HOMELESSNESS & HEALTH CONFERENCE

PRESCRIBING

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GENERAL PRINCIPLES

- Small quantities at a time (daily if needed)
- Checking with last previous prescriber
- Need to re-commence
- Reducing doses
- Avoiding adding ‘fuel to the fire in addiction’
- MI principles

HYPNOTICS

- Night sedation is known to be of limited value and carries risks of dependency, tolerance and abuse.

- As such, our policy is to avoid the use of night sedation where possible, explaining to the patient our rationale for declining to prescribe and offering alternative strategies for tackling sleep problems.

- We **DO NOT** prescribe Benzodiazepines as hypnotics.

1st LINE

- Prescribe **Promethazine** as a first-line hypnotic. This has the great advantage of not being addictive, although it's effects do seem to wear off with persistent use. We advise patients they can take up to 50mg at night.

- In a small number of cases, after careful review, we prescribe Z-drugs. If we do, it is for a maximum of 10 days (usually no more than 5 days), and on the understanding that this will probably not be repeated in the next consultation. We can sometimes offer further courses of this after a gap in treatment.

- All PRN hypnotic prescriptions should be endorsed with a maximum frequency of 5 nights out of 7.

ALTERNATIVES

- Mirtazapine – it is important that the patient is aware this is an antidepressant. 15mg is usually effective for sleep. Ideally an SSRI would be first line, but if poor sleep is the primary concern, then this can be chosen earlier than usual.
- Trazodone – this is often poorly tolerated, and is more likely to cause daytime drowsiness. For that reason we do not recommend this as first or second line.
- Amitriptyline – very effective for sleep, in doses 10mg up to 75mg. However as for Trazodone can be poorly tolerated, and **can be implicated in overdoses so prescribe with extra caution** if COPD or using drugs/alcohol.
- Quetiapine – 25mg-100mg nocte can be effective as a **short term** option. Metabolic side effects would dictate against using in the medium-long term as a hypnotic.

BENZODIAZEPINES

We try (VERY VERY HARD!) to avoid the use of Benzodiazepines. These are highly sought after and frequently abused, and are frequently implicated in overdose deaths. With our practice population we are particularly concerned about the risk of abusing Benzodiazepines alongside polysubstance and alcohol use. We do have a small number of long standing patients on small amounts of Diazepam, and these may present for a repeat when due.

Patients who have a continuous documented prescription (from previous GP/hospital - this should be confirmed before prescribing) are given continuation prescriptions.

These should be at most weekly, with a follow up appointment with a regular GP for review. Unless there are exceptional circumstances, the regular GP will commence a withdrawal regimen.

Urine drug screen will be taken before prescribing, to check that patient is taking medication. We do not support the prescribing of diazepam to patients who have been buying their own diazepam up to that point. We do so only in exceptional circumstances and with a clear withdrawal regimen and with weekly review.

Long term risks emerging of effects on memory and cognition.

BENZODIAZEPINES CONT'D…

We do not replace "lost" or "stolen" prescriptions unless in exceptional circumstances.

Prescribing in either of the above circumstances needs to be well documented and supported with rationale given the risk of fatal overdose or selling of these drugs.

Convert all benzodiazepines to Diazepam to simplify prescribing and reduce risk of overdose on multiple BDZ prescriptions.

Maximum dose is:

Diazepam 30mg daily. Only 2mg or 5mg tabs. Please note that the advice is that no matter how high the dose of diazepam has been prior to prescribing, a patient should not have a withdrawal fit provided that they are taking at least 30mg diazepam daily. It is therefore safe to start someone who has been buying 100mg diazepam daily on a reducing dose of 30mg daily.

OPIOIDS

Codeine:

- Avoid **codeine/opiate** based medication unless there is a clear indication and a clear plan for review in the short-term.
- Prescribe as an acute medicine rather than a repeat.
- Prescribe no more than weekly initially.
- If prescribing codeine or dihydrocodeine, we recommend opting for paracetamol-containing compounds, as this can reduce the risk of misuse. Although you also need to bear in mind the risk of paracetamol overdose.

OPIOIDS

Methadone/Buprenorphine :

Patients who abuse opiates are advised to attend the Pavilions drop-in clinic at Richmond House: http://www.pavilions.org.uk/contact

We **only** prescribe Subutex/Methadone to patients who are seen in our Thursday afternoon joint prescribing clinic run by Donna Evans (SMS nurse) and our Clinical Lead. These patients have been carefully assessed as being suitable.

The **ONLY** other situation in which WE prescribe these drugs is for a patient who is already on them and has just been released from prison/moved to the area, and who for a very good reason has not been able to engage with SMS as yet. If this is the case we would recommend providing only a 1 day prescription.

PREGABALIN

Pregabalin is now contraindicated for all patients with a history of dependence.

As such it is **not appropriate** to prescribe to most of our patients.

There is a high demand for it, and with difficulty we are switching our patients on it over to Gabapentin.

We do not start patients on Pregabalin.

If patients join the surgery already on it, the either start switching to Gabapentin, or give them a 1-2 week acute prescription and ask them to come in to discuss this further with one of the regular doctors. We need evidence of recent uninterrupted prescribing before continuing it.

NUTRITIONAL SUPPLEMENTS (Fortisips/Build-up drinks):

These have currency on the street, and as such are in high demand amongst our patients.

Our policy is to not issue these unless the BMI is under 18.5, or unless they have a life-threatening/palliative illness, or there is a very clear and time-limited indication such as jaw/dental surgery.

Patients who need nutrition who do not meet guideline recommendations should be supported to access sources of free or cheap food, appropriate to their circumstances which may include day centres, charity food distribution (e.g. ‘soup run’, Fair share etc) , evening meal providers such as One Church, or food banks. Our Receptionists should be able to help signpost to these services.

ALCOHOL DETOXIFICATION

We advise everyone who wants detox to attend Pavilions. We strongly advise against “home detox” due to the risk of brain damage and also fatal seizures and overdoses.

The only exception is if a patient is adjudged to be in a well-established withdrawal syndrome with an imminent risk of seizure and with absolutely no recourse to obtaining more alcohol, or who have partially completed a detox in hospital.

Prescribing in this case needs to be carefully documented with a clear risk assessment, and I would recommend **no more** than 3 days prescription prior to a further review by a GP at this practice**.**

The above situation is a rare eventuality, and prescribing an alcohol detox should be avoided if at all possible.

We would recommend the following guidelines:

- Daily pick up of prescriptions.
- GP Follow up every 2-3 days to issue next set of daily pick-up scripts.
- Start at Diazepam 30-40mg.
- Reduce by 5mg daily.

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QUESTIONS & COMMENTS

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