REPORT OF THE MEDICAL WORKING GROUP ON DRUG DEPENDENCE

GUIDELINES OF GOOD CLINICAL PRACTICE IN THE TREATMENT OF DRUG MISUSE

LONDON DHSS 1984

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***resigned 15 October 1984**

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SUMMARY

We recommend the following guidelines for good clinical practice in the treatment of drug misuse:

Guidance for all doctors (Chapter II)

1. All doctors have a responsibility to provide care for both the general health needs of drug misusers and their drug related problems (paragraphs 2-3).

2. The aim of treatment should be to help the drug misusers to deal with problems related to his or her drug misuse and eventually to achieve a drug free life (paragraphs 6-7).

3. The diagnosis of drug misuse is of central importance and every effort should be made before treatment to check that the history of drug misuse given by the patient is genuine (paragraphs 8-15). This involves:

    a. taking a careful history and conducting a physical examination (paragraph 12);

    b. testing of urine for the presence of drugs (paragraph 13);

    c. checking with the Home Office Addicts' Index (paragraph 15);

    d. arranging blood tests which may be useful in further assessment (paragraph 14).

4. Every doctor must notify the Chief Medical Officer of the Home office it he attends a patient whom he considers to be, or has reasonable grounds to suspect is, addicted to certain controlled drugs (paragraph 16).

5. Doctors and other staff should take care that no items (particularly prescription pads) of potential interest to drug misusers are left unattended or where they could easily be stolen (paragraph 18).

6. Reassurance and the prescription of non-controlled drugs may be an effective temporary measure in dealing with anxiety about anticipated withdrawal symptoms (paragraph 20).

7. When detoxification is undertaken, the doctor and the patient should have mutually agreed on the treatment regime (paragraphs 21-23 and Appendix).

8. Doctors are advised not to undertake long-term prescription of opioids unless in consultation and conjunction with a specialist in a drug treatment unit or elsewhere who has experience of this approach (paragraph 24).

Guidance for General Medical Practitioners (Chapter III)

9. Before initiating treatment of a drug misuser as a temporary or private patient, the general practitioner should, with the patient's knowledge, consult the patient's previous or current medical attendant (paragraph 2).

10. Whenever possible an appointment which allows sufficient time for a full diagnostic interview and physical examination should be offered (paragraphs 3-4).

11. At the first interview it should be made clear that treatment will not necessarily involve the prescribing of opioids or barbiturates nor will it involve long term maintenance prescribing (paragraph 5).

12. Depending on the interview time available immediate treatment of medical conditions, arrangements for specialist investigations and notification should precede a full assessment (paragraphs 6-11).

13. Referral to the local drug treatment unit and where appropriate to local authority social services or voluntary agencies should be considered (paragraph 13).

14. Following the diagnostic interview further consultations should be offered (paragraph 14).

15. If a decision to prescribe opioids is made, certain precautions are recommended (paragraph 15).

16. Pregnant women dependent on opioids need particular management and treatment (paragraphs 17-18).

17. Babies born to drug dependent mothers require careful supervision (paragraph 19).

Guidance for Psychiatrists (Chapter IV)

18. It is the responsibility of psychiatrists to ensure adequate arrangements for the necessary treatment and continuing care of those drug misusers referred to them, and in particular to provide advice and support for general practitioners in areas where there is no specialist drug treatment unit (paragraphs 1-3).

19. Psychiatrists should undertake the supervision and treatment of difficult or unstable drug misusers, including those dependent on barbiturates, in cooperation with the referring practitioner and other appropriate and available services. For more stable drug misusers the possibility of shared care with the general practitioner should be considered (paragraph 4).

20. The need for emergency admission of pregnant drug misusers to obstetric units and of barbiturate dependent patients for detoxification should be recognised, as should the need for early assessment and inpatient treatment of motivated opioid misusers who cannot tolerate withdrawal in the community (paragraph 5).

21. It is unwise to admit more than two or three drug misusers at any one time to a ward of a general psychiatric unit. Clear ward policies should be established and these should be explained to and agreed by the patient before admission (paragraph 6).

22. In-patient treatment should work towards reintegrating the drug misuser into the community and should involve detoxification, counselling of the patient, family, and friends, and help, or referral for help, with social and legal problems (paragraph 7).

23. Continued care after discharge, whether by outpatient attendance, by community based professionals or in residential accommodation, is essential and should be arranged before discharge (paragraphs 8-9).

Guidance for Casualty Officers (Chapter V)

24. It is important that in cases of drug misuse casualty officers should undertake preliminary investigations to determine the drug status of the patient, and should notify the Chief Medical Officer of the Home Office (paragraphs 1-2).

25. If the patient is willing and motivated, admission for treatment of medical complications and withdrawal from the drug of dependence is often the most appropriate response. If not, the casualty officer should treat the medical conditions of immediate concern and offer referral to other services for assessment and treatment of the drug misuse but should not prescribe controlled drugs (paragraph 3).

26. The patient's general practitioner should be informed of any patient attending a casualty department and given full information about any referral or treatment (paragraph 5).

27. Overnight admission to hospital is required for patients who are brought to hospital following an overdose, or are sufficiently disturbed to require sedation (paragraphs 6-7).

Guidance for Other Hospital Based Staff (Chapter VI)

28. The consultant staff of a hospital should all be involved in a coordinated effort to manage and treat drug misusers (paragraph 1).

29. It is important that expert advice about drug misuse is made available to all hospital staff to improve understanding of the problem and alert them to appropriate management procedures (paragraph 2).

30. If no expert advice is immediately available, an urgent referral should be made to the nearest specialist resource for advice on treatment and management (paragraph 4).

31. Acutely ill drug misusers requiring analgesics for the relief of organic pain will often need higher than the usual doses. Previous drug misuse is also an indication for a longer period of analgesic relief, and a more gradual reduction in dose, than for an otherwise comparable patient (paragraph 5).

Guidance for Police Surgeons and Prison Medical Officers (Chapter VII)

32. A drug misuser who has been detained should be seen as soon as possible by a medical practitioner for assessment (paragraph 2).

33. Police surgeons have a responsibility to alert police officers with whom they work to the potential problems of drug misuse, and of the need for observation and supervision (paragraph 3).

34. Drug misusers newly admitted to prison who have previously been receiving prescriptions for controlled drugs should be offered controlled detoxification (paragraph 4).

35. For those serving short sentences sympathetic consideration should be given to allowing continued visits from previous medical and other professional staff. Long-term prisoners should, if they wish, be referred to continued psychiatric or other appropriate support (paragraph 5).

36. In the pre-release period, the prison medical officer has a responsibility to warn ex-drug misusers of the potential danger of accidental overdose, arising from loss of tolerance during enforced abstinence (paragraph 6).

I INTRODUCTION

1. The Medical Working Group was set up by the Department of Health and Social Security as part of the response to the Treatment and Rehabilitation Report of the Advisory Council on the Misuse of Drugs (published in December 1982)[+], and on the recommendation of a Conference of representatives of a wide range of medical organisations, convened by the Secretary of State for Social Services in January 1983 to provide an early opportunity for the profession to consider its response to the Report.

2. Dr Philip Connell was invited by the Chief Medical Officer to be chairman of the Group. The membership of the Group was drawn from nominations, invited by DHSS, from representative medical bodies* and individuals with expertise. The Group had 6 one day meetings from February 1984 to July 1984.

Terms of Reference

3. We were asked to report within six months and were given the following terms of reference:

i. To prepare guidelines of good clinical practice in the treatment of drug dependence, for dissemination to the medical profession.

ii. To consider the feasibility of the extension of licensing restrictions in the treatment of drug dependence to include all opioid drugs:

a. in conjunction with the above;

b. taking into account the full range of views expressed on these recommendations in the Treatment and Rehabilitation Report of the Advisory Council;

c. in the light of present resources and of possible future developments.

This Report is confined to setting out our guidance on good clinical practice in the treatment of drug misusers. Our views on licensing will be the subject of separate advice to the Secretary of State for Social Services.

Background

4. The Treatment and Rehabilitation Report of the Advisory Council on the Misuse of Drugs established broad principles of a comprehensive approach to future management and treatment, in the light of the changing nature of the drug problem and the wide variety and increasing number of people now involved in drug misuse. The Report also recommended that guidelines should be prepared on good medical practice in the treatment of drug misuse and that these guidelines would help to identify those cases where prescribing practice might be regarded as irresponsible.

5. These recommendations received wide support at the Medical Conference in January 1983 and elsewhere in the profession. They have also been reaffirmed by the Advisory Council in their Prevention Report++ (paragraph 4.18), which was published while we were preparing this guidance. We endorse the need to provide clear guidelines to help doctors to contribute effectively to 'the need for a coordinated multidisciplinary approach, with the lead being taken by the profession or discipline most appropriate to the individual case' [Treatment and Rehabilitation Report, paragraph 5.5].

6. We appreciate that doctors are working in widely differing situations. Some may not have access to the support services we later commend. Nevertheless we have tried to prepare flexible guidelines to help all doctors, within the context of their own clinical practice, to provide an appropriate and constructive response based on their clinical judgment of the needs and circumstances of the individual patient. We envisage that the broad principles set out in these guidelines could usefully form a basis on which good clinical practice can be assessed.

General Considerations

7. We prepared our report against a background of increasing drug misuse. In 1983 the number of addicts** notified for the first time to the Chief Medical Officer of the Home Office was about 4,200 (50% more than in 1982), and the number of notifications of former addicts in 1983 was about 1,700 (28% more than in 1982). The number of addicts known to be receiving notifiable drugs from medical practitioners in treatment of their

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+ Treatment and Rehabilitation. Report of the Advisory Council on the Misuse of Drugs. (1982). HMSO.

* The General Medical Council, the Royal College of General Practitioners, the Royal College of Psychiatrists, the Joint Consultants' Committee, the British Medical Association, the General Medical Services Committee and the Association of Independent Doctors in Addiction.

++ Prevention. Report of the Advisory Council on the Misuse of Drugs. (1984). HMSO.

** For definition of 'addict' see footnote to paragraph 16 of Chapter 11.

addiction at 31 December 1983 was about 5,000 (16% more than at 31 December 1982). Since, however, not all addicts are notified, nor are all drugs of addiction notifiable (eg amphetamines, barbiturates), the number of addicts is much greater than the figures presented by the Home Office. Indeed, the Treatment and Rehabilitation Report stated that an extrapolation of (research) findings to the whole country would suggest a number of at least 20000 opioid addicts. In addition, there may be a similar number misusing other drugs" (paragraph 4.5). This estimate based on research studies is already three years out of date, and we have no evidence to suggest this trend is not continuing.

8. No matter how high the priority given to the implementation of the services recommended in the Treatment and Rehabilitation Report, practical considerations, such as training additional staff and expanding treatment facilities, will take time. Moreover, even when specialist provision has been brought up to the level recommended in the report, generalists, including general practitioners and the general hospital services (including general psychiatry), will continue, and should be encouraged, to play a major role.

9. We therefore recognised that we faced a situation of even greater disparity between the services available and the potential call on services than that considered by members of the Advisory Council on the Misuse of Drugs, when preparing their report on treatment and rehabilitation.

10. The Treatment and Rehabilitation Report drew attention to the lack of uniformity in the views and practice of doctors treating drug misusers, not only among those in special drug treatment clinics but also among those working in other settings. We believe there is now an emerging consensus and recognition that many drug misusers respond positively to appropriate treatment and rehabilitation. One particular concern, when the treatment includes prescribing controlled drugs, is to avoid overprescribing, and this danger exists irrespective of the situation in which the doctor prescribes. We therefore considered carefully the comments on prescribing safeguards in the Treatment and Rehabilitation Report (Chapter 7, pp 51-56) and the Prevention Report (paragraph 4.18, 34), as well as the views of consultants working in London Drug Dependence Clinics (British Medical Journal (1984) *288*, 767-769).

11. Our report emphasises the misuse of opioids, since this problem has caused major concern, but the principles we have outlined apply to many other forms of drug misuse.

II GENERAL GUIDANCE FOR ALL DOCTORS

1. The management and treatment of drug misusers present medical practitioners with special problems and challenges. With the geographical spread and increase of the problem through the country, many doctors, particularly casualty officers, general practitioners, and psychiatrists, are seeing patients in whom drug misuse is a problem. Few have had any experience of this work, and even fewer have had any specific training.

2. We believe that the preconceived idea that these patients are difficult and unrewarding perpetuates the lack of care and help provided for them. Research suggests that in time many will achieve increased stability in their lives and ultimate abstinence.

3. Drug misusers, like other patients, are entitled to all the services provided by the NHS. We are concerned to learn that some doctors, both in general practice and in the hospital services, are unwilling or reluctant to see drug misusers or advise on drug related problems, particularly in those areas where there are no specialist facilities or where referrals cannot easily be met by such services. It is the responsibility of all doctors to provide care for both general health needs and drug related problems, as they would for patients with other relapsing conditions.

4. We emphasise that, as well as treatment within the health service, a range of other facilities is provided by statutory and voluntary agencies, which in some cases will be the more appropriate response to the needs of the individual and his family.

5. We stress throughout our report the importance of support services. These may be community based, including probation officers, social workers, or other professionals working in the health and local authority services or voluntary agencies, or may be hospital based specialist drug treatment centres and laboratory facilities.

Principles of Treatment

6. We are concerned that 'treatment' seems to have become synonymous with prescribing the drug of dependence or a substitute. By treatment we mean the care of the drug misuser, not just drug treatment. We support the view expressed in the Treatment and Rehabilitation Report that doctors should try to deal with the problems of the person who is misusing a drug or drugs rather than concentrate on the drug-orientated approach. Treatment may or may not, depending on individual circumstances, include the prescription of a controlled drug, but, in our view, treatment is much more than this.

7. The aim of treatment is to help the individual to deal with problems causing as well as caused by his drug use, and eventually to achieve a drug free life. The role of support services, including family and friends, may be paramount in helping with problems of accommodation, employment and personal relationships.

8. Drug misusers are referred to a doctor by a variety of routes. They may be referred by a social worker, police officer, probation officer or other professional worker in a statutory or voluntary agency. In some cases there may be an impending court case. Others are referred by relatives or friends, who may accompany the patient to the surgery or hospital. Others are self-referred, seeking help for withdrawal symptoms, for drug related physical conditions such as abscesses, phlebitis or hepatitis, or to get off drugs. Many patients assume that a prescription is all that is required.

9. Some drug misusers may present with spurious physical symptoms, eg backache or dysmenorrhoea, hoping to obtain a prescription for the desired drug. Of those who claim to be involved in drug misuse, some are not taking drugs but hope to obtain a prescription for drugs which they will sell on the black market. Of those who receive a prescription, many may hope to receive more than they will use themselves, and will sell the excess to others.

10. Drug misusers are a heterogeneous group. They include:-

a. People, often adolescents, experimenting with drugs or taking them intermittently, who may not be physically dependent at the time of referral, and may have no major problems. They are, however, at risk of increasing the frequency of their use and thus potentially developing psychological and/or physical dependence with its related problems. They are also at risk of acute medical emergencies, including overdose.

b. Psychologically and/or physically dependent misusers whose lives are centred on drugs. They are often involved in a drug subculture, and usually have many related problems.

c. Stable drug users who are psychologically and/or physically dependent on opioids or other drugs which may initially have been prescribed to treat physical disorders. They rarely have associated problems and may require continued medication for the underlying organic condition. Within this small group of therapeutic addicts, however, is a minority whose main need has become their desire for drugs. Symptoms may be complained of which are no longer present. Identification, assessment, and treatment, of these patients may be difficult. They may also have additional social and legal problems.

d. Some long-term drug users may have initially obtained controlled drugs for the treatment of their addiction or may have always obtained their supply from illicit sources. They may nevertheless have maintained stability in their social and working lives, but may present with anticipated or current legal problems.

11. As well as the assessment of problems and symptoms in the patient, the diagnosis of drug use itself is of central importance. Before treatment is initiated, every effort should be made to check that the history of drug use given by the patient is genuine. Information from other informants, including family, friends and other professionals involved, may be of considerable value.

12. A careful history and physical examination is essential. lnjection marks over veins may be significant. Skin puncture marks in other areas may suggest intramuscular or subcutaneous use, or may be artefacts. Pigmentation or signs of past or present abscesses are significant. Examination for injection sites should include the arms, legs, groin and neck. For opioid drugs, pinpoint pupils which do not react to light are a valuable sign, and a small pupil which reacts sluggishly to light is suggestive. With multiple drug use, however, the sign may be absent.

13. lt has to be recognised, however, that patients who take drugs orally, intranasally or by inhalation (such as heroin/cocaine users who sniff, 'snort' or smoke) present a more difficult diagnostic problem which can only be clarified with any certainty by biochemical tests. An important corroborative diagnostic procedure is the testing of urine for the presence of drugs, although doctors should recognise that some drug misusers may attempt to falsify urine samples to give misleading results. Whenever possible the urine sample should be collected under observation, and random samples are valuable.

14. lt is essential when sending urine for tests to request a wide screen of drugs, including opioids, barbiturates, amphetamines, alcohol and minor tranquillisers, and not limit the enquiry to the drug use claimed by patient. Blood tests can also be of value in assessment, particularly for levels of barbiturate and minor tranquillisers.

15. A further aid to diagnosis is the *Home Office Addicts Index*, which contains information about addicts and forms a confidential data resource not available to the executive branch of law enforcement (police, customs, embassies etc). If the patient has previously been notified, the index will give information about the names of previous medical attendants, who can thus be contacted for information about the past history of drug misuse and treatment. Enquiries can be made by telephone but information is only available to doctors, on a call-back system following checks made by the Home Office Drugs Branch on the authenticity of the enquirer.[ϕ]

Notification

16. The Misuse of Drugs (Notification of and Supply to Addicts) Regulations 1973 require any doctor to notify the Chief Medical Officer of the Home Office in writing within 7 days if he attends a patient whom he considers to be, or has reasonable grounds to suspect is, addicted to any of the following controlled drugs: cocaine, dextromoramide (Palfium), diamorphine (heroin, dipipanone (a constituent of Diconal, hydrocodone, hydromorphone, levorphanol, methadone (Physeptone, morphine, opium, oxycodone, pethidine, phenazocine and piritramide. Papaveretum (Omnopon), which contains morphine, should also be notified.* Failure to notify within 7 days can result in disciplinary action against the doctor. The name, address, sex, date of birth and National Health Service Number of the patient (if known, together with the date of attendance and the name of the drug or drugs concerned, must be given. Notification does not imply that a prescription has been or will be given. lt is helpful, however, if information about any drugs), notifiable or not, which the doctor has prescribed or intends to prescribe is given. These notifications are compiled in the Addicts lndex, which is used to provide epidemiological data which contribute to the development of national policies on the management of the drug problem, and as a check against notifiable drug users seeking simultaneous treatment from more than one doctor.

17. It should be remembered that only doctors with a special licence issued by the Home Secretary are allowed to administer, supply, authorise the administration or supply of, or prescribe cocaine, diamorphine or dipipanone to a person addicted to any of the drugs notifiable under the 1973 Regulations. Cocaine, diamorphine and dipipanone include their salts and any preparations or other product containing these drugs or their salts. A licence is not required if the administration of cocaine, diamorphine, or dipipanone to an addict or any other person is for the purpose of treating organic disease or injury.

ϕ **Home Office Drugs Branch, 50 Queen Anne's Gate, London SW1H 9AT**

Enquiries can be made between 9 am-5 pm on (01) 273 2213

+ The Regulations provide that a person shall be regarded as being addicted to a drug if, and only if, he has as a result of repeated administration become so dependent upon the drug that he has an overpowering desire for the administration of it to be continued.

*** Further amendments to this list may be made in future legislation.**

Security

18. Recognising the persistence of some drug misusers seeking drugs of dependence and the inexperience of some doctors whose help is sought, we advise that every precaution should be taken to avoid leaving items of interest to drug misusers unattended. Doctors and other staff, whether in a general practitioner's surgery, hospital clinic, or casualty department, should be aware of the need for vigilance to avoid the risk of theft of drugs, prescription pads, syringes, and headed notepaper. This is of particular importance where frequent staff changes occur. Additional useful suggestions about improving security are listed, in the British National Formulary in the section dealing with Controlled Drugs. ln the relatively rare instances of the drug misuser adopting a threatening attitude the police should be informed.

Prescribing

19. The Misuse of Drugs Regulations 1985 require that prescriptions for controlled drugs listed in schedules 1, 2 or 3 (except phenobarbitone, sodium phenobarbitone and preparations containing them) must be in ink or otherwise indelible and must be signed by the doctor with his usual signature and dated by him. The patients name and address, the dose to be taken, the form and, where appropriate, strength of a preparation and the total quantity or, in the case of a preparation, the number of dosage units must be in the doctors own handwriting. If a prescription is to be dispensed by instalments, the prescription must also specify in the doctors own handwriting the number of instalments, the intervals to be observed, and the amount of the instalments. In all cases the total quantity or number of dosage units must be written in both words and figures.

20. Simple reassurance and the prescription of non-controlled drugs may be helpful and effective in alleviating the patients anticipated anxiety about withdrawal symptoms, until a full assessment has been completed. We advise that only in exceptional circumstances should controlled drugs be prescribed initially.

21. *Detoxification:* The term detoxification refers to the gradual withdrawal of an opioid or barbiturate drug either by the use of the same drug or a similar drug in decreasing doses, or by the use of other drugs not directly comparable. Guidelines for detoxification are presented in the Appendix.

22. It is important that, when detoxification is undertaken, it is made clear to the patient what the doctor is going to do. An agreement or contract should initially be established between the doctor and the patient as to what they have mutually agreed to undertake. During detoxification it is not uncommon for patients to find they cannot cope with the agreed withdrawal schedule. If the doctor is persuaded either to protract or to delay withdrawal unduly, a maintenance regime may be unwittingly established, or even an overall increase in the drug dosage.

23. In this situation the rate of withdrawal may require a renegotiation of the initial agreement, depending on the circumstances of the patient. In the event of repeated failures, either because the patient continues to use illicit drugs or because of unreasonable behaviour, the doctor may decide not to prescribe. Until further referral or transfer of the patient is arranged, however, continued medical care remains the responsibility of the doctor.

24. *Maintenance:* We consider that a doctor should not undertake to treat drug misusers by long-term prescription of opioids unless in consultation and conjunction with a specialist in a drug treatment clinic or elsewhere who has experience of this approach.

III GUIDANCE FOR GENERAL MEDICAL PRACTITIONERS

1. General practitioners are increasingly likely to see patients presenting with drug related problems in view of the increasing incidence of opioid addiction. We wish to encourage as many general practitioners as possible to treat these patients and to help them in every possible way, and also to encourage psychiatrists and drug dependence consultants to provide advice when requested. The following considerations, in addition to the general guidance in Chapter 11, are of particular relevance to those who may be working in areas with limited support services and whose training and experience is unlikely to have included problems of drug misuse.

2. Many drug misusers are not registered with a general practitioner, and may seek treatment as temporary or private patients. In accepting patients for treatment in these circumstances, the general practitioner should be aware of the possibility that the patient may have registered simultaneously with other doctors to ensure a regular supply of drugs. Before initiating treatment, including prescribing, the doctor should with the patient's knowledge consult the patient's previous or current medical attendant whether in general practice or a clinic, as is usual medical practice. At this stage the Addicts lndex, referred to on page 6, may be of help.

The first consultation

3. The nature of the first consultation will depend upon whether or not the general practitioner is aware that the patient is seeking advice about drug related problems. If this is known, it may be helpful to offer a long appointment which allows enough time for a full diagnostic interview and physical examination. Concerned relatives or professionals already involved should be encouraged to attend with the patient.

4. In many cases, however, the patient is likely to attend without forewarning of the problem. In these circumstances we suggest that doctors provide what help they can in the time available and offer a further interview as soon as possible, explaining to the patient and his family the need for a fuller evaluation of the problem before deciding on appropriate longer term treatment.

5. We strongly recommend that the general practitioner should explain clearly and sympathetically at the first interview that treatment will not necessarily involve prescribing of opioids or barbiturates, and will certainly not involve long-term maintenance prescribing.

6. At the first interview advice and any immediate treatment for medical conditions should be given. Where necessary, arrangements for special investigations should be made, eg liver function tests, screening for hepatitis B, and screening of urine for drugs.

7. We recommend that the patient is informed in due course of the doctors statutory requirement to notify the Chief Medical Officer of the Home Office of the patients drug addiction (see Chapter 11, paragraph 16). At the same time it is most important that the patient is reassured that such notifications are within the strict rules of medical confidentiality, and that the information is not available to the police or other law enforcement agencies.

Diagnostic Consultation

8. At the main diagnostic interview (which may occasionally be the first interview) the general practitioner is advised, as in all general medical consultations, to take a history and conduct a physical examination. Every effort should be made to check the history of drug use presented by the patient, as discussed in Chapter 11.

9. Even when a specimen of urine for drug screening has been obtained at a previous interview, one should be obtained at the diagnostic consultation, Whenever possible, the specimen should be passed under observation by the doctor or nurse, to avoid the possibility of an adulterated sample. The results of urine drug screening should be considered in conjunction with all the other available information, since the results of a urine test alone may be misleading.

10. It is also advisable to screen for hepatitis B, to exclude the presence of an infection or a carrier state.

11. Advice on the collection and transport of blood and urine samples should be sought from the local hospital laboratory services. To avoid the risk of infection, adequate precautions should be taken against contamination during venepuncture, and leakage from the container during transport. Containers should be appropriately marked with warning labels.

Treatment

12. For the young intermittent drug misuser, counselling about drug misuse and personal and family problems may be the most appropriate and effective response to his needs and those of his parents or family.

13. The aim of treatment for the physically dependent patient is to encourage a drug-free life, which in many cases will involve a change of lifestyle. Where facilities are available, referral to the local drug dependence clinic should be offered. Depending on the problems presented by the patient, referral to other specialist health services or to local authority social services or voluntary agencies may be recommended. It is important for the general

practitioner to be aware of local and national counselling services in this field, and that local medical organisations keep such information available. Local information may be available from the Secretary of the District Drug Advisory Committee, where established, as recommended in the Treatment and Rehabilitation Report.

14. We consider that the general practitioner should offer continuing care following the diagnostic interview. This should involve further assessment where necessary, continued counselling of the patient and family, and general medical care. The counselling could be undertaken by another member of the primary health team in cooperation with the doctor, over a series of appointments.

15. Drug misuse, even with some degree of dependence, is not in itself an indication to prescribe (see Chapter 11, paragraphs 20-24). If, however, opioid drugs are prescribed, we strongly recommend that liquid oral preparations (eg methadone mixture D.F. 1 mg/ml) are preferable to avoid the risks associated with injecting crushed tablets or melted suppositories, and also to reduce the potential for sale on the black market. Prescriptions should be given for a short period. Whenever possible the prescription should be sent or delivered to a local pharmacist rather than given to the patient, and arrangements made with the pharmacist to dispense, at least initially, on a daily basis. In a group practice, other colleagues need to be informed, to avoid double prescribing. The patient should be seen on each occasion by the prescribing doctor or a fully informed colleague. Prescriptions should not be left for collection from a receptionist. Full and accurate records of all prescriptions must be kept.

16. Withdrawal symptoms related to opioid use include running eyes and nose, agitation, muscle and stomach cramps, and insomnia. Except in heavily dependent misusers, these may not occur, or may be no more severe than a ‘flu-like’ condition. Many misusers experience severe anxiety in anticipation of withdrawal symptoms and others may exaggerate their symptoms in the hope of obtaining an opioid prescription. Temporary emergency treatment with non-controlled drugs may be considered, combined with simple reassurance, which is often valuable and effective. (For further details see the Appendix.)

Pregnant Women Dependent on Opioids

17. Pregnant women dependent on opioids should be referred to the obstetrician as an emergency for assessment for drug needs and possible detoxification or maintenance. The prescribing of opioids to such patients must be primarily considered in terms of the welfare of the fetus. Abrupt withdrawal of opioids may cause premature labour, foetal distress or death. It may be necessary for the general practitioner to prescribe oral methadone in consultation with the obstetrician or others involved pending admission, but any such prescribing should not be allowed to defer admission.

18. Some women are anxious about the involvement of statutory services, once their drug status is known. To maintain the welfare of the fetus recognition of these fears and sympathetic understanding of the mother is important. Domiciliary antenatal care may be essential for these patients because of the difficulties they may experience in keeping hospital appointments.

19. After birth the baby of a drug misuser needs immediate skilled paediatric care. Such babies are vulnerable to infection and irritable for some considerable time. Carefully planned post-natal care for both mother and baby, including the provision of adequate accommodation, is essential. Continuing support is often best provided by the general practitioner in cooperation with the health visitor.

IV GUIDANCE FOR PSYCHIATRSTS

1. Few psychiatrists have any specific training or wide experience in the treatment of drug misuse. Even fewer work in drug treatment units. Despite the fact that drug misusers are often no more or less difficult to manage than other psychiatric patients, some psychiatrists appear reluctant to accept them for treatment. The deficiencies in training are discussed in Chapter 8 of the Treatment and Rehabilitation Report.

2. The responsibilities and legal requirements of psychiatrists, including notification, diagnostic procedures and clinical assessment, are identical to those of general practitioners. With potentially more ready access to resources, including a multidisciplinary team, laboratory facilities and community services, psychiatrists are in a particularly responsible position in the field of drug misuse.

3. We consider it is their responsibility to ensure adequate arrangements for the necessary treatment and continuing care of those drug misusers referred to them. In particular, in those areas where no specialist drug treatment unit exists, they should provide advice and support for general practitioners. They should have knowledge of available local and national resources, and should seek to establish cooperative links with other statutory and voluntary agencies.

4. In psychiatry, as in other fields, the safeguards relating to prescribing, detailed in Chapter 11, should be observed. Supervision and treatment of difficult or unstable drug users, including those dependent on barbiturates, should be undertaken primarily by the hospital based team, in cooperation with the referring practitioner and other appropriate and available services in the community. Options include admission to hospital, treatment as a day patient, or treatment on an outpatient basis, depending on the facilities available. For more stable users the possibility of shared care with the general practitioner should be considered. In such cases, however, it is essential to establish clear agreement as to whether any controlled drugs will be prescribed and, if so, who will be responsible and what regime will be followed.

5. The need for emergency admission of pregnant drug users to obstetric units and of barbiturate dependent patients for detoxification should be recognised. Early assessment and inpatient treatment may also be essential for motivated opioid users who cannot tolerate withdrawal in the community.

6. We consider that it is usually unwise to admit more than two or three drug misusers at any one time to a ward of a general psychiatric unit. Clear ward policies should be established, and should be explained to and agreed by the patient before admission. The need for these policies should be presented as being in the individuals long-term interests. They should probably include the status and number of visitors, searching patients, and visitors with their permission, for illicit drugs and alcohol, random urine drug screens, and sanctions to be imposed in the event of failure to observe agreed treatment plans.

7. In addition to detoxification, assistance with social and legal problems should be initiated in cooperation with the social worker, general practitioner and other relevant statutory services or voluntary agencies. lnpatient treatment should work towards reintegrating the misuser into the community. Family and friends should be offered help to understand the problem and to accept the aim of the treatment, and given support so that they can give effective aftercare. Family therapy may be appropriate in some cases.

8. Continued follow-up after discharge, whether by outpatient attendance or by community based professionals such as community psychiatric nurses, is essential to help the individual maintain a drug free life and hence improve prospects for employment, social life, and integration into the family. To achieve this a coordinated approach is required, which may be reinforced by having an occasional case conference with all the professionals involved. For some people this contact and coordinated long-term management may be necessary for several years to provide continued support and effective early intervention if relapse occurs,

9. For others, residential care in hostel accommodation or in rehabilitation houses, which may be within either the statutory or voluntary sector, may need to be arranged to provide continued support in a drug free environment.

V GUIDANCE FOR CASUALTY OFFICERS

1. The general principles described in Chapter 1l for the diagnosis of drug misuse apply equally to doctors working in casualty department. Even though the main immediate concern may be an overdose, abscesses, septicaemia or other drug-related physical or psychiatric disorder, it is important that investigations (such as urgent urine screens for drugs) are routinely done to help to determine the drug status of the patient. The risk of a coexisting hepatitis should be recognised during assessment and treatment procedures.

2. We understand that the staff of casualty departments and those who administer them are not generally aware of their responsibilities under the Misuse of Drugs Act 1971 to notify addicts (see Chapter ll, paragraph 16). We remind doctors working in casualty departments that this compulsory requirement applies to them as to other doctors.

3. If the patient is willing and motivated, admission to hospital for treatment of medical complications and withdrawal from the drug of dependence is often the most appropriate response. A drug misuser, however, may be in an intoxicated state and be too confused to understand what treatment is being proposed. A calm and careful approach is often successful in persuading the patient to accept tranquillising medication, after which admission is more likely to be understood and agreed. If a patient is not willing to be admitted, the casualty officer should give treatment for medical conditions and offer referral to other appropriate services, but should not undertake to prescribe controlled drugs.

4. We consider that the general psychiatric or specialist drug treatment services should be organised to provide advice on emergency referrals, and to arrange for full assessment as an inpatient or outpatient subsequently.

5. The general practitioner should be informed by post of any patient attending a casualty department and given full information of any referral or treatment.

6. If a patient has been brought to hospital following an overdose, we regard the practice of early discharge following apparent recovery as dangerous. Such patients may die if more drugs are taken while they are in an intoxicated state. For these patients, and for those whose condition has been sufficiently disturbed to require sedation, overnight admission is required.

7. We understand that some hospitals have an arrangement for homeless intoxicated people to be held by the police in the cells. This seems to us to constitute an unacceptable risk to the patient and shifts responsibility to an agency not equipped with the expertise or resources to deal with medical emergencies.

VI GUIDANCE FOR OTHER HOSPITAL BASED STAFF

1. The consultant staff of a hospital, whether physicians, surgeons, virologists, obstetricians or others, should, in our view, be involved in a coordinated effort to manage and treat drug misusers both for the benefit of the patient and for the protection of society.

2. Management of a drug misuser on a general ward is often viewed with anxiety and misgiving. Discrimination against drug misusers should be avoided. It is important that expert advice is made available to all staff, both to improve understanding of the problem and to alert medical and nursing staff to the need for careful observation to prevent illicit drug use on the ward, for security precautions (see Chapter 11, paragraph 18), and for precautions during diagnostic and treatment procedures (see Chapter lll, paragraphs 8-11).

3. We understand that in many instances patients admitted with drug related conditions are either given the full dose of drug they claim to need or are given no medication to deal with withdrawal symptoms. In the first instance the individual may be discharged from hospital taking higher doses than on admission, in the second he is likely to discharge himself or to maintain himself with drugs smuggled into the hospital. The latter can result in a fatal overdose or contribute to an anaesthetic death.

4. If no expert advice is immediately available, an urgent referral should be made to the nearest specialist resource for advice on treatment and management.

5. Acutely ill drug misusers requiring analgesics for the relief of organic pain will often need higher doses because of their high tolerance to the opioid drugs. In our view it is clinically and ethically wrong to refuse analgesics because the patient is a drug misuser. Previous drug misuse may be an indication for a longer period of analgesic relief, and a more gradual reduction in dose, than in an otherwise comparable patient.

6. Surgeons and physicians should be aware of the hazards of a coexisting hepatitis (see Chapter V, paragraph 1).

VII GUIDANCE FOR POLICE SURGEONS AND PRISON MEDICAL OFFICERS

1. The general assessment procedures, including the statutory responsibility to notify, detailed in Chapter 11, are equally relevant to police surgeons and doctors working in the prison medical service in the management of recently admitted known drug misusers,

2. We consider that a drug misuser who has been detained should be seen as soon as possible by a medical practitioner for assessment. Where an individual is known to have been receiving a prescription for a controlled drug, consultation with the previous medical attendant is recommended before deciding on treatment. This is particularly relevant to individuals remanded in custody.

3. Police surgeons have a responsibility to alert police officers with whom they work to the need for adequate observation and supervision, to the dangers of overdose in custody, and to the early signs of acute withdrawal from barbiturates and the effects of combinations of drugs and alcohol. They should also ensure that police officers are fully informed of resuscitation measures should emergencies arise.

4. Drug misusers newly admitted to prison who have previously been receiving prescriptions for controlled drugs should be offered controlled detoxification. We agree with the Advisory Council's Report on Drug Dependents within the Prison System in England and Wales* 'that supervised withdrawal should take full advantage of the techniques developed by specialised units in the National Health Service'. (p13.2 iii)

5. For those serving short sentences (under one year) sympathetic consideration should be given to allowing continued visits from previous medical and other professional staff who might be involved in continued support after discharge. Long-term prisoners should, if they wish, be referred for continued psychiatric or other appropriate support.

6. In the pre-release period, the prison medical officer has a responsibility to warn ex-drug misusers of the potential danger of accidental overdose, arising from loss of tolerance during enforced abstinence.

7. In some areas parole release schemes for drug misusers have been initiated. They allow pre-release assessment by outside agencies in the statutory and voluntary sectors and lead to planned rehabilitation following discharge. We welcome this development and endorse the need for prison medical officers to keep themselves informed of such schemes. We favour further extension of this approach, in cooperation with the probation service and voluntary agencies. (Report of the Advisory Council on the Misuse of Drugs on Drug Dependents within the Prison System in England and Wales, 1980. Parole Release Scheme. 1983. SCODA,).

***Drug Dependents within the Prison System in England and Wales, Report of the Advisory Council on the Misuse of Drugs. (1980). Home Office.**

APPENDIX

MANAGING WITHDRAWAL SYMPTOMS AND DETOXIFICATION

General Principles

1. Withdrawal syndromes differ according to the particular drugs involved, the daily amounts taken, the duration of use and individual sensitivity.

2. Physical dependence is characterised by the development of tolerance, and in addition a physical withdrawal syndrome when the daily dose is stopped or abruptly reduced. Psychological dependence is most evident when drug takers fear cessation of supply of their drug. They often have an exaggerated view of the severity of withdrawal symptoms such that anxiety about withdrawal precedes actual physiological symptoms.

3. The severity and management of withdrawal symptoms is greatly influenced by psychological factors present in the treatment setting. Thus drug withdrawal regimes have optimal clinical impact when doctor and patient have got to know each other, and a basic contract about the regime has been mutually agreed. Doctor and patient must therefore be in clear agreement about the need to reduce the drug dose and the timescale of the regime. In general, it is best to respond to a patient's own determination and timescale to withdraw from drugs, rather than the doctor imposing a too speedy, or protracted regime. If a patient is eager to come off drugs quickly or abruptly, it may be better to support this clinically so as to reinforce motivation. If however the patient finds speedy withdrawal too stressful, the doctor can adjust the regime to be more gradual. Very long protracted withdrawal schedules, eg, for opioids, in excess of six months, are too close to a self perpetuating maintenance type schedule, and are to be avoided. All regimes should keep in the forefront a clear management strategy of eventual drug abstinence. _

4. During any reduction regime the patient requires encouragement and reassurance. The need for psychological support provided by the doctor friends and family members, or an associated counselling agency, cannot be over emphasised.

5. Both during and after withdrawal the need to anticipate longer term treatment and rehabilitation is essential.

Establishing a baseline daily dosage

6. A general principle for managing all detoxification regimes is the need to establish a baseline daily drug dose with the patient. This baseline is the minimum daily dose that enables stabilisation, so that the patient is objectively and subjectively free from withdrawal symptoms. The baseline dose can be calculated during a short hospital admission but in many cases it can be assessed either as an outpatient or in general practice.

Dependence on injection practice

7. Many patients more entrenched in drug taking are very dependent on injecting and injecting practice, such that dependence on the needle" is a major problem in its own right. In considering an oral prescription regime it must be recognised that oral doses which are more slowly absorbed cannot be expected to give the same euphoric effect as injected doses, and it is therefore essential to ensure that starting doses of oral medication are sufficient to guarantee comfort, and complete control of withdrawal symptoms.

Many simple adjustments in the domestic setting surrounding injection behaviour can be suggested which reduce the reinforcing nature of the needle, eg, taking oral medication in front of spouse or family members and encouraging them to actively support the patient in this new practice. Injection practice may continue during oral detoxification, but on a more intermittent basis. This should be discussed with the patient and not avoided, so that giving up the needle" is an integral part of the treatment strategy.

In some resistant cases it is appropriate to refer patients who are very needle-fixed to a psychiatric specialist with access to a clinical psychologist who can utilise behavioural and cognitive therapies in dealing with this problem.

The use of symptomatic medication

8. Some patients can be detoxified from opioid and other drugs without substitution of the addicted drug and a specific withdrawal regime. The use of non-addictive drugs for symptomatic relief may be valuable, but should only be used to enhance the psychological support offered by the doctor or others involved. They may also be helpful as an adjunct to a substitution withdrawal programme, where withdrawal symptoms are very severe. The following drugs have been found to be of particular benefit. Details of prescribing are in the British National Formulary.

a. Promethazine (Phenergan)

Promethazine, as an antihistamine with antiemetic and sedative actions, is useful for symptomatic treatment of mild physical withdrawal.

b. Propranolol (Inderal)

Propranolol is a useful drug for patients with a high degree of somatic anxiety symptoms in the withdrawal period. Doses are as recommended for general anxiety but should not continue for more than 2 weeks following a last dose in an opioid detoxification regime.

c. Diphenoxylate (Diphenoxylate and Atropine - Lomotil)

Diphenoxylate is a mild opioid with low addictive potential used in the symptomatic treatment of diarrhoea. It has little effect on anxiety and tension, but is of value when diarrhoea is a prominent symptom of opioid withdrawal. It may be used to effect with a small dose of thioridazine.

d. Thioridazine (Melleril)

Thioridazine, a phenothiazine tranquilliser with virtually no addictive potential, may be used in low doses to control anxiety about opioid withdrawal. Prescribing should not post date the last opioid dose by more than two weeks.

It is contraindicated in withdrawal from barbiturates and other sedatives.

e. Benzodiazepines

These drugs have a high addictive potential in dependent patients and prescription should preferably be avoided. If prescribed, they should be given in small amounts for no more than one month overall, at therapeutic doses. Long acting forms, eg diazepam, may have some value in minimising the likelihood of epileptic seizures, in patients with a history of seizures in sedation withdrawal.

f. Clonidine Hydrochloride and opioid antagonists.

Clonidine hydrochloride and opioid antagonists may be used by experienced practitioners in an inpatient setting. They are not suitable for general practice prescribing.

Opioid Drug Stabilisation and Withdrawal Regimes in Hospital

9. High dose opiate misusers, or those with other severe physical or psychiatric pathology, may best be assessed, and a baseline daily dose established, in hospital.

The drug of choice for prescription is oral Methadone Mixture DTF (1mgmml. There are no clinical grounds for heroin or any other opioid being prescribed unless the patient shows an allergic reaction or other intolerable side effects of Methadone.

A drug history of the preceding week's drug use, and the use of the opioid Methadone equivalents shown in Table 1, will give a reasonably accurate daily drug requirement in oral Methadone. Most patients will fall between 20-60 mgm of Methadone, and even those patients claiming high use of illicit heroin, eg, 0.5 gm - 1.5 gm (on average 30% pure heroin by weight) are usually comfortably stabilised on a daily dose of Methadone not exceeding 80 mgm.

If the patient is admitted 8 hours after his last illegal opioid drug use, 5 mgm or 10 mgm oral Methadone Mixture (1mgm1 ml) can be given by mouth as required, usually 2-4 hourly, until the patient is comfortable, alert, and stabilised. Injectable opioid drugs are not suitable for this titration, and should be avoided. The patient's opioid needs should be titrated against the clinically manifest withdrawal symptoms, eg, tachycardia, mydriasis, perspiration, rather than the psychological component.

After 72 hours, the total Methadone dose can be summated and divided to calculate a reasonable baseline daily or twice daily dose. This dose can then be used as a starting dose for an inpatient or outpatient detoxification.

TABLE 1: OPIOID EQUIVALENTS FOR PRESCRIBING

It is not possible to directly convert the effects, time duration and addictive potential of opioid based drugs to a fixed equivalent of methadone. The following table is a rough guide only*.

DRUG		METHADONE EQUIVALENT
Street Heroin	1 gramme at £60-90	80mgm (should not be attempted as outpatient)
Street Heroin	½ gramme at £35 1/4 gramme at approx 2 x £10 'bags'	40 - 60mgm 30 - 40mgm
Pharmaceutical Heroin	10mgm tablet 10mgm freeze dried ampoule 30mgm freeze dried ampoule	10mgm 10mgm 25mgm
Methadone	Physeptone ampoule 10mgm Mixture (1mgm/1ml) 10ml linctus (2mgm/5ml) 10ml suppository 50mgm 100mgm	10mgm 10mgm 5mgm 30 - 40mgm 80 - 100mgm (should not be attempted as outpatient)
Morphine	10mgm ampoule	10mgm
Diconal (dipipanone)	10mgm tablet	0 - 5mgm
DF118 (dihydrocodeine)	30mgm tablet	0 - 3mgm
Palfium (dextromoramide)	5mgm tablet	5 - 10mgm
Pethidine	25, 50mgm tablet 50mgm ampoule	3 - 5mgm 5mgm
Temgesic (buprenorphine hydrochloride)	0.2mgm tablet 0.3mgm ampoule	2.5mgm 4mgm
Fortral (pentazocine)	50mgm capsule 25mgm tablet	4mgm 2mgm
Codeine linctus 100ml Codeine phosphate	300mgm codeine phosphate 15mgm, 30mgm, 60mgm tablets	10mgm 1,2,3mgm
Actifed compound 100mgm	200mgm Codeine phosphate	6mgm
Gee's linctus 100ml	16mgm anhydrous morphine	10mgm
Dr Collis Brown 100ml	1.4% opium	10mgm

If Heroin is smoked, or inhaled (chasing the dragon), rather than injected, the methadone equivalent can be reduced by one third.

*Based on information from City Roads project, London (The Heroin street prices are those in London 1984).

Inpatient withdrawal can be effected over shorter periods, eg 4 days for less than 10 mgm Methadone, and large doses can be withdrawn over 10 days, when constant staff support is available. A slower withdrawal, however, may be employed if desirable.

A baseline dose in excess of 40 mgm may require 3 - 4 weeks in hospital,

TABLE II: IN PATIENT REGIMES FOR WITHDRAWAL OF OPIOIDS

Baseline dose in Methadone

Days	1	2	3	4	5	6	7	8	9	10
5 mgm	No prescription required									
10 mgm	10	10	6	6	3	3				
15 mgm	15	15	8	8	4	4	2	2		
20 mgm	20	20	12	12	8	8	4	4	2	2
25 mgm	25	25	15	15	8	8	4	4	2	2

Baseline doses in excess of 25 mgm should be lowered by 5 mgm every 2 days until 25 mgm is reached, and then the 10 day regime followed,

Longer term withdrawal regimes may be instituted from hospital outpatient and day patient settings where support from a multidisciplinary team is available.

Hospital practitioners can use the pink prescription form FP10HPAd) on which 14 days prescription can be written conveniently for daily dispensing (two days supply on Saturdays).*

Opioid drug stabilisation and withdrawal in general practice.

10. Certain types of patients are probably not treated ideally in a general practice setting: those with marked physical and psychiatric pathology, the socially chaotic and uncooperative patient, and some patients on very high daily doses (in excess of 0.5 gms illicit heroin. General practitioners who are very experienced in managing drug misusers can manage these high dose cases, but the average general practitioner will best refer to a hospital based service whenever possible.

Certain categories of patient are best treated in general practice. They include:

i. The, often young, intermittent drug misuser who is not physically dependent.

ii. Stable therapeutic' addicts.

iii. Those patients whose opioid drug use is less than one year’s duration, who may be sniffing or smoking illicit heroin, and who are not yet regularly injecting.

Some of these patients, particularly the low dose, highly motivated individual can be detoxified without any opioid prescription, by the use of symptomatic non-opioid prescribing (described above. However, the availability of regular support and counselling from the doctor, his clinical team, or other associated counselling agencies is of particular importance in this approach. The daily baseline opioid dose can be calculated using the Methadone equivalents in Table l, and, as in hospital practice, the drug of choice is Methadone Mixture D.T.F. (1mgm/1ml). If it is thought that the patient is grossly exaggerating his daily drug requirement, the baseline should be established at no more than 60% of the alleged dose, and usually at not more than 60 mgm of Methadone.

*As stated in the British National Formulary, the special pink form National Health Service (Scotland) H.B.P.(A) is available to hospital practitioners in Scotland for prescribing certain controlled drugs by instalments; and blue form National Health Service (Scotland) H.B.P. for supply in Scotland on only one occasion.

Where practitioners have the opportunity for closer domiciliary or surgery contact with the patent, a more objective titration of physical dependence can be made by giving the patient 10 mgm of Methadone Mixture and arranging to observe him again 4 hours later. If withdrawal is not controlled, a further 10 mgm can be given, and repeated, until physical symptoms are controlled in a series of visits over 36 hours.

In assessment, practitioners should bear in mind that the majority of patients suitable for withdrawal in general practice will be unlikely to need more than 40 mgm of Methadone daily. General practitioners can use the blue prescription form FP 10 (MDA) on which 14 days prescription can be written conveniently for daily dispensing (two days supply on Saturdays).

Specific prescribing regimes

11. a. Two week Methadone detoxification:

In general practice this regime is only suitable for a recently confirmed opioid misuser, with less than one years use, and a daily use of not more than 40 mg equivalent Methadone. The patient should have stable accommodation, with strong support from family or determined friends. Motivation needs to be high and can be encouraged by daily contact at the surgery or at the patients home to support him through any panic or anxiety and to plan further rehabilitation. Symptomatic non-opioid drug prescribing is useful but adjunctive use of benzodiazepines and similar tranquillisers should not be longer than 4 weeks and whenever possible should be avoided.

As daily prescription and dispensing will be necessary to control the dose, it is useful to write out daily prescriptions for a week's supply, and to send the prescription directly, or by post, to a pharmacist who has agreed in advance to dispense. When the regime covers Sunday, a two day dose must be dispensed on Saturday.

25mg of Methadone (25mls) should be given initially and may follow prior reduction from a higher starting level. If possible the pharmacist should maintain the volume of liquid base at 25mls per day, but for safety reasons the actual dose of Methadone must be clearly stated on each bottle. A typical course might be:

Methadone Mixture (DTF) 25mg (3 days); 20mg (3 days); 15mg (3 days); 10mg (3 days); and 5mg (3 days).

b. One to two month detoxification:

This is suitable for a rather more entrenched drug misuser with a higher daily dose, less personal and domestic support, but adequate motivation. The patient should be assessed as above, and during the detoxification regime seen once or twice weekly at home or at the surgery, to provide support and to assess progress and motivation. Where possible, occasional random urine drug screens should be sent to a local laboratory. Counselling from a social worker or other agency is recommended. Daily, or with exceptionally stable cases, twice weekly, dispensing should be arranged through the pharmacist.

A 28 day regime might be as follows

Methadone Mixture (DTF) 30mg (4 days); 25mg (3 days); 20mg (4 days); 15mg (3 days); 10mg (4 days); 6mg (3 days); 3mg (7 days). The volume of dispensed Methadone base liquid should not be less than 20 mls throughout.

A two monthly regime might be:-

Methadone Mixture (DTF) 40mg (7 days); 35mg (7 days); 30mg (7 days) 25mg (7 days); 20mg (7 days); 15mg (7 days); 10mg (7 days); 5mg (7 days). The volume of dispensed Methadone base liquid should not be less than 20mls throughout.

Adjunctive use of benzodiazepines and similar tranquillisers is to be avoided.

c. Three to six month detoxification:

Longer term detoxification regimes may be more suitable for patients with 5 years or more drug use, (of up to 0.5 gm a day illicit heroin or equivalent), or without complicated or chaotic multiple drug and alcohol misuse. These regimes should only be used for patients who are domestically stable, eg, with a family and a job, where daily attendance or a long period away at a rehabilitation residential community is not convenient, or might place the domestic situation in jeopardy.

For some patients it is useful to maintain a stable dose for a month or two months to allow them to make adjustments in their personal life, and to tackle problems related to illicit drug use. This maintenance period should not be prolonged and it should be made clear from the outset that it is only a prelude to a detoxification regime such that prescribing will terminate within a 3 or 6 month period.

Assessment, prescribing and dispensing arrangements are exactly as in shorter term regimes with an emphasis on daily dispensing.

During the contracted regime the doctor should see the patient at least once a fortnight, and arrange additional supportive counselling for him and his family with a social worker or community agency. Where possible occasional random urine drug screens should be sent to a local laboratory. Some patients find the last doses very difficult to come off and may require a short hospital admission for the final reduction.

For a baseline dose of 60mg Methadone Mixture (DTF) the reduction regime might be as follows

Methadone Mixture DTF 60mg (2 weeks; 50mg (2 weeks; 45mg (2 weeks; 40mg (2 weeks; 35mg (7 days); 30mg (7 days); 25mg (7 days); 20mg (7 days); 15mg (7 days); 10mg (7 days); 5mg (7 days). The final volume of Methadone base liquid should not be less than 20mls.

Adjunctive use of benzodiazepines and similar tranquillisers is to be avoided.

Failure to cooperate in a long term reduction regime should not be allowed to develop into the fixed prescription of long term maintenance, and the essential strategy of reduction should be therefore followed through. When detoxified patients, with or without support, relapse into illicit drug dependence, further opioid prescriptions should not be initiated without great care to recontract only for detoxification.

Barbiturates and related sedatives

12. Barbiturates and related sedative drugs, eg, glutethimide (Doriden, and chlormethiazole (Heminevrin, cause physical dependence at doses around.600mg barbiturate equivalent per day, and are associated with higher risks of morbidity and mortality during withdrawal than occurs with opioid drugs. Thus at a daily dose of 600mgms barbiturate equivalent, 1:10 patients will have a major epileptic fit following abrupt withdrawal of the drug.

Mild physical dependence on barbiturates is characterised by tremor, anxiety, weakness and insomnia, in a syndrome very similar to the alcohol dependence syndrome; and at higher doses, a hallucinatory delirium, or delirium tremens, often accompanied by epileptic seizures will occur.

lt is worth noting that after withdrawal of short acting barbiturates, convulsions occur within 2 to 3 days, whereas, after long acting barbiturates, they may not appear for 10 days.

Patients who are abusing many sedative drugs and have a chaotic life style, such that stabilising a daily drug dose of barbiturates is virtually impossible, cannot satisfactorily be helped outside a secure hospital ward setting.

Withdrawal in hospital

13. Assessment of the daily dose of short acting barbiturates is obtained from the drug history. Pentobarbitone elixir 200mgm orally is substituted, -6 hourly until the patient is stabilised, comfortable, and alert. The calculated daily baseline dose should then be maintained for 24-36 hours. Thereafter a gradual daily reduction by 10% of the total barbiturate dose, or 100mgm pentobarbitone, is established. If withdrawal symptoms occur, the dose should be maintained for 1-2 days, until the patient stabilises, before further reduction.

Throughout this regime, it is essential to have close supervision from nursing and other staff on the ward. It is not suitable for ambulant patients in a general practice setting.

Withdrawal in general practice

14. Detoxification using long acting phenobarbitone in elixir or tablet form should only be used when inpatient hospital detoxification facilities are not currently available.

Table Ill provides phenobarbitone equivalents for use in the withdrawal regime.

The patient should be seen by the outpatient doctor or general practitioner at least twice during the 8 day withdrawal regime described below, and as much extra support as possible should be arranged from family, friends, or other members of the primary health care team.

TABLE III: PHENOBARBITONE EOUIVALENTS FOR PRESCRIBING

Drug	Oral Sedative Dose	Equivalent Phenobarbitone Dose
Amylobarbitone (Amytal)	100mgm	30mgm
Butobarbitone (Soneryl)	100mgm	30mgm
Cyclobarbitone (Phanodorm)	200mgm	30mgm
Heptabarbitone (Medomin)	200mgm	30mgm
Quinalbarbitone (Seconal)	100mgm	0mgm
Quinalbarbitone & Amylobarbitone (Tuinal)	50mgm + 50mgm	30mgm
Pentobarbitone (Nembutal)	100mgm	30mgm
Glutethimide (Doriden)	250mgm	30mgm
Methyprylone (Noludar)	200mgm	30mgm
Methaqualone* (Illegally imported varieties)	250mgm	30mgm

For each 100mgm of short acting barbiturate previously taken by the drug misuser, 30 mgm of Phenobarbitone is substituted, subject to a maximum of 300 mgm Phenobarbitone daily: eg, a drug misuser who takes 9 x 100mgms Pentobarbitone (Nembutal) daily will require 9 x 30mgs Phenobarbitone 270 mgm Phenobarbitone, as an initial daily dose.

The daily reduction regime would then be

Day 1]
Day 2] **Tabs Phenobarbitone 90 mgm t.d.s.**

Day 3]
Day 4] **Tabs Phenobarbitone 60 mgm t.d.s.**

Day 5]
Day 6] **Tabs Phenobarbitone 60 mgm b.d.**

Day 7]
Day 8] **Tabs Phenobarbitone 30 mgm b.d.**

It is not necessary in most regimes to add a formal anti-convulsant such as phenytoin (Epanutin). Phenothiazines such as thioridazine (Melleril) should also be avoided as they lower the threshold for epileptic convulsions.

Heminevrin

15. Physical dependence on chlormethiazole (Heminevrin) commonly causes epileptic seizures in withdrawal, and less commonly a serious hallucinatory delirious state. Hospital admission is essential for very gradual withdrawal using chlormethiazole itself together with an adjunctive benzodiazepine anti-convulsant cover.

Following detoxification the patient is likely to experience irritability and sleep disturbance for up to 3 months. Thus continuing counselling and support by the doctor or his staff during this period will often be essential.

***No longer available in United Kingdom.**

Benzodiazepines

16. Patients can become dependent on anxiolytic and hypnotic medication that has been taken for a long time and this occurs not infrequently with benzodiazepines. Definite withdrawal symptoms are often seen in patients abruptly stopping benzodiazepines taken in normal dose for longer than 3 to 4 months. These include anxiety, tension, apprehension, dizziness, insomnia and anorexia. Most symptoms subside within 5 to 6 weeks of stopping benzodiazepine anxiolytics and hypnotics, but a few patients may have persistent or enhanced symptoms for several months.

Management of withdrawal from dependence on benzodiazepines is also difficult because the withdrawal symptoms may first occur several weeks after the last dose. These may be followed by other symptoms which may persist for months. Abrupt withdrawal can result in seizures, but, unlike those in barbiturate withdrawal, seizures in benzodiazepine withdrawal can occur from days to a few weeks after abstinence.

No patient should be abruptly withdrawn from benzodiazepines. Patients who have not experienced withdrawal symptoms, but who may be dependent should be gradually withdrawn over 4 weeks. Patients who have experienced withdrawal symptoms require sympathy, support and explanation of their symptoms with a readiness on the doctor's part to accept unusual and prolonged symptoms as withdrawal phenomena, and not as a neurotic overreaction.

TABLE IV: PHENOBARBITONE EQUIVALENT TO COMMON BENZODIAZEPINES

BENZODIAZEPINE	ORAL DOSE	EOUIVALENT PHENOBARBITONE DOSE
Chlordiazepoxide (Librium)	25mgm	30mgm
Clorazepate (Tranxene)	15mgm	30mgm
Diazepam (Valium)	15mgm	30mgm
Flurazepam (Dalmane)	30mgm	30mgm
Lorazepam (Ativan)	2mgm	30mgm
Oxazepam (Serenid)	10mgm	30mgm
Temazepam (Euhypnos, Normison)	30mgm	30mgm
Triazolam (Halcion)	0.125mgm	30mgm
Nitrazepam (Mogadon)	10mgm	30mgm
Medazepam (Nobrium)	10mgm	30mgm
Lormetazepam (Noctamid)	1 mgm	30mgm
Laprazolam (Dormonoct)	2mgm	30mgm
Ketazolam (Anxon)	30mgm	30mgm
Flunitrazepam (Rohypnol)	1 mgm	30mgm
Clobazam (Frisium)	10mgm	30mgm

a. A withdrawal schedule for 15 mgm of Diazepam or equivalent over 5 weeks would be

Tabs Diazepam 5mgm t.d.s. (1 week); 4mgm t.d.s. (1 week); 3mgm t.d.s. (1 week); 2mgm t.d.s. (1 week); 1mgm t.d.s. (1 week):

b. In a patient who has been taking a dose of benzodiazepines which is above the generally recommended dose, eg, more than 30 mgms diazepam or equivalent daily, more severe withdrawal symptoms may occur, including nausea, vomiting, tremor and a range of perceptual problems. Fits may accompany discontinuation from high doses, and psychotic features can occur, even from normal dose discontinuation.

A withdrawal schedule for 30 mgm diazepam or equivalent over a minimum period of 7 weeks would be:

Tabs Diazepam 10mgm t.d.s. (1 week); 8.5mgm t.d.s (1 week); 7mgm t.d.s. (1 week); 5.5mgm t.d.s. (1 week); 4mgm t.d.s. (1 week); 2.5mgm t.d.s. (1 week); 1mgm t.d.s. (1 week):

c. In cases of severe dependence or where the dose of benzodiazepines is well in excess of the normal daily dose the withdrawal schedule should be arranged over an even longer period, perhaps 2 to 4 months.

d. Patients who are exceedingly handicapped by withdrawal symptoms may need hospital admission and a substitution withdrawal schedule, using phenobarbitone, as described in the section on sedatives.

In severe withdrawal syndromes patients will benefit from several months of support and counselling, or attendance at a tranquilliser withdrawal self-help group.

Alcohol

17. Abrupt abstinence from alcohol usually requires tranquillisers dispensed daily to avoid risk of overdose or misuse. On balance many practitioners favour diazepam as the drug of first choice. A practical but modifiable regime is as follows;

Diazepam 10mg q.d.s. (3 days); 10mg t.d.s. (3 days); 5mg t.d.s. (2 days); 5mg b.d. (2 days).

Many patients can be ambulant, but resting through this period. Ideally, after 10 days, no further tranquillisers or hypnotic medication should be prescribed.

Many physicians and psychiatrists still favour chlormethiazole (Heminevrin) for detoxification in spite of mounting evidence of problems of dependence. For those who continue to favour this drug a suitable and modifiable regime is as follows:

Chlormethiazole 1.5gm t.d.s. (2 days); 1gm t.d.s. (2 days); 500mg t.d.s. (1 day).

This drug should not be given to problem drinkers who are not in hospital, or prescribed on a maintenance prophylactic anxiolytic basis as the dependence risks are too high in this group of patients.

Stimulants

18. Stimulants such as amphetamines, methylphenidate (Ritalin) and cocaine all cause a powerful psychological dependence but not a classical physical withdrawal syndrome. There is therefore no indication to prescribe stimulant drugs to drug misusers during the psychological withdrawal period. Many drug misusers dependent on stimulants experience insomnia and depression when they stop using the drugs, but only rarely is this prolonged so as to indicate antidepressant medication. If the depression is severe hospital admission may be the wisest course.

Other Drugs

19. Cannabis, solvents, and the hallucinogenic drugs (eg, LSD) do not commonly cause physical dependence with marked withdrawal symptoms, and therefore withdrawal regimes of substitution drugs are not indicated. Symptomatic treatment for psychological symptoms is often of value.

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Treatment and Rehabilitation: Report of the Advisory Council on the Misuse of Drugs (1982), HMSO; and

Prevention: Report of the Advisory Council on the Misuse of Drugs (1984) HMSO, are available from HMSO outlets.

Drug Dependants within the Prison System in England and Wales (1980) can be obtained on application to the Home Office. 50 Queen Annes Gate, London SW1 H 9AT.

Parole Release Scheme (1983) SCODA can be obtained from the Standing Conference on Drug Abuse, 1- 4 Hatton Place, Hatton Garden, London EC1 N 8ND.

A list of specialist non-statutory services and their addresses can also be obtained from the Standing Conference on Drug Abuse (address above).

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