EASTERN HEALTH BOARD

AIDS/Drug Addiction Services

INVENTORY OF POLICIES

OCTOBER, 1998.

MISSION STA TEMENT

The AIDS/Drugs Service promotes a drug free lifestyle and in partnership with other statutory and voluntary agencies provides prevention, treatment, rehabilitation and aftercare programmes to minimise the harmful effects of drug addiction and prevent the spread of HIV and other infections.

Our strategy is to promote a drug free lifestyle, develop outreach contact with the greatest possible number of drug users, to decide on the appropriate treatment and to encourage all drug users to move to a more normal lifestyle.

The strategic objectives of the AIDS/Drugs Service, in line with the Ministerial Task Force Reports on the Measures to Reduce the Demand for Drugs, are to provide, in conjunction with voluntary agencies where appropriate:

- Education and prevention programmes.
- Services aimed at delivering advice and harm minimisation programmes to drug misusers not in contact with services, including advice on safer drug user, ways to reduce the risks of HIV and Hepatitis transmission, safer sex and advice on good health.
- Treatment programmes which have as their objective in the short-term control of the drug misusers addiction within the context of the long-term aim of a return of the drug misusers to a drug free lifestyle.
- Aftercare and rehabilitation programmes to assist misusers access education, training or employment opportunities.
- Evaluation of the various service responses to ensure maximum effectiveness.

POLICIES INDEX

Section A - Treatment

Section B - Viral Illnesses

Section C - General

Section D - Administrative

The Eastern Health Board's AIDS/Drug Addiction Service endeavours to standardise clinical policies and procedures in order to develop best practice guidelines based on best current clinical and administrative practice and evaluative research.

These guidelines will facilitate and inform staff in clinical/administrative decision making. They will support and guide staff in improving service quality be reducing variations in care particularly in clinical or administrative areas were research evidence or consensus is lacking.

They reflect the state of current knowledge about effective and appropriate care and can only improve patient care if they are used in practice.

These regionally developed guidelines will form a template from which clinical teams may further develop additional guidelines tailored to local conditions.

Pat McLoughlin
Programme Manager

October 1998

MEMBERSHIP OF THE WORKING GROUP

Dr. Joe Barry (Chairperson)	***Specialist in public health medicine***
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Mr. Ben Keaveny	***Education Officer***
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POLICY NO. 1

Early Intervention Treatment Programme for Persons Using Op

1. Medical:

This will involve full assessment and physical examination pass to detoxification. This may be non-opiate detoxification where appropriate (e.g. using Lofexidine) (Lofexidine prescribing protocol available). Young smokers who have been using heroin for a longer period may need a short methadone detox.

Detoxification will be of 8 to 10 weeks duration but may be longer in some circumstances. If a G.P. is offering a longer reduction this must be discussed with the consultant psychiatrist and the young persons parents.

2. Counselling:

Counselling will be offered to this young group of patients. This will include one to one counselling on a weekly basis plus group work and family therapy where available which will give an opportunity for the parents to be involved in the treatment process.

3. Prevention:

Alongside such programmes for young smokers the Board is committed to developing earlier intervention services for those young people at risk, who might get involved in drug misuse or who are first beginning to dabble with drugs so that adequate counselling and liaison with school services, probation services and other services can be undertaken at an early stage.

POLICY NO. 2

Treatment Guidelines for Young Drug Users

Treatment options will depend on the age of the user, the length of use and degree of dependency.

From the outset it needs to be emphasised that, like all treatment programmes, there needs to be a degree of flexibility and a need to tailor programmes to the individual.

Drug users should be encouraged into service as soon as possible after starting using.

In devising services for young users it is helpful to divide this group initially by age.

- Under 15 years
- 15-17 years
- 18-22 years

It is important to emphasise the difference between drug misuse and drug dependency. In assessing dependency it is advisable to use the ICD 10 criteria for drug dependency. If the user does not fit the criteria for dependency it is advisable not to treat with methadone and to offer counselling and family support.

Those under 15 years of age should be under the care of Consultant Psychiatrists.

The second group may be treated on an outpatient capacity. However, prolonging the detoxification should depend on the user giving biweekly opiate free urine samples. If a person continues to abuse while on methadone treatment an inpatient detoxification should be explored. The option of low dose maintenance needs to be explored as an alternative to abstinence and should be considered in young users, who have begun to inject. Methadone should only be commenced in this group after an assessment by a consultant psychiatrist.

The third group may also be treated in an outpatient setting. These programmes should be separated from intensive stabilisation programmes offered to more chronic long term addicts and should also include greater counselling, family therapy and rehabilitation and aftercare components than the treatment programmes offered to long term users. Reductions should be tailored to the individual. If the young user appears to be motivated and engages adequately in services offered the methadone detoxification should be as slow as is required to keep the addict drug free. Shorter detoxifications should be offered to poorly motivated individuals and those who do not engage without reason in counselling or other therapies.. Finally many heroin users also abuse other drugs including Benzodiazepines, Tricyclics such as Dothiepin (Prothiaden), MDMA (ecstasy), LSD, Alcohol and Cocaine. Poly drug abuse should always be considered in a drug user presenting to service and each drug needs to be treated individually and collectively.

POLICY NO. 3

Policy for Needle Exchange

Needle exchange is available to persons over 18 years.

Parental consent required for persons under 18 years.

Persons aged 16-18 may be offered needle exchange without parental consent provided that the following applies:

- Definite evidence of previous injecting drug use
- Attempts to get parental consent refused

Persons below 18 years may be given needles on a once only basis if:

- Attempt to get parental consent refused;
- If deemed to know risks and benefits of behaviour and thereby capable of consent.

Notes to be kept on impression of client's ability to consent:

- Age;
- Stoned/drunk;
- Living away from home;
- Ability to consent given all factors.

Consultant psychiatrist informed on same day of needle exchange. Young person informed of need to see Consultant Psychiatrist before second needle exchange given.

An underage person presenting a second time for a needle will need to be assessed by the consultant psychiatrist before being given a needle.

This assessment will need to be by appointment.

POLICY NO. 4

Mobile Clinic Policy

The mobile clinic is a harm reduction strategy aimed at injecting drug users who are awaiting treatment or have been transferred to a low dose methadone programme.

The mobile service is catchment area based and is a low-threshold programme, offering methadone at a fixed dose of 20mg daily.

The mobile service can be first line therapy, step down from other programmes or pre-inpatient detoxification.

Patients being placed on low dose methadone and needle exchange on the mobile clinic will have to meet the same criteria as those being placed on methadone maintenance. (See attached policy on methadone maintenance). Patients will be assessed for this service by the consultant psychiatrist or discussed with same.

The usual rules of conduct that apply at the clinics will apply on the mobile clinic with an emphasis on security for staff and other patients and the dispersing of loitering and other misbehaviour in the immediate vicinity of the mobile clinic. Patients who misbehave locally and who loiter in the area may be refused their 20 mgs. of methadone on the following day but perhaps given needles where these are required.

Further referral to other services can be made as appropriate. For example if somebody wishes to have blood tests or is deemed to be suffering from a psychiatric illness or to require more in-depth counselling, those patients will be referred through the mobile clinic to the appropriate service.

Offer Hepatitis C screening. Hepatitis B vaccinations and H.I.V. assessments to patients presenting to the service.

Needle Exchange:

The usual protocols and procedures that apply to other needle exchanges will apply.

POLICY NO. 5

Interim Treatment

Each patient will be assessed by a doctor in the initial stages with a view to patients fulfilling the criteria for methadone maintenance:-

(a) That they be over 18 years of age.
(b) That they be using opiates for a minimum of two years and / or injecting for one year.
(c) They have gone through at least one detoxification attempt.
(d) De facto any patient under the age of 20 would only be given this option after very careful consideration.
(e) Special circumstances may dictate being accepted on the programme without fulfilling all of the above criteria e.g. partner of drug user.

Staffing of such clinics would involve general practitioners and a nurse who would see them on a day to day basis, look after abscesses, give brief intervention at a counselling level and make referrals where appropriate to other professionals (e.g. counselling) or agencies as required.

That patients would be put on a dosage range of methadone from 20 to 40 mgs. which the staff looking after these patients would decide. However, a ceiling of 40 mgs. is set.

The general assistants and the nurse would take urines where appropriate. Urines will be taken for monitoring of progress on a weekly basis so that patients would not be docked their methadone if they failed to give clean urines. These urines would be used to evaluate patients on the programme so that at the end of 6 months the most appropriate treatment plan for them can be put into effect.

Evaluation:

There would be an evaluation at the beginning and end of the programme for all those participants. Patients coming to the end of the Interim programme would have their progress evaluated using the following parameters:

1. Ability to supply clean urines;
2. Attendance at clinics;
3. Behaviour at clinic and evidence of other drug misuse e.g. Alcohol, benzodiazepines;
4. Clinical judgement of GP and nurse;
5. All patients will be discussed at the team meeting before being streamed to methadone maintenance or low dose.

Counselling:

This type of interim programme will not require counsellors. However patients may need priority access to counsellors if there are complex/acute issues involved. In general the nurse and doctor will provide acute crisis intervention where required. Obviously when patients go for methadone maintenance they would require a full time counsellor.

Viral screening with appropriate pre/post test counselling and safer sex workshops should be offered to participants. Repeat as appropriate to further risks or annually.

POLICY NO. 6

Methadone Maintenance

The following are the criteria for inclusion of a person on a methadone maintenance programme.

- They must meet physical, emotional and behavioural criteria for addiction as set down by the International Classification of Diseases No. 10.
- They must be aged over 18, but those between the ages of 18 and 20 will require a more extensive investigation before being commenced on methadone. This would require an extensive drug history going back more than two to three years, which will need careful clarification,
- They must have an extensive one-year history of intravenous drug use.

Special cases that need not meet the above criteria for admission will include the following:

- Patients who are HIV positive.
- Partners
- Patients who are pregnant.

These patients will be offered detoxification, maintenance or inpatient services as appropriate.

Young people, 18 years old and younger:

Young persons under the age of 18 will need their parents to attend and give parental consent. There should be a history of at least one failed detoxification, usually two to three preferably at inpatient level. However, where patients have a very long history that can be verified this condition may be waived.

Young persons 18 years and younger will require very careful assessment and consideration at team meetings and will need the formal decision of a consultant psychiatrist before commencing methadone maintenance.

Dosages above 80mgs can only be offered after consultation with the Consultant Psychiatrist

Assessment:

Patients will only be included in the programme after assessment by the clinical team, including full medical history, recent drug history, past drug history,

(psychiatric history) including treatments and will require to provide release of information on all relevant medical documents relating to previous treatment. This assessment should include urine screening for illicit substances, full blood screen including FBC, ESR, LFT's, Hepatitis B and C and HIV testing.. Previous detoxification as well as residential programmes need to be ascertained. Clarification of their drug history and the length should be ascertained where possible from the relevant agencies either over the telephone and charted and signed and preferably with follow up histories from the relevant agencies. Their HIV and Hepatitis status will be established where possible. Included in the assessment will be a psychiatric mental state where indicated. Referral to the consultant psychiatrist may be required and a full physical examination with relevant investigations where necessary. Investigations will include a urine drug screen at the time of examination and a patient will need to show opiates in the urine in order to be included in the programme. In addition to the medical assessment outlined above, each patient will need to be assessed by a counsellor in addiction. After all these assessment are completed the patient details will be brought to the clinical team for discussion before being included in the methadone maintenance programme. In certain instances referral for further assessment by the consultant psychiatrist may be required.

Patients from Interim Programme

All patients coming from the interim programme need to be presented at the clinical team meeting before being taken on methadone maintenance. All patients will need a full counselling assessment before staring methadone maintenance.

Urine Testing

- Before commencing treatment two to three urine screens will be taken on separate occasions as determined by the clinician. The first of these have to be sent to the laboratory.
- Twice weekly urine screening for methadone and opiates in patients who are stabilising.
- Weekly screening for opiates will be the minimum requirement for all patients after stabilisation.
- Patients not receiving daily supervised ingestion will require a weekly methadone screening.
- Monthly screening for methadone, amphetamines, alcohol, cocaine, tricyclics, benzodiazepines and other drugs are required on all patients. This should be sent to the laboratory.
- Patients on a short detoxification e.g. less than 12 weeks will require more regular full screening which should be a minimum of once weekly to the laboratory.
- Patients who have a specific problem e.g. those who have a problem with drugs such as cocaine, alcohol, benzodiazepines, tricyclics etc will require weekly or more frequent screening for that drug.
- Patients who are stable for 12 months or longer on substitute maintenance treatment may be moved to twice-monthly urine screening.
- Random screening in addition to the above should be taken from time to time.

Detoxification

It is envisaged that the team will offer full opportunity for detoxification and follow-up programmes. This will include a provision of adequate beds to allow for easy admission for detoxification. Detoxification will also be offered at an early stage to those who are not deemed to have a serious physical dependence and to have a short history of addiction.

Recovery Programmes

It is planned that these will be put in place and will involve day programmes, intensive counselling and psychotherapy as well as group psychotherapy as required. It is hoped that we can offer some longer term residential placement, in half way houses and hostels, as part of the programme. Vocation placements and employment are seen as critical to full recovery from addiction.

POLICY NO. 7

Methadone Maintenance Contracts

A. Contract for Intensive Stabilisation Programme [I.S.P] with a view to Long Term Methadone Maintenance

If you wish to be placed on methadone maintenance you will require to go through an intensive stabilisation programme. Your tolerance is lower in the beginning of this programme so that is the best time to try to stabilise.

For their part the clinical team will dispense your methadone on a daily basis. They will also undertake to give you sufficient appointments and to give adequate notice of any postponement/changes in appointment times.

Initially you will be seen by a doctor twice a week to stabilise you and an appropriate dose of methadone prescribed. You will be required to give supervised urines at least twice a week. Failure to give a urine will count as an opiate positive urine. You will be expected to provide urines clear of opiates by the end of the second week of the I.S.P. to move onto the regular methadone programme. Failure to stabilise and give urines free of opiates will lead to one month of a low dose methadone/needle exchange programme. This low dose programme will last for one month and will be dispensed at a special time in the clinic and/or at our mobile clinic. Three failed I.S.P.'s will lead to being placed on low dose (20 mgs. Methadone) needle exchange, clinic or on mobile clinic for three to six months. You can then reapply for a methadone maintenance.

After two months of urines free of opiates you can earn take-aways for every second day. If your urine is positive for opiates thereafter you will be brought back to daily dispensing. Four months of urines which are opiate free will lead to twice weekly take-aways, provided you are not deemed to have a second substance abuse problem which is out of control e.g. regularly stoned on benzodiazepines or you are abusing or dependent on alcohol or other substances. After six months of clear urines you can earn weekly take-aways and begin preparation for methadone maintenance in a general practice setting. The contract rules re: violence, threats, dealing, fixing, being stoned and general misbehaviour will apply and may necessitate being banned from all programmes for a period, if of sufficient severity. The clinical teams decision in this regard is final.

Signed: _____ Signed: _____

Date: _____ Date: _____

Your contract may be modified by mutual agreement with your clinical team, depending on special circumstances.

B. Contract re. Loitering

There is a strict policy regarding loitering and general behaviour outside the clinic or on the surrounding streets at any time of the day. Anyone seen loitering or acting in an inappropriate manner outside the clinic or on the surrounding streets will be subject to the following sanctions:-

1st offence will lead to a 10 mg reduction in Methadone

2nd offence will lead to a 20 mg reduction in Methadone

3rd offence will lead to a 50% reduction in dose of Methadone

4th offence will lead to termination of treatment at the clinic for a period of one month

If after the period of one month you return to the clinic and are seen to be loitering again you will be suspended for a three month period. If after this you return to the clinic and are "seen to be loitering you will be suspended for a six month period.

SIGNED: _____ SIGNED: _____

DATE: _____ DATE: _____

POLICY NO. 8

Treatment of Pregnant Drug Users

Drug Liaison Midwives have been appointed to make contact with substance misusing women who are pregnant and to liaise between the obstetric hospitals the drug treatment services.

Detoxification can be offered to pregnant drug users after discussion with the clinical team.

No detoxification should be considered in the first trimester and except for small reductions in methadone it is recommended that women attempting to detoxify do so in an inpatient setting.

There is also a need for stabilisation programmes for patients who are on methadone.

A pregnant patient who is unstable should be admitted for stabilisation where practical.

Because of the complex nature of treatment of the pregnant drug user it is imperative that these patients have comprehensive follow-up from the drug liaison midwife in liaison with the clinical nurse and general practitioner to ensure all aspects of the patients case are addressed.

The drug liaison midwife will be responsible for ensuring that the patient has full medical, psychological, obstetrical and social assessment of their needs from the relevant professional and/or the drug liaison midwife.

Liaison with the obstetric hospital and other services as required e.g. Social services where other children are deemed to be at risk and/or where the mother may wish in-patient admission etc.

They will also be responsible for drawing up a detailed clinical/psychological/social care plan for each woman.

These detailed care plans should be written and presented monthly to the clinical meeting.

Assessment of the woman's pregnancy will need to be charted and liaison with the obstetrical team actively pursued. The pregnant woman's drug status will need careful review and where unstable on opiates will require in-patient referral. Patients should be warned of the risks of alcohol, nicotine and benzodiazepine use and where needed may have a benzodiazepine detoxification, provided the patient is opiate stable.

Assessment of the living conditions that the baby will return to needs to be part of the ongoing assessment by the drugs and obstetrical teams in consultation with the drug liaison midwife.

When considering the environment that children are returning to the following should be Borne in mind:

1. The presence of normal provisions such as food, clothing and housing.

2. Sufficient daily care for the child.

3. Access to medical care.

4. Sufficient emotional care at home.

5. Access to schooling.

Education around risks to babies and contraceptive advice needs to be made available to women of childbearing age.

POLICY NO. 9

Transfer to General Practice

1. Patients will only be transferred to general practice from the Eastern Health Board Clinics when the patient has stabilised on methadone dosage.

2. Urine screening facilities will be organised between the Eastern Health Board and the G.P. Supervised urines once a week will be taken from the patient.

3. A joint meeting between the general practitioner and the team will be arranged at the time of transition of the patient to general practice if required.

4. G.P.'s who wish to become involved will need to undergo training from the I.C.G.P. / E.H.B. training team.

5. Methadone dosage beyond 80mgs may not be increased without the patient re-attending for assessment with the Eastern Health Board Specialist Team.

6. A contract will be drawn up with the patient outlining the points made above and getting patients agreement to same before being transferred to the general practitioner.

7. The personal safety of the general practitioner as with all staff who are working with patients with drug addiction will be of paramount importance. Policies and protocols will be in place at Central level to discourage patients form abusing their relationship with their general practitioner. It is also envisaged that as far as possible more difficult patients, those with dual diagnosis, in particular personality disorders, history of serious violence, alcohol problems or other serious psychiatric disorders will be kept at a central level and that other issues of safety will be addressed between the Eastern Health Board and general practitioners to ensure the general practitioners and their practices do not come under any additional stress from facilitating these patients.

8. It is agreed by the Eastern Health Board that patients who have been referred out and who destabilise in general practice can be transferred immediately as an emergency case back to the Eastern Health Board. This will be facilitated within 24 hours where required. Patients may then need a further period of re-stabilisation before being transferred back to general practice if this is thought appropriate.

9. A person transferring to G.P. practice should do so through the appropriate G.P.Coordinator.

POLICY NO. 10

Alcohol Policy

Patients who are alcohol dependent or involved in harmful use who are attending the treatment clinics should attend an alcohol treatment programme to work with their opiate/alcohol cross addiction.

The following points were discussed and decided on:

1. Testing for alcohol should be objective (always use breathalyser).

2. Clients will be breathalysed with random selection.

3. The cutoff point for reduction of methadone will be

   80mg% -150% alcohol - half dose
   more than 150mg% alcohol - no methadone.

The clients will be breathalyzed by the doctor, pharmacist or nurse.

POLICY NO. 11

Policy on Psychiatric Referral

Acute emergency referral will be required in the following situations:

- Acutely psychotic patient
- Acutely mentally ill patient
- Suicidal/homicidal patient

These patients will initially be assessed by their GP or addiction counsellor. The consultant psychiatrist will undertake further assessment of these patients where possible.

Procedure:

Immediate referral of patient to an in-patient facility:

Telephone contact and written referral to local psychiatric team, the consultant psychiatrist in substance misuse must make referral (wherever possible). However, delays should be avoided where patient is seriously at risk and should involve immediate transfer to psychiatric unit. Depending on residence of the patient, transfer by ambulance may be required or taxi arranged as minimum. The patient may need to be accompanied by a member of the clinical team where he/she is unable to guarantee safety and attendance at designated unit.

Patients who are unwilling to be admitted but are deemed to be a serious risk to themselves or others may need to be admitted using the provisions of the Mental Health Act of 1945.

Letter of referral to accompany the patient where the admission is arranged through A/E or equivalent in psychiatric hospital.

General Psychiatric Referral:

The clinical team has the opportunity to refer to the psychiatrist working within the clinic to weekly O.P.D. clinic. Clinicians are encouraged where in doubt about a client's psychiatric state and relevant treatment options to refer. Early referral may prevent a need for more intrusive psychiatric treatment intervention at a later date.

POLICY NO. 12

Special clinic for patients with addiction problems who have serious behavioural problems

There are a small number of patients with addiction problems who also fall into the category of severe behavioural disturbance.

It is proposed that the Health Board negotiate with Trinity Court to provide within our remit there for a special clinic for those patients presenting with particularly difficult behavioural problems.

It is suggested that this clinic perhaps be at the end of the day for an hour and that these patients would be accommodated at a special clinic where staff particularly trained in the management of these difficult patients would be on duty to work with them.

POLICY NO. 13

Confidentiality

Confidentiality is an issue which is raised time and time again by staff working in the area of substance misuse.

It is a vitally important component of any individual's ongoing treatment and management. However, at times the issue can be somewhat blurred by individual patients who use the area of confidentiality with some staff members to place a staff member in a difficult moral situation. Basically, the terms of confidentiality for any individual are the same as those, which are used in other hospitals. Therefore, confidentiality is understood to exist between the whole clinical team dealing with a certain individual.

This should be explained to patients on referral to the service, and should be the basis of any counselling or therapeutic relationship. This avoids the situation whereby a" piece of information is imparted to a staff member, and the staff member feels unable to gain support from other members of the clinical team around the issue which has been raised.

Given acceptance of the above situation, there are a number of other considerations to be made.

Firstly, any discussions between the clinical team in relation to an individual patient should not be carried out in communal areas, or in corridors. They should be carried out in an office to protect the confidentiality of the patient. Interviews with patients and discussions in relation to their treatment once again should not be carried out in corridors, or communal area, and in all cases the individual patient should be brought to a secure office to continue this,

Files in relation to clinical information and blood results should be kept in a locked filing cabinet, and not removed from the clinic premises. Any requests for information, either from a hospital, Probation and Welfare Service, General Practitioner or other individuals can only be given out once informed written consent has been obtained from the individual patient. A standard consent form for release of information should be in the clinic to allow this to happen. Even with this consent, clinical staff should exercise caution when discussing information regarding individual patients over the phone. In the event of disclosure of information a specific consent form needs to be received before disclosing drug history/treatment and HIV status.

There are, however, certain situations where the clinical team or the Consultant Psychiatrist may have to operate outside the bounds of confidentiality.

If there are concerns regarding the welfare of a child, the consultant psychiatrist has got the responsibility to refer the relevant issue to the community care/social work team, thereby ensuring that the welfare of the child will remain paramount.

If there is significant concern amongst the clinical team about homicidal intent of an individual patient towards another individual, then once again the team may have to operate outside the bounds of confidentiality.

If a patient is expressing serious suicidal intent and tends to leave the clinic to act on this intent, then there is a responsibility on the treating clinician to override confidentiality of the patient on this basis.

The viral status of patients attending obstetric hospitals may be disclosed to their obstetric team where patient's consent has been sought and consistently refused.

All staff should observe the boundaries of confidentiality and be familiar with them, and that any information sharing, which occurs within a team, should maintain the ethos of confidentiality within the clinical team for an individual.

POLICY NO. 14

Testing for Viruses

All patients should be offered viral screening including HBV, HCV, and HIV All testing for viruses should be carried out within four weeks of the patient presenting for treatment or where patients refuse to test a signed refusal form should be lodged in their chart. Where patients are HBV. negative vaccination should be encouraged (including consent to treatment) and followed with HBV antibody titre to ensure an adequate response.

HCV testing should be offered and performed with informed consent of patients. Where patients have difficulty in testing they should be given further counselling by a specialist counsellor (e.g. HIV counsellor). Patients who are HCV. positive should be referred to the HCV. clinic. Patients who are drug stable or drug free for twelve months will be referred to the Hepatology Clinic for work up of HCV. treatment after a P.C.R. test has been performed.

HIV testing is to be encouraged in all cases of risk. Doctors, nurses or counsellors' will offer pre-testing counselling. Patients should be referred to HIV. Counsellors where difficulties in pre-test work are encountered. A checklist of such difficulties will be attended to as criteria for appropriate referral in the interest of best practice and patient care. Results should be given by the doctor with referral to the HIV counsellor where there are positive results or negative results where skills training, behaviour modification or other complications require follow-up.

Any patient who refuses to have any of these above tests should sign the standard deferral/disclaimer form. If the patient refuses a note should be put in the medical chart. All pre-test counselling should be recorded on a standard proforma form and noted in medical chart where such exists. The standard patient infectious diseases record sheet should be filled out and left at the front of the patient's medical chart, *(see appendix I)* In the case of public testing clinics where charts are not held proforma forms, consent forms and results are to be filed by the appropriate practitioners. Counselling with regard to the test result should be recorded by the counselling practitioner and noted in the medical file where appropriate.

POLICY NO. 15

Hepatitis C

Clinical Patients:

All patients in a treatment programme should be offered Hepatitis C test by their doctor, within four weeks of starting on the clinic or have signed a refusal form regarding testing.

Other Patients:

Patients not in treatment may have Hepatitis C test if it is requested and considered appropriate by the doctor.

Patients to be asked for name of GP/other doctor to whom they will be referred if result is positive.

Positive results will be given by the doctor on duty, who will discuss and make arrangements for follow up care.

Chart will be made out and these arrangements recorded.

That patients be detoxed from opiates or be on methadone maintenance for one to two years before being considered for interferon or other antiviral therapy for HCV.

That patients show a clear willingness to be treated and after counselling understand as far as possible the nature of the risks and benefits of such treatment and are still willing to take part in a treatment protocol.

That they have stable environment.

That they are not currently suffering from a major psychiatric illness such as major depression or psychosis which is in an acute phase.

That any dual addictions such as benzodiazepines or alcohol are in remission or in a stable state.

Treatment will be under the consultant hepatologist/infectious diseases consultant.

POLICY NO. 16

Patients in Whom Testing for Viruses Should be Deferred

Anyone whose ability to give consent is impaired e.g.

- Stoned or drunk
- Mental Handicap
- Under 18 years of age - see below

Attending elsewhere for counselling, where it may be in the client's interest to confer or refer as appropriate. Anybody who is unwilling to have a test (disclaimer form to be signed). Those requiring extended counselling prior to testing. This is best achieved over a number of visits.

Current psychiatric patients where it may be in the interest of best practice to confer.

Anyone who does not have a viable/operative support network.

If any of the above circumstances apply the case must be discussed with the doctor before any commitment to test is made.

Under Age Testing (Less than 18 years):

For persons aged between 16-18 years on whom a clinical decision has been made that they are capable of giving informed consent, testing can be carried out.

Persons under 16 years require parental consent.

Where it is not possible to get parental consent the case should be discussed with the consultant psychiatrist.

HIV Testing of Drug Users:

It is felt that it would be in the interest of drug users attending the health board drug treatment services to be aware of their HIV status. The decision as to how this should be broached should be taken between the counselling and medical staff of the drug services in conjunction with the client. HIV test result will be given by the patients doctor and where required post-test counselling will be carried out by the HIV Counselling service and liaison will be made and follow up will be taken on by whichever service is deemed most appropriate.

It is the policy of the service to share information in the interests of best care of HIV+ patients with specialist HIV teams in the hospital setting with the informed consent of patients by means of a release of information form. Information is shared across disciplines on a need to know basis.

POLICY NO. 17

Policy on Security

Adverse comments from local residents and retailers should be followed up immediately by a visit or telephone call from staff members. The purpose of this procedure is to ascertain the nature of the complaint and report back to the clinical team if it involves a client of the service.

Make set appointment times with patients thus decreasing waiting time and frustration.

In general the policy is to keep to a minimum the number of patients attending the clinic at any one time, so that waiting areas and corridors provide free and easy access for those who are attending for treatment.

Those receiving methadone should be the only people attending at the methadone dispensing location.

Clients will only be called to the methadone area when called by a general assistant.

The clinic secretary with general assistants will keep a list of patients, thereby ensuring that orderly scheduling of appointments occurs.

Threats and violence

In general when a patient threatens a staff member it is envisaged that the staff will try to work actively with the person to defuse the situation and help the patient express their frustration in a more appropriate manner.

Serious verbal intimidation will be looked upon as a serious matter and will be brought up at the next clinical meeting where it will be discussed.

Intimidation and serious threats will be dealt with in a similar manner to a violent incident *(see below).*

Physical violence between patients or against a staff member, either on the premises or in the immediate environment, will lead to automatic discharge. The person or persons involved will be asked to leave and escorted off the premises. If the incident is of a very serious nature then immediately the most senior staff member present will make contact with the Gardai. Where the immediate danger is defused three requests will be made to ask the person or persons to leave the premises: on failure to leave the Gardai will be called. The general assistants have the primary responsibility for security but other staff

will back them up if the need arises. Where there is a very serious incident or threat of violence a buzzer will sound and all staff will be expected to drop what they are doing and assemble at the area concerned, as a backup to the general assistant. Any violence will lead to an automatic suspension, the length of time to be determined by the clinical team. Weapons drawn or used will carry much more severe consequences. An incident report will be written up at the time of the incident, by staff observing or involved in the incident. An incident book should be kept in each of the clinics.

The clinical team, at the next clinical meeting, will review each incident of violence. The team will discuss the incident report and the whole matter. A representative General Assistant will be present for this discussion. In the interim the patient will be offered a prescription to a local pharmacy to supply them with methadone up to the day of the clinical team meeting. The clinical team will look at the facts and having reviewed and established the persons involved in the incident, will confirm the suspension for a minimum of one month and generally maximum of six months, depending on the level of violence involved. The person so suspended from the programme will be met by a delegation from the clinical team within two working days of the clinical team meeting.

Further prescribing and treatment will be at the discretion of the clinical team. The person so suspended may be offered daily take-aways with l0mg reduction each day. The detoxification will not last longer than eight days. Thereafter clinical responsibility for the person's methadone will not rest with the clinic. However, they will be free to see a counsellor or a doctor outside the programme if this is agreed with the person involved. It will be against the policy of the clinic for doctors to prescribe maintenance treatment outside of the agreed detoxification schedule, for people so suspended.

Staff affected by any incident of violence will be checked by another team member to assess if they are fit to continue work. Staff seriously affected by threats or violence can seek health care through the health board's personnel department.

In general staff should anticipate problems and provide enough staffing to deal with the difficult issue with a particular patient if this is required. As a further preventative measure it is envisaged that general assistants and other relevant staff would go through a training course on control and restraint thereby increasing awareness of methods of dealing with potentially violent situations. Such a course on control and restraint is available from the health board.

Dealing on or near the premises

Where there is substantiated evidence of dealing on or near the premises this will lead to suspension of the dealer. Any such substantiated evidence will first be brought before the clinical team meeting so a decision can be made on the duration of the suspension. The duration of the suspension will depend on other factors in the situation. The clinical team will have flexibility on the time of the suspension but this must not be less than one month and initially no longer than six months. This person will not be offered further medical or counselling within the building but can seek help from services outside. Detoxification will be provided as above.

Fixing or using drugs on the premises

Any use of drugs on the premises will be reviewed by the clinical team meeting and appropriate action taken. Persistent using on the premises will lead to suspension by the clinical team for a set period.

POLICY NO. 18

Creche Policy

No parent is allowed to leave the building without his or her child.

All children come down to the creche. The only exceptions are if parents are only coming in for their methadone with no appointments.

Parents must call down to the creche to collect their child.

Childcare worker should attend team meetings and report on developmental progress of children and any concerns regarding children to clinical staff.

POLICY NO. 19

Waiting List/Non Attenders Policy

1. The nursing team will handle enquiries regarding the waiting list. Pregnant drug misusers and H.I.V. positive patients who are unwell will be given emergency access to treatment. Those who are under 18 years of age constitute an emergency and will be given immediate access to treatment, which might initially be counselling. Where a waiting list is in existence patients will be assessed using the medical/psychiatric/social/addiction sliding scale in order to prioritise patients most in need.

2. Non attenders will be regarded as void following 4 weeks of not attending unless he/she presents a valid excuse (i.e.) in prison or hospital. The nurse will write to client after 1 week to attend within the following week. If a patient is absent for less than 1 week following return the client will only get 1/2 dose till seen by G. P. If away from clinic longer than 1 week the patient will have to see a G.P. before methadone is dispensed.

   A separate list be kept with non-attenders names and if a client misses one day his/her name will be added to this list to aid accurate record keeping of non-attenders.

   Those chronic non-attenders names should be discussed at the clinical meeting.

3. Clients who have had numerous dirty urines and or refusals and who are failing to stabilise on the ISP should go to the mobile clinic for one month.

   In order to make space for new patients any client that has 3 failed Intensive Stabilisation Programmes goes to low dose programme for 3 months and should come through the Interim Programme before been taking back onto Methadone Maintenance.

POLICY NO. 20

Policies for the Pharmacy in Addiction Centres

Patients:

In any changes in methadone a doctor has to furnish the pharmacist with a dose adjustment sheet and it should correspond with the clinic treatment list.

The pharmacist will give any patient absent for seven consecutive days half dose unless he/she can prove they have been in receipt of their methadone from another institution. An absentee book should be kept in the pharmacy. The absent patient should be entered on a daily basis and discussed at the clinical meeting.

If patients are in hospital and are discharged their own doctor should see them. In the absence of the doctor the pharmacist's duty is to double check with the hospital if they were given their methadone that day or not. If they have not received their methadone they will be given the same dose of methadone as written on the list.

If any patient comes stoned he/she will be asked to come in the afternoon to be seen by their doctor. If they still come stoned in the afternoon the pharmacist will refer the patient to be seen by a doctor.

For any patient coming under the influence of alcohol the pharmacist will breathalise him/her.

Any member of staff that suspects any patient is stoned should inform the pharmacist.

There will be no replacement of methadone if the bottle of methadone is stolen or broken outside the premises. No exceptions are made unless approved by the consultant psychiatrist.

If any patient gets sick the pharmacist will given him/her half the dose as long as it is witnessed by one member of staff. Otherwise the pharmacists give no methadone in consultation with their prescribing doctor where available.

Any intensive stabilisation programme patient that comes in the afternoon will be docked automatically by 10 mls. unless they furnish the pharmacist with a valid excuse. If the patient constantly comes late his/her case should be discussed at the clinical meeting.

Any patients who are on take-aways are expected to return his/her labelled bottle to the pharmacy. This should be entered in the computer Y (yes) bottle, or N (no) bottle to keep a record (to prevent leakage of Methadone). If the patient fails to return the bottle his/her take-aways should be stopped and he/she should be referred to his/her own doctor.

When patients are going on holidays, the pharmacist should be notified a day before. Beside the name on the list the doctor should write the date the holiday starts and the date the patient returns to the clinic for treatment.

Patients who are short term in prison (35 days for females and 14 days for males) if released should be referred to his/her doctor. In the absence of their doctor the pharmacist phones the Female Section of Mountjoy Prison 806 2907 or the Male Section 830 3745 to know what dose was given to them that day. The dose should be the same as last given in the prison.

Patients who are on long term sentence should not be given any dose by the pharmacist until they are seen by their own doctor.

Patients who do not attend for one week should be brought to the attention of the nurse.

POLICY NO. 21

Administrative Conditions to be Fulfilled Before Starting Treatment

Client currently being assessed with a view to commencing treatment must fulfil the following conditions first.

Four recent passport sized photographs of client.

Proof of residency in the clinic catchment area. i.e. a letter from the Department of Social Welfare or Dublin Corporation confirming clients address.

Proof of identification must be provided.

If there are any difficulties for the client supplying any or all of the information the client must notify a staff member immediately.

POLICY NO. 22

Policy on Court Reports

Considerable preliminary work has to be done before court reports are formulated because of the adversarial nature of courts and the possibility of clinical staff being drawn into complex arguments and cross examinations. It is considered important to guide clinical staff in the matter of requests for court reports.

Only the medical team should put the relevant test results including urine/saliva results into the report.

All court reports need discussion with the consultant psychiatrists before being sent to third parties or the court.

General Practitioners should discuss court reports with the consultant where childcare issues or serious offences are involved.

Court reports should be discussed with patients before being sent.

Court reports need the written consent of the patients before being released, unless directed by the courts.