TOP TIPS IN TWO MINUTES: HARM REDUCTION FOR PRIMARY CARE

National:	From news headlines you may be aware that drug related deaths (DRDs) are at their highest level since records began in 1993. The latest year for which Public Health England has data is 2015 when there were 2,300 DRDs. Most of the increase in deaths is from heroin and "accidental poisoning" rather than suicide. The reasons for the increase in deaths are multiple and debated[1][2]
Cambs:	Thankfully mortality rate in our region has remained stable over the past ten years. According to Public Health England, Cambridgeshire had 29 DRDs in 2014 and 27 in 2015. This year our Drug & Alcohol Action Team (DAAT) reviewed local deaths locally[3]. The Coroner's Office identified 48 deaths in 2015 that fitted the national DRD definition and/or included reference to drug misuse. Most deaths occurred in Cambridge City and Fenland. The pattern of Drug Related Deaths in Cambs is similar to that in England & Wales: ▪ Deaths are occurring in older, sicker drug users, typically men aged 40+. The majority had significant physical disease e.g. COPD, cirrhosis. ▪ 75% of deaths occurred in heroin users, mostly known to inject. Over two-thirds had previously overdosed. ▪ At the time death the majority were not known to drug treatment services but almost half had consulted a GP in the month prior to their death. ▪ ¾ of people had past or present problems with alcohol. Alcohol was cited as a combined cause of death with drugs in a third of cases. ▪ Polydrug use. On average, a person had four drugs (including alcohol) in their body at time of death. A quarter of deaths were attributable to mixed drug use. ▪ Deaths often involved multiple Prescription Only Medicines (POMs) in addition to illicit drugs and alcohol. There is a correlation here as the frequency with which some prescribed medicines inc. gabapentin and pregabalin are found in drug misuse deaths has risen significantly, but as yet there is no evidence such as of causation.
Relevance for Primary Care	This article will focus on what how individual GPs and practices can play a role in reducing premature mortality amongst drug users:
1) Encourage opiate users to self-refer to the local community drug service	▪ There is clear evidence that drug treatment not only improves an individual's health and reduces their risk of premature death but benefits society by lowering crime and net health costs. For many drug users, engaging with drug treatment can be the catalyst for address their physical and mental health needs. ▪ Drop-in assessment clinics run from Monday- Friday at various locations in the county; no referral or appointment is needed. If your patient is dependent on heroin and wants Rx they can usually get started on an opiate substitute within three weeks. ▪ A suggested Read code is "Informal referral - signposted to other agency"(XaXR2).
Not interested…	When a person who injects drugs (PWID) consults you they may not want to stop using drugs but can still be concerned and want to do something about their health. There are number of "harm reduction" interventions you can offer in primary care:
2) Raise awareness about "take-home naloxone"	▪ Hospitals and ambulances have used the opiate antagonist naloxone for years to reverses the effects of opioid overdose. In 2015 legislation made "naloxone kits" more widely available with the aim of reducing DRDs. Since the start of the Naloxone project in Cambridgeshire, Inclusion have handed out 700+ kits with over 35 being successfully used. ➢ Don't prescribe in primary care but signpost drug users, concerned friends and family to your local drug service where they can obtain a kit and training. Even if your patient does not wish to change their drug use they can obtain naloxone without supplying their personal details or registering with the service. ➢ Training covers recognition of overdose, basic resuscitation and how to administer the injection which comes in a little yellow box like an Epi-Pen. 
3) Don't forget to ask and advise @ alcohol & smoking	▪ People who use drugs often misuse alcohol, increasing their risk of harm through sedation and overdose. Alcohol potentiates Hepatitis C induced cirrhosis too. ▪ Up to 95% of people who use drugs smoke. Underlying respiratory disease exacerbates the respiratory complications of opiate use and leads to a higher risk of death. Smoking cessation, flu vaccination, spirometry to diagnose COPD are all valuable interventions you can offer.
4) Liver health	➢ Test- BBV inc. Hepatitis C as up to ½ of all PWID have active hepatitis C infection. Drug services offer their clients BBV testing from a finger prick and notify you of the results. Patients do slip through the net so if missed, try to do this in 1y care. ➢ Treat –Please offer referral if active Hep C infection, as new treatments are available and very effective. Drug service can directly refer to 2y care. ➢ Vaccinate- The Green Book recommends Hep A & Hep B vaccine for PWID. They have increased risk of contracting Hepatitis B. If they have chronic liver disease from alcohol or Hep C, acute infection with hepatitis A can be very severe. Raise claim for prescription via FP10.
5) POMS	▪ Exercise caution when responding to patient requests for benzodiazepines, sleeping tablets, opioid analgesics and gabapentinoids from patients with current and past addiction. ▪ The precise role of these POMs in recent DRDs is unclear. However as drug users get older, COPD, cirrhosis and occult heart disease increase vulnerability to respiratory depression, arrhythmias and accidental overdose when multiple POMs are combined with heroin and alcohol. ▪ Persons with current or past addiction might have hyperalgesia and altered drug tolerance. They may not have

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<tr><td></td><td colspan="2">developed alternative ways of coping with pain and distress. Long term disturbances in sleep are common even years after recovery from addiction. Opioid analgesics given for acute pain can precipitate relapse after years of abstinence. These medicines can be diverted and misused e.g. pregabalin has euphoric effects.
▪ GPs can feel intensely pressured to prescribe by the patient and by the lack of alternatives.
➢ If you do prescribe, please inform the drugs service doctor so they are aware of the potential for interaction & harm with any opiate substitute they are prescribing.
➢ Vice versa, it is good practice to record that your patient is being prescribed an opiate substitute from elsewhere, on the repeat prescribing view of System One or EMIS. A clinic letter from the drug service, sent at a minimum of three monthly will contain details of the drug and dose. This will remind you about important interactions e.g. prolongation of QT interval if citalopram is prescribed on top of methadone.</td></tr>
<tr><td>6) Consider providing “shared care” to your own patients</td><td colspan="2">▪ You are likely to have a handful of patients who are on methadone long term. If they are stable- medically and psychosocially, please consider “shared care”. In this arrangement, your patient remains under the care of the drug service. You prescribe methadone to your patient, with recommendation and advice from the drug service who review the patient three monthly.
▪ This frees up capacity in the drug service to work more intensively with the most complex chaotic drug users –the ones at high risk of death.
▪ Training and payment for this primary care work is paid through a Service Level Agreement.</td></tr>
<tr><td>Community Drug & Alcohol Services</td><td>Inclusion Recovery, Cambridgeshire, part of South Staffordshire & Shropshire NHS Foundation Trust,
Tel: 0300 55501010
GPwSIs in Substance Misuse, Dr John Crawford, Dr Rupinder Basi, Dr Richard Weyell, Dr Tom Wrigley and Dr Howard Blatchford work within Inclusion. You can contact Mark Buitendach who is the Clinical Lead for advice e.g. suspected dependency on POMS) and to discuss individual patients. Print out list of clinics to give your patients
http://www.inclusion-cambridgeshire.org.uk/our-services/making-a-referral</td><td>Peterborough – Aspire, part of Change, Grow, Live charity.
Tel: 01733 895624
Patients can self refer to clinics in Peterborough, Orton & Bretton.
There is a referral form on their website health professionals can use.
https://www.changegrowlive.org/content/aspire-peterborough-self-referral-form</td></tr>
<tr><td>Further Reading</td><td colspan="2">Take Home Naloxone
▪ SMMGP FreeLearn: Naloxone Saves Lives http://www.smmgp-elearning.org.uk/
▪ http://www.prenoxadinjection.com including video http://www.prenoxadinjection.com/medical/injecting.html

Misuse of Prescription Only Medicines. Various national and local pathways exist which if followed reduce the likelihood of misuse developing.
▪ RCGP have produced four factsheets on "Addiction to medicines". They can be read at the bottom of the page at http://www.rcgp.org.uk/substance-misuse
▪ The Opioid Aware toolkit is helpful if you are thinking of prescribing opiates for chronic pain http://www.rcoa.ac.uk/faculty-of-pain-medicine/opioids-aware
▪ Gabapentin/Pregabalin warning prescribers about the risk of the misuse https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/385791/PHE-NHS_England_pregabalin_and_gabapentin_advice_Dec_2014.pdf
CPCCG Safety Matters Issue 30 (Feb 2015) and Prescribing Matters Issue 2 (Oct 2013) reiterated the risks.
▪ Sedatives; Guidance for the use and reduction of misuse of benzodiazepines and other hypnotics and anxiolytics in general practice” http://www.smmgp.org.uk/download/guidance/guidance025.pdf
▪ Local Pain Pathway https://www.cambridgeshireandpeterboroughccg.nhs.uk/health-professionals-homepage/patient-pathways/pain-management/
▪ Stimulants; use local Adult ADHD pathway http://www.cambsphn.nhs.uk/Libraries/Shared_Care_Guidance/Adult_ADHD_Shared_Care_Guideline_Version1Nov_2013.sflb.ashx

Good advice on handling these potentially difficult consultations:
▪ Dr's Chris Longstaff and Rob Schafer's consultation model http://primaryhomelesshealthcare.weebly.com/addiction-to-prescription-medication.html
▪ Prescqipp Webinar (register with @nhs.net address to access) https://www.prescqipp.info/recorded-sessions/media/dealing-with-drug-seeking-behaviour-webinar-19-october-ruth-bastable</td></tr>
<tr><td>Author:</td><td colspan="2">Dr Melanie D’Souza, GP &Advisor to Cambs Drug & Alcohol Action Team, melaniedsouza@nhs.net</td></tr>
<tr><td>Date:</td><td colspan="2">May 2017. Website links checked May 2017</td></tr>
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[1] https://www.gov.uk/government/publications/health-matters-preventing-drug-misuse-deaths
[2] Middleton J, McGrail S, Stringer K. Drug related deaths in England and Wales. BMJ 2016;355:i5259
[3] Investigating Drug Related Deaths, Cambridgeshire & Peterborough, Cambridgeshire County Council, May 2017 (unpublished)