 24 hours with the patient in a state of withdrawal to get the maximum therapeutic effect.

The regime starts with stabilization.

On the first day, the patient is given 4mgs of Buprenorphine and reviewed after 4 hours.

The patient should then be reviewed daily, titrating the dosing against the signs and symptoms of withdrawal. On day two the dose is increased to 16mgs per day and in increments of 4mgs per week up to a maximum of 32 mgs.

Once established, the patient should be kept on the stabilising dose until as many of the psychosocial factors that may lead to a relapse are addressed.

The dose should then be reduced as per individually agreed detoxification regime.

2.3 Monitoring and Side Effects

Monitoring

As per Section 1.4. Patients should be seen every working day during the period of stabilisation.

Buprenorphine should be prescribed daily for the first week of withdrawal, and subsequently with prescriptions for no more than three days at a time.

Side Effects

These can be difficult to distinguish from the symptoms of withdrawal

Constipation; headache; insomnia; asthenia; nausea; dizziness; postural hypo tension; sweating.

Rarely, respiratory depression; hepatic necrosis; hepatitis and hallucinations.

Mental State Assessment

It is not uncommon for clients to become aware of their true mental state after switching to and stabilising on Buprenorphine. The Get Sorted doctor should regularly assess the client's mental state and treat any mood disorder/ psychosis including insomnia with the appropriate psychotropic medications as indicated in the Associated Mental Health Issues Guidelines.

2.4 Additional Information

- Department of Health – 1999 – Drug Misuse and Dependence: Guidelines on Clinical Management
- Schering Plough – 1998 – (Subutex) High dose Buprenorphine for the Treatment of Opiate Addiction: Product monograph
- British National Formulary - 2004
- Misuse of Drugs Regulations – 2001
- Nursing and Midwifery Council – 2004 – Guidelines for the Administration of Medicines.

3. Guidelines for Prescribing Methadone

3.1 Background

Methadone is an opiate agonist. It acts at the same receptor sites as heroin, but is longer acting.

For detoxification, a liquid preparation at a concentration of 1mg/ml is usually used.

Methadone is not licensed for use in under 18's.

3.2 Dosage

The aim is to reduce withdrawal symptoms to a minimum, whilst minimising the likelihood of intoxication or overdose.

The patient's previous use of opiates, including quantity and route of administration, needs to be taken into account, together with use of other drugs such as alcohol and benzodiazepines.

Inappropriate dosing can lead to death, through cumulative toxicity.

Young people should be started on a low therapeutic dose level following full and thorough clinical assessment of their level of use.

Their status should be reviewed after 4 hours, and additional medication given if they are showing moderate or severe signs of withdrawal.

Table 1. Appropriate additional dosage of methadone, titrated against signs of withdrawal.

Severity of withdrawal	Additional dosage
Mild	None
Moderate (muscle aches and pains, pupil dilatation, nausea, yawning)	5 - 10mg
Severe (vomiting, piloerection, tachycardia, elevated blood pressure)	10 - 20mg

3.3 Monitoring

As per Section 1.4.

The young person should be seen daily until they have been established on a stabilising dose, which may take 5 to 10 days.

Once stabilised, the young person's commitment to complying with a reduction regime should be reassessed, and as much support as possible put into place to maximise the likelihood of success of such a regime.

Following stabilisation, and assessment of the young person's motivation, a slow reduction should be started, with the daily dose reduced by 5mg every one to two weeks.

Prescriptions should be written for daily dispensing, and the young person seen at least twice weekly through the period of the detoxification.

The young person's clinical nurse lead and the Get Sorted Doctor should discuss with the young person the possibility of switching to Buprenorphine once the daily maintenance dose of Methadone reaches 25mgs. per day.

If a young person is non-compliant with methadone treatment and continues to misuse substances and alcohol, immediate cessation of methadone treatment and consideration of an alternative must occur due to the high risk of potentially fatal respiratory depression.

3.4 Prescription of controlled drugs

Opiates are controlled drugs. This means that there are additional legal requirements relating to the storage and prescription of these drugs over and above those that apply to the majority of medicines. It is important for all members of the team to keep in mind that these additional legal requirements arise in part because these drugs can be particularly dangerous in their effects and their addictive properties and also because they have a high street value.

3.5 Additional Information

- Department of Health – 1999 – Drug Misuse and Dependence: Guidelines on Clinical Management
- British National Formulary - 2004
- Misuse of Drugs Regulations – 2001
- Nursing and Midwifery Council – 2006 – Standards of proficiency for nurse and midwife prescribers.

4. Guidelines for Prescribing Lofexidine

4.1 Background

Lofexidine is an alpha-2 adrenergic agonist and is a non-opiate treatment available for opiate detoxification.

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

4.2 Which patients?

Lofexidine is ideally suited for younger heroin users who neither require nor want substitution treatment. Individuals need to be well motivated with low levels of heroin use.

It is also most suited to those who have a good support network already in place and this must include a home environment appropriate for detoxification.

It is not suitable for anyone with low blood pressure as it can cause hypotension.

4.3 Detoxification Method

The initial dose of Lofexidine should be 1 tablet (200mcg) b.d. increasing this by 1–2 tablets daily up to a maximum of 12 tablets per day according to the severity of the withdrawal symptoms. Providing opiates are not used, the detoxification should take 7-10 days. At the end of this treatment period the dosage should be gradually reduced over 2-4 days to prevent the risk of rebound hypertension.

Short- term adjunct medication prescribing for symptomatic relief should be considered:

Insomnia	- Zopiclone 7.5mg po nocte
Stomach Cramps	- Quinine Sulphate 200mg bd/tds
Diarrhoea	- Loperamide 4mg po stat, then 2mg po tds
Joint/muscle pain	- Ibuprofen Gel tds to affected areas

In addition to pre-treatment checks, B.P. should be monitored ½ hour after ingestion of first dose, and then daily throughout course of treatment.

The young person should be seen daily during the course of treatment to monitor withdrawal symptoms and medication use. This time should also be utilised to provide encouragement and support to both the young person and their parent/carer. The support and involvement of the parent/carer is vital and they must be fully advised, educated, involved and supported throughout and beyond the physical detoxification process.

4.4 Additional Information

- Department of Health – 1999 – Drug Misuse and Dependence: Guidelines on Clinical Management
- British National Formulary - 2004
- Britannia Pharmaceuticals Ltd – 1996 – (Britlofex) Lofexidine HCI Fact Pack

5. Guidelines for the Prescription of Naltrexone

5.1 Background

Naltrexone is a long acting competitive antagonist at opiate receptors. It blocks the effects of other opiates, such as heroin, for up to 72 hours and can, therefore, be used as an adjunct to help maintain abstinence and to prevent a relapse in opiate dependent individuals.

If the patient uses heroin while Naltrexone is in their system, then they will not experience any effects from the heroin.

It must be explained to patients taking Naltrexone, that any attempt to overcome the blocking effect of Naltrexone can be extremely dangerous and result in fatal overdose.

Other medications containing opiates should not be prescribed whilst the patient is taking Naltrexone and in the case of acute trauma where the patient may require pain relief, the medical team must be informed of the use of Naltrexone.

Clients taking Naltrexone should carry a medical alert card.

5.2 Induction

Liver function tests should be carried out.

The patient should be free of other opiates for ten days before taking Naltrexone. This should be established by means of a hospital urine test three days prior to induction, and a urine dipstick test on the day of induction.

The patient then undergoes a Naloxone challenge test in which they are given 0.8mg of Naloxone by a subcutaneous route. They are observed for signs of opiate withdrawal for one hour, and, if no signs are present, can be started on treatment with Naltrexone.

The initial dose is 25mg Naltrexone. After 24 hours, the patient is given 50mg.

The daily maintenance dose is 50mgs per day.

5.3 Additional Information

- Department of Health – 1999 – Drug Misuse and Dependence: Guidelines on Clinical Management
- British National Formulary - 2004
- DuPont Pharma – 2001 – (Nalorex) Naltrexone Hydrochloride Fact Pack

6. Guidelines for Benzodiazepine Prescribing

6.1 Background

Benzodiazepines act as muscle relaxants, anticonvulsants, sedatives and hypnotics. This makes them very useful in the treatment of anxiety, insomnia, epilepsy, and

muscular spasm and as preliminary relaxant prior to administration of a general anaesthetic.

However, their powerful anxiolytic effect combined with their short duration of action make them potentially highly addictive. Usually, they should only be prescribed for short periods (2 – 4 weeks) to protect against the development of physical dependence.

Withdrawal of Benzodiazepines must be gradual. This is because sudden withdrawal can lead to convulsions and/or an acute confusional state resembling delirium tremens.

Within Substance Misuse Services, there are two main indications for use of Benzodiazepines, i.e. detoxification of alcohol dependent clients and management of dependence on Benzodiazepines and other hypnotics and sedatives.

6.2 Benzodiazepine Dependence and Withdrawal

Use of Benzodiazepines should be confirmed by urine testing, examination and careful history taking.

If the young person is taking a Benzodiazepine other than Diazepam, then their drug of choice should first be replaced with an equivalent dose of Diazepam. This is because Diazepam has a relatively long half-life, and so can be given once a day. It is also available in tablets of various strengths.

Table 1. Appropriate doses of common Benzodiazepines equivalent to 5mg. of Diazepam.

Drug	**Dose of Diazepam**
Chlordiazepoxide	15 mg
Diazepam	5 mg
Lorprazolam	500 microgram
Lorazepam	500 microgram
Oxazepam	15 mg
Temazepam	10 mg
Nitrazepam	5 mg

6.3 How much to prescribe

The initial dose should be less than the patient claims to be taking, with a review of the patient regularly during the first week of detoxification to ensure that they are not either being made drowsy by the prescribed medication or suffering intolerable withdrawal symptoms.
If the evidence suggests that the initial dose is too low, then an additional dose should be prescribed, and the dosage regime revised upward. If the evidence suggests that the initial dose is too high, then a dose or doses may be withheld, and the dosage regime should be revised downward.

The patient should be encouraged to divide the daily dose to minimise daytime drowsiness.

Rate of withdrawal is partly determined by the young person's ability to tolerate symptoms, but a reduction of around one eighth of the total initial dose each fortnight is a useful target.

6.4 How to prescribe

Initially, the young person should be seen daily for the first week, with prescription of Diazepam on a daily basis.

After this, the young person should be seen at least weekly for the duration of the detoxification, with prescription on a weekly basis.

6.5 Symptoms of Withdrawal and Monitoring

Patients withdrawing from Benzodiazepines can show:

Anxiety symptoms:	anxiety, sweating, insomnia, headache, tremor, nausea.
Disordered perceptions:	feelings of unreality, abnormal bodily sensations, abnormal sensation of movement, hypersensitivity to stimuli.
Major complications:	psychosis, epileptic seizures.

The patient should be asked to keep a diary of these symptoms, with additional recording of observable symptoms by the clinical nurse lead.

6.6 Additional Information

- Department of Health – 1999 – Drug Misuse and Dependence: Guidelines on Clinical Management
- British National Formulary – 2004
- Misuse of Drugs Regulations - 2001

7. Guidelines for the Clinical Management of Alcohol Detoxification

7.1 Criteria for Home Detoxification:

a. The young person must be alcohol dependent – this will be evidenced following full assessment and signs should include raised Gamma GT levels, observed physical signs of withdrawal, daily or very heavy binge drinking i.e. every other day, drinking soon after waking. Workers should visit the young person early in the day before they start drinking to observe severity of withdrawal symptoms.
b. The young person must be residing in a suitable home environment. Consideration must be given to the presence of younger siblings and the potential impact upon them of witnessing the detoxification process. The involvement of a parent/carer is a requirement for the treatment process.
c. The young person must have a full physical and psychological examination to include a full assay of blood tests.
d. The young person is motivated to stop drinking.
e. An agreed package for relapse prevention and aftercare is in place.

N.B. any past history of alcohol withdrawal fits or serious mental health problems, would preclude home detoxification as a treatment option and consideration must be given to use of in-patient detoxification facilities.

7.2 Alcohol reduction

Before attempting an alcohol detoxification utilising prescribed medication, stopping use should be tried by a controlled/managed alcohol reduction regime. This should be individually calculated following assessment of the young person's drinking.

Step 1 – initial clinical appointments should include the parent/carer who is going to be involved in supporting the young person through the detoxification process to enable them to be provided with information about the withdrawal and what symptoms would require immediate medical attention.
Step 2 – consumption should be reduced to the lowest level possible without inducing withdrawal symptoms.
Step 3 – reduce consumption to the level at which withdrawal symptoms start.
Step 4 – reduce consumption unit by unit until zero.

N.B. when designing an alcohol reduction regime with a young person, it is imperative that guidance is given on regulating the times that the alcohol is consumed so that the daily allowance is not used in one go in the early part of the day.

7.3 Detoxification using prescribed medication

If controlled/managed drinking has been unsuccessful and criteria for home detoxification are met, the following method should be used: -

- Follow step 1 as for alcohol reduction.
- Prescribe Chlordiazepoxide 10-40mg q.d.s. The medication can be cumulative so no driving, operating machinery and exercise caution generally in early part of detox. Reduce dosage steadily over 2 weeks.
- A more suitable alternative to Chlordiazepoxide for young people is Oxazepam 25-50mg po nocte. Reduce dosage steadily over 2 weeks.
- If insomnia is a problem, use Hydroxycine 25-100mg po nocte until sleep pattern is restored.
- Prescribe Multivitamins B.P.C. 1 t.d.s. and Thiamine 25mg o.d. for 2 weeks.
- Encourage adequate fluid intake.
- Encourage food but be aware that appetite may not pick up for several days.

7.4 Monitoring

The young person should be seen daily throughout a prescribed detoxification to be given daily prescription and to arrange any dose adjustments in conjunction with the doctor. Alcohol breath testing must be utilised to monitor compliance with the treatment regime. Both the young person and their parent/carer should be involved in the daily monitoring of both physical and psychological well-being.

Following successful completion of the physical detoxification, workers should encourage and support young people to remain engaged with the aftercare package, which may need to include, repeat physical and psychological assessment.

See attached forms.

7.5 Additional Information

- Health Advisory Service - 2001 – The Substance of Young Needs Review 2001
- SCODA & The Children's Legal Centre -1999 – Young People and Drugs: Policy guidance for drug interventions
- SCODA – 2000 – Assessing Young People's Drug Taking: Guidance for drug services
- British National Formulary - 2004

8. Guidelines for the Management of Associated Mental Health Issues

8.1 Mental Health Examination

This should take account of the following:

Appearance:
If a young person is unkempt and dirty, this may indicate heavy usage and psychosis or depression.
Are they intoxicated – maybe alcohol?
'Stoned' – vague, not focused – not attentive.
Excited and talkative, sleep deprived or anorexic – maybe crack usage?

Speech:
Note the rate, rhythm and if coherent. Is there pressure of speech? Is the content appropriate?

Mood – both objective and subjective:
Depression may be present with retardation, sad facies, slow response and no modulation to voice. There may be sleep disturbance, typically intermittent with early morning awakening in depression but also in withdrawal from opiates. Poor appetite, weight loss, low energy and lack of concentration may also be found with substance misuse.

Suicidal ideation – previous attempts and detailed planning with rumination is ominous and should trigger a psychiatric referral.

Psychotic depression with delusions of worthlessness and contamination needs urgent treatment. It can be difficult to distinguish a high-risk presentation from an 'acting-out' presentation. A flat affect with the absence of obvious secondary gain can sometimes help to reach a decision.

Schizophrenia can sometimes be masked by substance misuse. Here there is usually a sense of isolation in the individual, a degree of autism, an inability to use metaphors, a failure of reality testing, as well as the more obvious symptoms such as auditory hallucinations (characteristically in the third person) and delusions.

Visual hallucinations are usually part of a drug-induced psychosis.

Cognition:
Conscious level may be affected, giving rise to inattention, abstractibility and failure to focus or comprehend. The individual may have a learning disability. Brain damage due to substances may be present with short-term memory loss, disorientation in time place and finally recognition. The system of confabulation

(filling memory gaps with plausible fantasies) can indicate acute alcohol encephalopathy requiring parenteral B vitamins.

Insight:
It is a good prognostic indicator when a young person is able to take a realistic view of their situation.

Psychosocial factors:
Taking into account the young person's current situation, biography and family structure.

Psychiatric history:
Any past, current or pending mental health service involvement in addition to enquiring about any family history particularly of psychosis, suicide, bipolar disorder or substance misuse.

8.2 Management of mental health issues

Prescribing:

Olanzapine or Risperidone – for persons with drug induced psychosis.

Trazadone 75mg – 150mg po nocte – for persons using crack cocaine

Tricyclics – Lofepramine 50mg-75mg po nocte. This is less sedating with less antimuscarinic side effects than other tricyclic antidepressants. SSRI's should be avoided in the under 18 age group. Trazadone is a suitable alternative with a dose range of 75mg-150mg titrated according to symptoms.

Zopiclone 3.75mg-7.5mg po nocte, for sleep problems. Benzodiazepines should not be prescribed for this purpose.

If a young person presenting to Get Sorted clinical service provision is already under the care of a mental health physician, no prescribing of psychiatric medication will occur but U-19's service doctor will ensure full liaison between the services to address the individual's needs appropriately.

The U-19's doctor will initiate and monitor treatment where appropriate in line with service guidelines but will ensure appropriate referrals occur to address individuals longer term mental health needs.

8.3 Additional Information

- Health Advisory Service - 2001 – The Substance of Young Needs Review 2001
- SCODA & The Children's Legal Centre -1999 – Young People and Drugs: Policy guidance for drug interventions
- SCODA – 2000 – Assessing Young People's Drug Taking: Guidance for drug services
- British National Formulary - 2006

9. Guidelines for the Management of Associated Physical Health Issues

9.1 General Health Assessment

A physical examination should only be carried out with the additional presence of a qualified nurse and attention given to issue of gender.

Consideration should be given to the young person's general appearance, any loss of weight, whether the young person appears malnourished, condition of skin, examination of injection sites, heart sounds, B.P., lungs, abdomen. Signs of peripheral neuropathy. Cranial nerves - do pupils react? May alert one to syphilis. Examine Fundi.

Whether the young person is up to date with immunisations, dental and optical health should not be forgotten.

A medical history should be obtained from the young person and any significant matters verified with the parent/carer where appropriate or the G.P. Any concerns the young person has relating to their physical health should also be addressed/investigated. This may include matters relating to sexual health, B.B.V.'s and family planning, which should be handled with delicacy.

9.2 Investigations

Routine blood tests: FBC, ESR, U & E, LFT, Gamma GT, Blood sugar, Folate and Vitamin B12 may be required and should be requested in accordance with service GP liaison protocol (see section 11). Chest x-ray may be indicated and require referral to hospital by U-19 service doctor.

9.3 Treatment

Treatment for a physical condition may be initiated by the Get Sorted service doctor who will subsequently write to the young person's G.P. as per protocol to share information and request any necessary continuation of treatment.

Should the young person require referral to another agency to address their physical health needs, this is the responsibility of the Get Sorted service doctor to ensure this occurs.

Any treatment offered should take into account issues of competency and consent to treatment as detailed in Section 1.3 of this document.

9.4 Additional Information

- Health Advisory Service - 2001 – The Substance of Young Needs Review 2001
- SCODA & The Children's Legal Centre -1999 – Young People and Drugs: Policy guidance for drug interventions
- SCODA – 2000 – Assessing Young People's Drug Taking: Guidance for drug services

10. Guidelines for the clinical assessment and management of crack/ cocaine use

10.1 Background

Crack and cocaine are controlled under the Misuse of Drugs Act and is categorised as a class 'A' drug.

Crack/cocaine is not physically addictive so there is no substitution therapy available, it can however create a very strong psychological dependence. Crack and cocaine work by triggering the release of chemicals that are already present in the body – adrenaline and dopamine. It is important to note that these chemicals are part of the body's response to danger and pleasure.

10.2 Crack/cocaine Health Issues

Crack and cocaine can damage health in many ways, some of which can be fatal. Some of these risks can be increased by the way that the drug is used and also by the route of use. The bottom line is that there is no safe way to use.

Effects on the heart:

Heart failure can happen to anyone taking crack or cocaine, it does not matter how much they are taking or how long they have been using for. People who already have heart disease or heart defects are at an even greater risk. When taking crack or cocaine you can increase the risk of possibly having a heart attack by 23 times in the hour after use, especially if used in conjunction with alcohol.

Strokes and Seizures:

Strokes are thought to be caused by the constriction of blood vessels and the repeated increase in blood pressure. These combined factors can sometimes cut off the blood supply to parts of the brain (causing seizures/blackouts) and also in some cases cause delicate blood vessels to break (causing bleeding in the brain).

Respiratory System:

Crack/cocaine associated lung problems include:

Pulmonary oedema	-	Build up of fluid in the lungs
Pulmonary haemorrhage	-	Bleeding in the lungs
Pulmonary barotraumas	-	Air escaping lungs, by holding in crack smoke
Foreign bodies in lungs	-	Poor pipes, no gauze's used
'Crack' lungs	-	Cough, shortness of breath, fever, inflamed lung

Crack use can affect the cilia, which makes users more susceptible to bronchitis, pneumonia, pleurisy etc. There is also an increased risk of TB. The symptoms of TB are similar to those of heavy crack/cocaine use so may not be easily identified.

Liver Damage:

If alcohol is used in conjunction with cocaine then the stress upon the liver will become increased as cocaethylene is produced. This has potential serious consequences if the user is Hepatitis C positive.

Immune System:

Crack and cocaine impair the immune system by damaging CD4 T cells. Poor diet and unhealthy lifestyle can also contribute to a poor immune system. This should recover once the young person has stopped using.

Excited Delirium:

Excited delirium (agitated delirium) is thought to be caused by the build up of dopamine in certain areas of the brain after repeated binges of crack or cocaine. The symptoms of excited delirium include:

- Bizarre or violent behaviour
- Hyperactivity
- Hypothermia
- Extreme paranoia

And may be followed by a heart attack.

Mental Health Issues:

Psychiatric diagnosis that may be complicated by the use of crack or cocaine include:

- ADHD – cocaine may act as self medication
- Paranoia / anxiety disorders
- Bi-polar disorder
- Schizophrenia – dopamine theory may indicate possible medication action
- Depression / suicidal thoughts
- Visual and auditory hallucinations
- Compulsive and eating disorders
- Crack/cocaine induced psychosis

It is vital that full assessment of the young persons mental health is undertaken and needs addressed.

Other Health Issues:

- Stomach pains and severe digestive disorders
- Weight loss – complicated further if combined with an eating disorder.
- Kidney damage
- Skin problems
- Dehydration
- Hypothermia
- Can exacerbate asthma and increase attacks
- Complications with epilepsy and sickle cell

10.3 Treatment Interventions

Initial treatment interventions should include education about crack/cocaine, as the young person needs to understand how and why the drug works to enable them to resist.

Cognitive Behaviour Therapy – there is increasing evidence that cognitive behavioural approaches are effective interventions for stimulant users. The treatment plan should challenge the dysfunctional thinking processes associated with crack and cocaine use and address the triggers and cravings associated with the

substance misuse. It is imperative that strategies for relapse prevention are also incorporated.

Prescribed Medication – Trazadone – 75-100mg po nocte may be useful if the young person is experiencing problems with anxiety, agitation and insomnia.

10.4 Monitoring

As with any treatment plan, clinical interventions must only be considered as part of a wider, holistic plan of care.

Crack and cocaine users can move very quickly between various stages of recovery and it is important that indicators like; responses to triggers/cravings and physical and mental health are carefully monitored. This is to enable assessment of the young person's vulnerability to lapse and relapse and co-ordination of the appropriate response.

The young person should be seen by their clinical nurse lead twice weekly and reviewed clinically on a weekly basis.

10.5 Additional Information

- Health Advisory Service - 2001 – The Substance of Young Needs Review 2001
- SCODA & The Children's Legal Centre -1999 – Young People and Drugs: Policy guidance for drug interventions
- SCODA – 2000 – Assessing Young People's Drug Taking: Guidance for drug services
- National Treatment Agency – Draft 2003 – Treating Crack and Cocaine Misuse: A resource pack for treatment providers.

11. G.P. Liaison Protocol

Shared care is a model that can be applied to any close cooperative work between agencies or services, which directly improves the treatment of the individual drug misuser. It most often involves arrangements between specialist and general practitioner services. However, a multidisciplinary approach necessitates shared working across, and between, a number of different agencies and professionals within the drugs field and beyond.

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

However, due to the specialist nature of services provided by the Under 19's Substance Misuse Service, this policy will focus on the liaison between the service and GP's, utilising guidance contained in the 'Orange Book' to promote best practice.

- All practitioners when comprehensively assessing a young person will make contact with the GP to verify that the young person is registered with them, to

invite them to contribute any relevant information and to cross reference for any medical problems and/or prescribed medication. It is the key workers responsibility to ensure that this occurs.

- The clinical nurse lead will be responsible for forwarding a copy of the action plan to the GP on its completion.

- The service Doctor / Nurse Specialist will inform the GP in writing of any medication prescribed by the service to a young person and when any changes are made to dosage and/or treatment provided.

- Clinical nurse lead will ensure GP's are invited to attend/contribute to the individual clinical review process where appropriate.

- Following full clinical review, the nurse specialist will ensure a letter is sent to the GP evaluating treatment progress to date and outlining future treatment plans.

- Any requests to the GP for blood tests, continuation of non-substitute prescribing or other treatment should be put in writing by either the service Doctor or nurse specialist.

- GP's will be informed by the nurse specialist in writing of discharge plans and in the event of unplanned discharge.

- In the event of a young person refusing to see the service Doctor, but willing to see their own GP, it is the responsibility of the Clinical Lead Nurse Specialist, with the consent of the young person, to liase and negotiate with that individual client's GP regarding care provision. The intended outcome of this would be for the young person's GP to provide the medical care normally provided by the Get Sorted Service Doctor, with the full support of the Clinical Lead Nurse Specialist and advice / consultancy available from the service Doctor when required.