THE SHEFFIELD AREA PRESCRIBING GROUP

Prescribing Guideline for continuing alcohol relapse prevention medication in primary care.

(Drugs included in this guideline are acamprosate, disulfiram, naltrexone)

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Statement of Purpose

This prescribing guideline has been written to enable the continuation of care by primary care clinicians of patients initiated on alcohol relapse prevention medication (acamprosate / disulfiram / naltrexone), by the Alcohol Treatment Service, Sheffield Treatment And Recovery Team, SHSC NHS Foundation Trust, Sheffield.
Primary care will only be requested to take over prescribing within its licensed indication for relapse prevention of alcohol dependence

(Note - Nalmefene remains to be 'RED' in Sheffield traffic light drug list)

Responsibilities of the Specialist service prescriber

- To discuss benefits and side effects of treatment with the patient/carer and obtain informed consent.
- To initiate the medication and provide medication specific counselling as appropriate for the patient /carers.
- To arrange initial and subsequent reviews with the key worker/specialist.
- To prescribe medication for at least a month (two months in the case of disulfiram) or until patient is stable.
- To contact patient's GP to request prescribing and send a link to or a copy of this prescribing guideline.
- To advise the GP regarding length of treatment and arrangements for psychosocial interventions (PSI) offered to the patient. (Note-this includes PSI by the key worker, individual counselling sessions with a PSI counsellor, mutual aid groups in the city run by other agencies as well as at START)
- To provide a bespoke discharge plan with the patient which would include; consent to continue the medication; patient to report to the GP /START if any issues; patient to inform GP if they resume drinking . The discharge plan will also include a list of the psychosocial interventions available, offered and taken up by the patient. A copy of the discharge plan will be shared with the patient and the GP surgery so they can use to guide further follow ups, if needed.
- To discuss and communicate any updates, concerns and non-compliance with the GP regarding patient's therapy.
- To highlight circumstances in which to stop the prescribing e.g. non-attendance, resumption of regular drinking etc. as per within this guideline
- To respond to GP concerns and advise accordingly in a timely manner. Note the service is open access so patients can also drop in to be seen.

Concomitant use of more than one medication remains under specialist discretion, and is not covered by this guideline, however clinicians may be asked to prescribe and this should be discussed / agreed on a case by case basis.

Responsibilities of the primary care clinician

- To agree to prescribe for patients in line with the prescribing guideline.
- To report any adverse reactions to the referring prescriber and, where relevant, the MHRA (see yellow card).
- To continue to prescribe for the patient as advised by the specialist.
- To undertake monitoring as per prescribing guideline, refer to details in appendix 2.
- To inform the consultant/specialist if the patient discontinues treatment for any reason.
- To seek the advice of the consultant/specialist if any concerns with the patient's therapy.
- To conduct a 6 monthly medication review, or more frequent if required, and encourage the client to engage in PSI support as advised/offered by the commissioned alcohol service as long as the medication is continued to be prescribed.
- The specialist service will have shared details of interventions offered / taken up by the patient in the discharge plan. Patients on medication should be 'overseen' monthly for the first 6 months on treatment. This can be in the form of face to face contact or telephone call (this could be done by the GP, practice nurse, pharmacist or other clinician / NMP within the practice). The adherence to alcohol abstinence and medication should be discussed, along with enquiring if medication is being tolerated or if the patient has any concerns. **The advice from the specialist service can be sought at any point if concerns or clarification needed.**
- After being on treatment for 12 months, discuss continued need with the patient. Relapse prevention drug treatment continued beyond 12 months may require discussion with the specialist. Monitoring to continue in line with details in appendix 2.
- GPs can signpost patients to various self-help and recovery groups e.g. SASS, Alcohol Anonymous etc. for support beyond 6 months post discharge and if needed to continue prescribing relapse prevention medication. The continued need should be reviewed on a regular basis (see below)
- In case of *relapse, stop the relapse prevention medication and re-refer appropriate patients to the specialist for review (see table for details)

Responsibilities of Patients or Carers

- To attend specialist clinic and/or GP clinic appointments as advised. Failure to attend will potentially result in the medication being stopped.
- Present rapidly to the GP or specialist should they relapse to drinking alcohol
- Report any suspected adverse effects to their specialist or GP whilst taking any relapse prevention medication.
- To read the patient information leaflet given to them and follow advice for correct dosages etc.

- Attend psychosocial intervention sessions provided by the specialist services and/or other recovery groups.
- To inform the specialist, GP or community pharmacist dispensing their prescriptions of any other medication being taken – including over-the-counter medication.

Indication

Alcohol relapse prevention medication is used as an adjunct to psychological interventions to support those who are trying to remain abstinent by reducing the desire for alcohol.

Background information

Relapse prevention medication is recommended in a review of the effectiveness of treatment for alcohol problems by the National Treatment Agency (now on gov.uk). NICE Alcohol use disorder : Diagnosis, assessment and management of harmful drinking and alcohol dependence recommend the use of

- natrexone and acamprosate as first line
- disulfiram as second line

for treatment after successful withdrawal from alcohol.
Pharmacological treatment should be offered alongside appropriate psychosocial support from a suitably qualified professional.

Monitoring and Additional information

Regular blood monitoring of natrexone and acamprosate is not required. However consider the monitoring for recovery of liver function and as a motivational aid for service users to show improvement.
Disulfiram recommends 6 monthly LFTs.
If using relapse prevention medication longer term, or concerns with renal function, carry out periodic U and Es to check renal function does not worsen as;

- acamprosate is contraindicated in patients with renal impairment (serum creatinine >120 micromol/l)
- Naltrexone is contraindicated in severe renal impairment

It is recommended if alcohol relapse prevention drug is prescribed patients should be stay under monthly supervision during the initial 6 month period.
Many patients will be getting support from various psychosocial services, however it is recommended during this time monthly (fortnightly for first two months if taking disulfiram) contact is made with the patient to check; adherence to abstinence to alcohol and relapse prevention medication; check for tolerance / side effects.

Refer to drug summary table (Appendix 2) for best practice for each medication.

Re-Referral guidelines

Should a patient need to be re-referred the Sheffield Treatment and Recovery Team patients can access the service either by self-referral by telephone or written referral by any health professional.
Telephone advice can be sought from a consultant psychiatrist/NMP if required.

See appendix 1 for contact details

Financial Implications
GP taking over prescribing for relapse prevention medication will improve patient access to the medication and hence compliance leading to successful abstinence; it will also create more capacity within specialist services for dealing with more complex cases.

Cost of medication (from January 2019 Drug Tariff, however prices may vary depending availability of the medication)

Medication	**Cost for one month's supply**
Acamprosate	£33.75 - £67.50
Disulfiram	£29.48 - £59.97
Naltrexone	£30.36

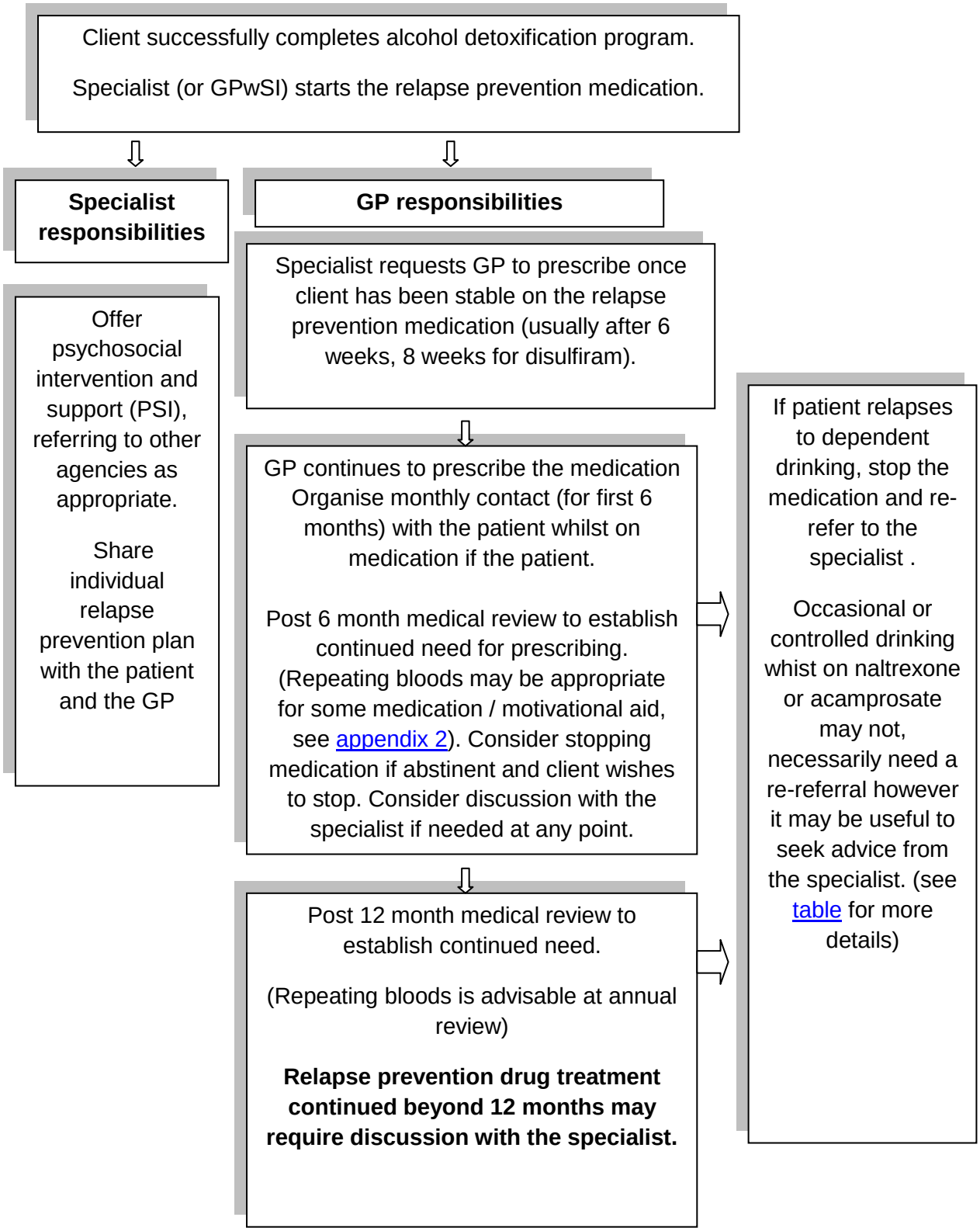
Support, education and information
SMART/Recovery groups run via Sheffield Health & Social Care NHS Foundation Trust, Fitzwilliam Centre and Sheffield Alcohol Support Service

AA groups: www.alcoholics-anonymous.org.uk

SASS : www.sheffieldalcoholsupportservice.org.uk

Also see local recovery group information for patients in Sheffield -
http://sheffielddact.org.uk/drugs-alcohol/wp-content/uploads/sites/2/2013/06/Recovery-Groups-in-Sheffield.pdf

Brief summary flowchart



Above all to be read with full guidance (see appendix 2), BNF and SPC of the individual drugs

References:

BNF via https://bnf.nice.org.uk/

Summary of Product Characteristics via www. medicines.org.uk

SPC for disulfiram - http://www.mhra.gov.uk/spc-pil/?prodName=DISULFIRAM%20TABLETS%20200%20MG&subsName=DISULFIRAM&pageID=SecondLevel

NICE guidelines

Alcohol: school-based interventions (PH7) Published date: Nov 2007

Alcohol-use disorders: diagnosis and management of physical complications (CG100) Published date: June 2010

Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence (CG115) Published date: February 2011

Alcohol-use disorders: prevention (PH24) Published date: June 2010

NICE Quality standards

Alcohol: preventing harmful use in the community (QS83) Published date: March 2015

Alcohol-use disorders: diagnosis and management (QS11) Published date: August 2011

SHSC pathway available on

http://shsc.nhs.uk/wp-content/uploads/2017/03/Alcohol-Services-Info-A5-leaflet-FINAL-Oct2015.pdf

Resources on GOV.UK available on

https://www.gov.uk/health-and-social-care/drug-misuse-and-dependency

National Treatment Agency (updated 2010), 'A Summary of the Review of the effectiveness of treatment for alcohol problems'.

(accessed via http://www.dldocs.stir.ac.uk/documents/alcoeffective.pdf)

Appendix 1


Sheffield Health and Social Care NHS
NHS Foundation Trust
start
Sheffield Treatment and Recovery Team
Sheffield Alcohol Services
Who are we and what do we do?
We are two teams of health and social care professionals who provide a number of services to people who misuse, or have an addiction to alcohol. Our aim is to provide packages of care to assist in reducing alcohol intake, or to become abstinent.
How to get help
The Open Access team opens the door to all alcohol services in Sheffield. If you, or someone you know has a problem with drinking, you can contact us. Anybody can call us:
Call
0114 226 3000
You will be offered an appointment within 7 days
You can ring for yourself
You can call for someone else
A professional who is worried that someone they are working with has problems can contact us.
Open Access
We assess drinking habits and provide support, advice and information to anyone wanting to make changes to those drinking habits. We also provide advice and support to people affected by someone else's drinking. We will refer to other services when appropriate, including...
Secondary Care Alcohol Services
www.shsc.nhs.uk/service/sheffield-alcohol-services

(Appendix 2)	Naltrexone	Acamprosate	Disulfiram
Therapeutic indication	For use as an additional therapy within a comprehensive treatment program including psychological guidance for detoxified patients who have been opioid-dependent (see section 4.2 and 4.4) & alcohol dependence to support abstinence.	To maintain abstinence in alcohol-dependent patients. It should be combined with counselling	Alcohol deterrent compound. as an adjuvant in the treatment of carefully selected and co-operative patients with drinking problems accompanied by appropriate supportive treatment.
Contraindications **(This list is not exhaustive, BNF and drug SPCs will remain authoritative)**	1. Acute hepatitis/ liver failure/ Severe hepatic impairment (ALT>2xnormal range) 2. Currently dependent / prescribed opioids, since an acute withdrawal syndrome may ensue. 3. Has a positive screen for opioids or who has failed the naloxone challenge test. 4. in conjunction with an opioid containing medication 5. hypersensitivity to naltrexone hydrochloride or any of the excipients 6.severe renal failure	1.Older people >65yrs 2.Children <18yrs 3.Lactating women 4.In cases of renal insufficiency (serum creatinine >120 micromole/L) 5. Severe liver insufficiency (Childs-Pugh Classification C). 6.Weigh risk Vs Benefit in Pregnancy	1.Presence of cardiac failure / recent MI 2.coronary artery disease, CVA, 3.uncontrolled hypertension, 4.severe personality disorder, 5.suicidal risk or psychosis- specialist decision if to initiate 6. known hypersensitivity 7. severely deranged LFTs 8. Pregnancy and breastfeeding
Side effects **(This list is not exhaustive, BNF and drug SPCs will remain authoritative)**	Nausea, vomiting, abdominal pain, diarrhoea, constipation, reduced appetite, increased thirst, chest pain, anxiety, sleep disorders, headache, increased energy, irritability, mood swings, dizziness, chills, urinary retention, delayed ejaculation, decreased potency, joint and muscle pain, increased lacrimation, rash, increased sweating; rarely hepatic dysfunction, depression, suicidal ideation, tinnitus, speech disorders; very rarely hallucinations, tremor, idiopathic thrombocytopenia, exanthema	Diarrhoea, Pruritus, maculo-papular rash, abdominal pain, nausea, vomiting, flatulence, Frigidity or impotence, decreased libido, vesiculo-bullous eruptions, hypersensitivity reactions including urticaria, angio-oedema or anaphylactic reactions.	Drowsiness, sweatiness, halitosis, alteration in taste, impotence, dizziness and headache Hypertension Dermatological reactions including acneiform eruptions, allergic dermatitis Optic Neuritis, peripheral neuritis, polyneuritis Cholestatic and Fulminant Hepatitis Psychotic reactions (inc persecutory, depressive and manic presentations +/- hallucinations)
Drug interactions **(This list is not exhaustive, BNF and drug SPCs will remain authoritative)**	Concomitant administration of naltrexone with an opioid-containing medication should be avoided. Methadone in substitution treatment. There is a risk of onset of withdrawal syndrome. *Association to be taken into account:* barbiturates; benzodiazepines, anxiolytics others than benzodiazepines (i.e meprobamate), hypnotics, sedative antidepressants (amitriptyline, doxepin,	In clinical trials, acamprosate has been safely administered in combination with antidepressants, anxiolytics, hypnotics and sedatives, and non-opioid analgesics Pharmacokinetic studies have been completed and show no interaction between acamprosate and diazepam, disulfiram, oxazepam, tetrabamate, meprobamate or	Caution: Disulfiram inhibits hepatic microsomal enzymes leading to interference of the metabolism of a variety of prescribed drugs Warfarin – enhanced effect therefore careful monitoring of INR required Tricyclics – Disulfiram increases the plasma concentration of tricyclics by 50% risk of toxicity may need to reduce dose or use

	mianserin, trimipramine), sedative antihistaminics H1, neuroleptics (droperidol). Data from a safety and tolerability study of co-administration of naltrexone with acamprosate in non-treatment seeking, alcohol dependent individuals showed that naltrexone administration significantly increased acamprosate plasma level.	imipramine.	alternative antidepressant. Amitryptiline – increased disulfiram reaction. Phenytoin – metabolism inhibited increasing risk of toxicity Temazepam – increased risk of toxicity Theophylline – metabolism is inhibited so increased risk of toxicity. Metronidazole, isoniazid and paraldehyde interact with Disulfiram increasing the risk of psychotic reaction.
When to start	Treatment must begin only when any opioid has been discontinued for a sufficiently long period (about 5 to 7 days for heroin and at least 10 days for methadone).	Initiated as soon as possible after the withdrawal period and should be maintained if the patient occasionally relapses.	Suitable patients should not have ingested alcohol for at least 24 hours
Baseline monitoring	Extended LFTs incl GGT	U&E incl Serum Creatinine, FBC, extended LFTs incl GGT	U&E , extended LFT incl GGT
Maintenance dosage	Start 25mg per day initial test dose and aim for 50mg daily as suitable.	Adults age 18-65 years: - *body weight 60kg or more* : 666mg (2 tablets) Three times a day with meals (2 at breakfast, 2 at midday, 2 at night) - *body weight < 60kg* : 666mg (2 tablets) at breakfast, 333mg (1 tablet) midday, 333mg (1 tablet) at night, with meals,	200mg (or 100mg) daily for 6 months. Higher doses may be required after specialist assessment.
Monitoring / support to patient by specialist service	To offer post treatment recovery support interventions which can be delivered through: phone calls; e-mail; message contact or the provision of post treatment recovery group sessions. This is offered; Every two weeks for the first 6 weeks (8 weeks for disulfiram) prior to discharge		
Monitoring requirements in primary care	Do not use blood tests routinely, but consider them to monitor for recovery of liver function and as a motivational aid for service users to show improvement. Monthly contact with the patient to check; adherence to abstinence to alcohol and relapse prevention medication; check for tolerance / side effects.	U&E incl Serum Creatinine, LFTs to make sure levels don't worsen to be contraindicated. Do not use blood tests routinely, but consider them to monitor for recovery of liver function and as a motivational aid for service users to show improvement. Monthly contact with the patient to check; adherence to abstinence to alcohol and relapse prevention medication; check for tolerance / side effects.	6 monthly extended LFTs Ad hoc U&E incl Serum Creatinine to make sure levels don't worsen to be contraindicated. Monthly contact with the patient to check; adherence to abstinence to alcohol and relapse prevention medication; check for tolerance / side effects.
*How long to	Usually up to 6 months, or longer for those benefiting	Usually up to 6 months, or longer for those	No longer than six months without review.

continue	from the drug who wants to continue with it. Seek specialist advice if to prescribe beyond 12 months. Treatment should be stopped if drinking persists 4–6 weeks after starting the drug.	benefiting from the drug who wants to continue with it. Seek specialist advice if to prescribe beyond 12 months. Treatment should be stopped if drinking persists 4–6 weeks after starting the drug.	Seek specialist advice if to prescribe longer. Treatment should be stopped if patient restarts consumption of alcohol