Somerset Guidelines for Shared Care (Substance Misuse) 2009

Primary Care and Turning Point Drug & Alcohol Service

Aim:

To ensure a safe and consistent approach to the treatment of people with drug dependence when jointly managed between Primary Care and Turning Point, the specialist drug and alcohol service for the county of Somerset.

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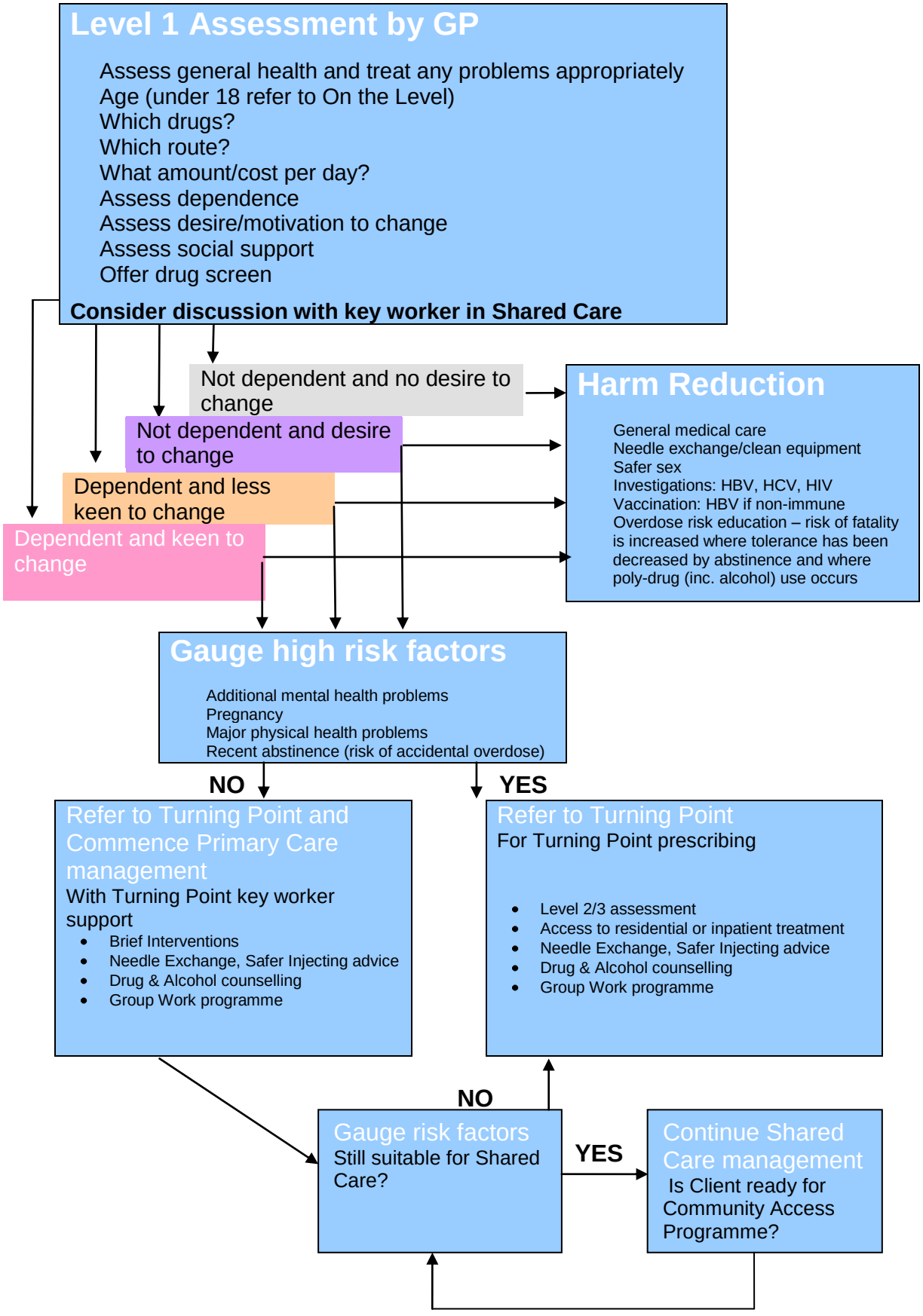
Contents

Diagram 1 Shared Care Summary Flow Chart



Introduction

Definition of Shared Care

'The joint participation of specialists and General Practitioners (and other agencies as appropriate) in the planned delivery of care for patients with a drug misuse problem, informed by an enhanced exchange of information beyond routine referral and discharge letters.

It may involve the day-to-day management by the GP of a patient's medical needs in relation to his/her drug misuse, and may involve prescribing substitute drugs.

Such arrangements would make explicit which clinician was responsible for different aspects of treatment'.
Reviewing Shared Care Arrangements for Drug Misusers (Dott, 1995 in Beaumont, B., 1997)

The value of Shared Care

'Shared Care as a model can be applied to any close co-operative work between agencies or services that directly improves the treatment of the individual drug misuser. It most often involves arrangements between Specialist and General Practitioner-Services.'
Drug misuse and Dependence UK Guidelines on Clinical management (Department of Health 2007)

The lifestyle of an individual who is misusing drugs tends to lead to an increase in health problems and/or incidents, which may lead to him/her seeking attention from his/her General Practitioner (GP). The family doctor is viewed as the natural first point of contact for those seeking help with such issues.

The advantages of a drug user being treated in Primary Care are that the service can be more stabilising, is less conspicuous and more accessible. One can observe that there is an 'increasing preference by drug misusers to receive care in a Primary Care setting within the community wherever possible as it reduces the feelings of stigmatisation' (DoH 1999). There is also evidence that suggests that patients receiving treatment from their GP expressed greater satisfaction with it and reported a better emotional state in comparison to patients receiving treatment from a specialist Drugs Service. *(Speed* et al*., 2000* in *Mistral and Smith 2001)*

Shared Care in Somerset and the specific application of this policy

It is acknowledged that Shared Care of people with drug problems extends far beyond prescribing and includes joint working between statutory and non-statutory agencies, such as Turning Point, in terms of drug treatment and co-ordination. Pharmacies also play an important role in providing supervised consumption and liaising with drug treatment service when required.

The term 'key worker' used in this policy applies to Turning Point Drugs & Alcohol workers with named workers' roles and responsibilities clearly defined on each patient's Shared Care agreement.

The specific application of this policy at this time in Somerset is to guide the working process of GPs and identified key workers and to encourage and develop consistent codes of good practice within a Shared Care model for the treatment of substance misuse in Somerset. It is orientated mainly around prescribing substitute opiates in the management of opiate dependence.

This will be a dynamic policy that will need to be reviewed regularly in order to respond to the evolution of Shared Care and growing expertise amongst GPs in Somerset. See Appendices 2 and 3.

These guidelines should be read in conjunction with *Drug Misuse and Dependence – UK Guidelines in Clinical Management* (DoH 2007)

General medical services and drug dependence

All GPs should offer general medical services (GMS) and basic harm reduction interventions for all drug users including stimulant users. This should include the following:

- Advice regarding safer injecting and avoidance of blood-borne virus transmission, including local needle exchange facilities.
- Advice on safer sex.
- Advice on contraception, smear tests.
- Testing for Hepatitis B and C and HIV with pre- and post-test discussion.
- Vaccination for Hepatitis A and B where appropriate.
- Referral to hepatology and other secondary medical care services as necessary.
- Inquiry about past drug use.
- Inquiry about other drug-related problems.
- Referral to infectious diseases services where necessary.
- Referral to specialist drug treatment services where necessary/appropriate.
- Referral to voluntary agencies offering supplementary services where necessary/appropriate.
- Signpost to additional help (counselling, benefits, housing).

Types of GP involvement in Shared Care in Somerset

GPs can be involved in providing Shared Care in a number of ways and should decide which is or are most appropriate at a particular time, taking into consideration:

- Practical issues such as availability of office space.
- Skills and knowledge of practitioners.
- Patient preference.

Surgery-based Shared Care
The surgery offers Shared Care for its own patients and appointments with the specialist key worker take place at the surgery itself. This is most appropriate where adequate space is available and is the preferred model. The key worker may be based in the surgery for part of the working week and may hold a regular clinic to which the GPs can refer patients for initial assessment or ongoing support. Remuneration is in line with the Standard Local Enhanced Service Specifications.

Clinic-based Shared Care
The surgery offers Shared Care for its own patients but appointments with the specialist key worker take place at another location, most commonly Turning Point. This form is suitable where there is insufficient space at the surgery or where the location of the clinic is more convenient for the patient to attend. Remuneration is in line with the Standard Local Enhanced Service Specifications.

GPs with a Special Interest (GPwSIs)
GPwSIs provide Shared Care to patients who are either registered with them or whose own GPs are not able or willing to participate in the Scheme. They may offer the service to a catchment area or as an outreach to a smaller community with no drug treatment provision. The GP and specialist key workers are likely to work from the same location on the same day. These GPs can also have an advisory, supportive and educational role to other GPs embarking on the scheme or already providing Shared Care. The balance of functions will be dictated by local factors such as: the availability of ordinary Shared Care; the severity of presenting needs of patients; levels of knowledge and skills or other GPs in the area.

GPwSIs have substantial knowledge and experience in drug treatment. The overall framework and level of numeration are detailed in the GPwSI Enhanced Service Specification.

GPs supporting specialist services
GPs can also provide medical cover as part of Turning Point's Drug & Alcohol Team. Remuneration is paid by Turning Point for each half-day clinic session per month.

The Somerset Drug and Alcohol Action Team (SDAAT) support the range of options described above and will also continue to work closely with the Shared Care Monitoring Group (SCMG) to ensure the developments in Shared Care are as consistent as possible across the county.

Shared Care pathway

Although the pathway of each service user will differ the general process initiated by a GP is outlined in Diagram 1 on page 5.

Of course, if a patient becomes unsuitable for Primary Care management in the Shared Care environment (e.g. severely increased chaos, pregnancy, change in mental health) then they should be referred back to the central (Turning Point) team locally.

The movement of patients can be in both directions, with Shared Care accepting back stable patients from central (Turning Point) teams.

Aims of treatment

- Reduction in the number of drug-related deaths.
- Reduction or cessation of illicit or non-prescribed drug use with or without the ultimate goal of abstinence.
- Cessation of sharing of injecting paraphernalia for drug use.
- Improved physical and emotional well-being.
- Reduction/cessation of criminal activity.
- Improved personal and social behaviour.
- Reduction in the risk of prescribed drugs being diverted onto the illegal drug market.
- Cessation of injecting behaviour.
- Relative abstinence from illegal drug use.

Relative contraindications for GP prescribing

- Chaotic poly-drug use.
- Patients with serious mental health problems.
- Patients assessed as posing a risk of violent or aggressive behaviour.
- Pregnancy.
- Children at risk.

The above contraindications may not apply to GPwSIs

Specialist services will concentrate on substance misuse complicated by:

- Severe mental health problems. Where the mental disorder is of a nature and severity in itself to require psychiatric services, the patient should be referred to both Turning Point and the local Community Mental Health Team (CMHT).
- Stimulant or complex poly-drug misuse.
- Persistently chaotic or challenging behaviour.
- High-risk injecting behaviour (groin, neck).
- Under-18 with drug dependency (On the Level).
- Patients who have not responded positively to Shared Care intervention.
- Referrals for assessment for in-patient detoxification.
- Referrals for residential rehabilitation.
- Pregnancy.
- Children at risk.

Management of the patients' treatment though a Shared Care pathway

Referral

- The GP should make it clear whether they will be willing to engage in a Shared Care Programme.
- Following initial assessment of a patient wanting treatment, the GP sends the standard referral form to Turning Point.
- The patient is registered with the team.
- Referral requests may be generated by other organisations, including Turning Point itself.
- Self-referral.

Assessment

The GP should:

- **CONSIDER**
  - Drug history, past and recent. Money spent on drugs each day.
  - Injecting behaviour.
  - Symptoms of dependency.
  - General health.
  - Mental health.
  - Motivation for change.
  - Patient's perception of need.
  - Current medication.

- **LOOK FOR**
  - Signs of dependency/injection sites.
  - Signs of intoxication or withdrawal.

- **ARRANGE**
  - Drug screen by urine or oral swabs.
  - To get blood.
  - Testing for viral exposure at an appropriate early point (liver function tests and full blood count should also usually be included in initial investigations).
  - Provide harm-reduction information.
  - Hepatitis A and B vaccinations.
  - Referral for assessment at Turning Point (using standard referral form).

The key worker will complete the assessment by adding their own findings and may use information obtained from other involved professionals. Their assessment will conform to a tier-3 assessment as defined in Appendix 1 and take into account the patient's treatment goals. They will also complete a Treatment Outcome Profile (TOP) form with the client.

No substitute medication should be prescribed unless or until the patient's drug screening has been conducted and has proved positive for opiates.

Planning treatment and care

Following full assessment by the specialist key worker, a recommended treatment plan is sent to the GP. (See also *Record keeping*, below). This should include the goal for prescribing, i.e. detoxification or longer term prescribing.

The Shared Care treatment agreement is to be signed by the patient (Appendix 4) prior to commencing treatment.

Regular appointments are established and may be more frequent during titration/stabilisation/detox. All patients must be seen at least once every three months.

Consideration is given to the related psychological and social needs of the patient in the broader care plan. The patient may have needs that can be met by other members of the specialist multidisciplinary team, e.g. CMHT day services, group work, social worker. Such arrangements form part of the treatment agreement and are detailed on the written Care Plan. A proforma exists for obtaining patients' written permission to share confidential information.

Agreement for dispensing medication is reached with the pharmacist concerned. The patient should be issued with clear information about the pharmacy and arrangements for receiving medication. (See *Dispensing,* below.)

The Interval Prescribing 3-way agreement for Supervised Consumption from Somerset Pharmacies will then be signed by all parties.

Prescribing substitute drugs in Shared Care

Whether to prescribe?

The principle of harm minimisation:

- Treatment aims to alter the consequences of drug dependency by reducing drug-related harm to the individual and to society. Substitute prescribing follows the harm minimisation approach to opiate dependence and is known to be effective.

Functions of a prescription:

- Helps to maintain contact with the drug user.
- Reduces or prevents withdrawal symptoms.
- Reduces need for criminal activity to buy street drugs.
- Offers opportunity to stabilise drug intake and lifestyle.

A prescription for substitute drugs should only be considered if:

- Drugs are being taken daily.
- There is convincing evidence of dependence (including objective signs of withdrawal in the case of opiates).
- When the patient's goal is to stabilise their drug use.
- The doctor and patient are clear that substitute prescribing could help the patient to achieve changes in pattern of drug use or lifestyle.

Substitute medication should not be prescribed until the assessment is complete and there is an informed treatment plan. Prescribing is the particular responsibility of the doctor signing the prescription. The responsibility cannot be delegated.
The intermediate practitioner may advise or initiate treatment in the intermediate clinic before referring back to the GP for continuation of Shared Care.

Note: There is no good clinical evidence that substitute drug treatment for stimulant dependence (amphetamine, cocaine) is helpful.

Prescribing in a Shared Care agreement is only part of the response to opiate dependence. In order to be effective, it must be supported by appropriate psychological and social support strategies.

Which drug to prescribe?

Use assessment (history, urine/saliva toxicology, drug diary) to decide on which drug and how much. Consult with Turning Point.

BUPRENORPHINE (Subutex) is a semi-synthetic derivative of opium and a useful alternative to methadone. It was licensed (1999) for the treatment of drug dependence. It has an effective duration of at least 24 hours with a half-life of 20-25 hours and two-day dosing has been found to be effective. It is available in 0.4 mg, 2 mg and 8 mg tablets. Doses up to 32 mg can be used for maintenance. There is a risk of it being used for injection.

Administration is via the sublingual route and it takes effect in 90-120 minutes. It strongly binds to morphine receptors and so introduction will displace other opiates and cause a paradoxical acute withdrawal syndrome – it should therefore only be initiated according to the guidance, when a patient is already in withdrawal. Buprenorphine binds to opiate receptors more strongly than other opiates. This means that higher doses of buprenorphine (>12 mg) have a partial blocking effect. There is a theoretical but not yet proven advantage that patients will be less likely to use heroin on top.

Consider buprenorphine for:

- Patients new to treatment who are seeking opiate maintenance treatment.
- As a detoxification tool in patients who want to become drug-free.
- Patients who are ready to become opiate-free and wish to use an alternative to methadone.
- Patients who are on low doses of methadone (less than 30 mg) and wish to become drug-free.
- In cases where methadone (or other prescription) has not enabled the patient to stabilise.
- Patients who are unwilling to receive a prescription of methadone after appropriate information given.
- Patients who require low-dose methadone maintenance but are reluctant to take methadone as a long-term treatment.
- Patients who are not already pregnant or breast-feeding. (Buprenorphine may be continued if a patient becomes pregnant during treatment.)

- In cases where there is a risk of overdose, a lower risk of respiratory depression with buprenorphine is an advantage.
- Suboxone is a branded version of buprenorphine that has naloxone added to reduce the risk of street diversion.
- In patients who are also drinking heavily, the overdose risk may be lower than with methadone.

Buprenorphine should be prescribed according to the detailed guidelines published by the Royal College of General Practitioners (RCGP). See Error! Reference source not found.**.**

METHADONE MIXTURE, 1 mg per 1 ml, has proven health and social benefits and is an accepted licensed treatment of opiate dependence.

Methadone is the drug of choice for most patients since it is long-acting (half-life), straightforward to titrate, unlikely to be injected and has evidence of its efficacy.

How much to prescribe?

TITRATION FROM HEROIN ONTO METHADONE

Assess RECENT (last month) and CURRENT USE

- The history of money spent daily on heroin.
- Weight of drug used daily (smoked heroin needs less oral substitution than injected).
- Prescribed drugs, alcohol and street drugs used.
- Remember that the risk of OVERDOSE is greatest in first two weeks of methadone treatment because patients will still be inclined to use heroin on top.
- The initial starting dose must be decided through discussion between the GP and the key worker. The starting dose should rarely exceed 30 mg and may be less in low-weight individuals. Doses should be titrated up slowly, no more frequently than twice weekly, and by no more than 20% of the preceding dose at each occasion. The evidence points to methadone dose levels of 60-120 mg being more effective than lower dose regimes.

Discuss PROS and CONS of methadone treatment with the patient:

- Explain that it is a once daily liquid dose to be taken in front of the pharmacist.
- It will not cause euphoria.
- That the initial dose may not be high enough and may need some adjustment and that overdose is a considerable risk unless the patient either stops, or very substantially reduces, his/her heroin use.

Best Practice Example of Titration Regime

DAY 1

- Start Monday or Tuesday, ideally, as two doses will be given on Saturday, increasing the risk of overdose. Ideally no heroin since evening before to demonstrate withdrawal symptoms.
- Ring nominated pharmacist (who should be convenient to patient and supportive of Shared Care) to introduce and describe patient and confirm arrangements. Patient ID may be required.
- Advise strongly against using 'on top' heroin and to abstain from alcohol (risk of overdose and delay of stabilisation).
- Explain that methadone effects last for more than 24 hours and that the drug builds up over several days after every dose increase.
- Give one day's script for methadone mixture, 1 mg in 1 ml, to be dispensed daily and marked 'supervised consumption'. The starting dose should usually be 30 mg (but less can be used if appropriate e.g. 10 or 20 mg) to reduce the risk of overdose.
- Give written information (e.g. *The Methadone Handbook*).

DAY 2

- Ask about withdrawal symptoms (time of onset and severity) and symptoms of intoxication and overdose.
- Ask about heroin use.
- Increase dose by 5-10 mg if withdrawal symptoms warrant this.

DAY 3 onwards

- Review if necessary. Consider increases of 5-10 mg of methadone, increments probably every 3rd day of 5 mg or weekly 10 mg until stable/withdrawal suppressed.

Titration appointments can be weekly, instead of daily, according to resources. GPs may prescribe methadone using the blue instalment dispensing prescription FP10 (MDA). (A maximum of 14 days installed dispensing can be prescribed.) See Appendices 5 and 6.

Initially prescriptions should be written for daily dispensing and issued weekly prior to review by the key worker and until a stable dose is established.

Ongoing treatment

- Patients will receive daily-supervised consumption of a substitute medication for at least the first three months of treatment. Exceptions to this may be made following discussion with the key worker in Turning Point Somerset, Drugs Service. Arrangements will be reviewed after three months. If all those involved in the treatment agreement consider it is safe to do so, then the level of supervision and frequency of dispensing may be gradually relaxed. (If the pharmacist is involved in this process then patient compliance can be included into the decision making process.)
- The period of supervised consumption should be extended if the patient has not stabilised on the prescribed methadone (e.g. continued supplementary use of illicit substances).
- Exception to this should be considered for patients who are clearly making good stable progress and those in full-time education when daily-supervised consumption arrangements might jeopardise their social stability.

- Only the identified GP should issue the patient's prescription for substitute medication (a deputy should be delegated during periods of leave). Other partners and locums should avoid entering into discussions relating to substitute prescribing with the patient. However, it would be hoped that more than one GP at the practice has completed the RCGP Certificate Part 1.
- It is the patient's responsibility to ensure they have a valid prescription issued to the pharmacy (either having been sent by post or collected by patient). Initially, the GP or key worker should see the patient regularly to titrate the dose upwards. If the key worker is primarily reviewing the patient, then GP and key worker should be in weekly direct contact (phone or face to face, not letter) reviewing dose.

Dispensing

- Methadone mixture will be dispensed at a specified (Health Authority contracted) pharmacy agreed with the patient. The pharmacist shall be contacted prior to receiving the prescription and will be sent a copy of the Somerset Policy, Guidelines and Interval Prescribing 3-way Agreement. See also Appendices 8 and 9. The pharmacist should be sent the specific care programme for the patient since they are often the professional in most regular contact with the patient and will need to know which professionals to contact when necessary.
- The pharmacist will notify the prescribing doctor (or key worker) if the patient does not attend for dispensing for three consecutive days. In these circumstances the prescription will be voided until the patient has made contact with the GP or key worker. Following this contact a review discussion will take place between the GP and the key worker as to whether it is safe and/or productive to recommence the methadone prescription. Similarly, the pharmacist should be informed of changes to the care plan or if the patient is known to be unable to collect.
- The pharmacist reserves the right (by means of the signed contract) to refuse service to the patient if unacceptable behaviour is displayed. The pharmacist should make immediate correspondence to Turning Point and the patient's GP to this effect.

Follow-up

- Patients will be monitored through face-to-face contact with the key worker on at least a fortnightly basis at first. Unstable or newly commenced patients will need to be seen more frequently. Stable patients going through periods of maintenance will be seen at intervals agreed by all parties. It is expected that patients will also meet with the GP on at least a three-monthly basis if very stable.
- Reasonable attempts should be made to retain the patient in the treatment process if they miss an appointment. After two missed appointments the safety of continuing the prescription without seeing the patient should be reviewed. It may be necessary at this stage to cease substitute prescribing or commence a withdrawal regimen. (See *Managing relapse,* below).

Record-keeping and communication

- Both the GP and the key worker are responsible for ensuring that any reports from drug assays they have taken are copied from Primary Care to Secondary Care and vice versa.
- If the key worker is 'attached' to a practice, detailed recording may take place within the Primary Care record system and summary referring to the Primary Care records entered into Secondary Care database.
- If the key worker is working remotely from the Primary Care environment, they will maintain records within the secondary care database and liaise with the GP through a mutually agreed method of communication (e.g. email, facsimile, letter, telephone, meetings). The method of communication needs to allow for frequency of communication around prescription changes. The preferred method of communication should be detailed on the patients written care programme.
- The key worker will be responsible for ensuring that a written care programme or plan is entered into the secondary care database and distributed to all relevant parties.
- All Somerset patients overseen by a key worker at Turning Point, whether in the core service or in Shared Care, will be risk assessed by Turning Point. The risk assessment will be regularly reviewed and will form the basis for the frequency of multidisciplinary reviews within Turning Point. Those presenting the highest risk must be reviewed the most frequently. Following each review, the key worker will send a written summary to the GP outlining any significant developments of changes to the overall plan.

Managing lapses (episodes of 'on top use')

- Lapses are commonplace in even the most motivated patients and some tolerance is necessary in order to achieve the broader aims of treatment.
- Lapses should be raised with the patient exploring 'triggering events' and consequences. Such discussion should be orientated towards developing relapse and prevention strategies and associated lifestyle changes. The key worker will be responsible for providing the majority of these interventions.
- When exploring the reasons for lapsing, consideration should be given to whether the substitute dose has been sufficient.

Managing relapse

Substitute prescribing may be terminated if:

- The patient continues or returns to regularly using illicit drugs in addition to the prescribed substitute and it is considered that continuing the prescription adds iatrogenic risk of overdose or compound dependence. The risk of diversion (supplying the prescribed substitute to others) may be a reason for terminating the prescription.
- There has been a complete breakdown in the treatment process through repeated non-attendance to appointments or violence towards staff.
- If more than three consecutive daily doses of methadone have not been picked up, it is necessary to assume that it may not have been taken and tolerance will be lost – in which case restarting the same dose may risk overdose. In such a situation, it may be necessary to restart methadone at a lower dose and titrate back to the preceding dose as appropriate. The risk of overdose after failed pick ups of buprenorphine is lower.

Termination of treatment is a serious step, especially if there may be a return to high-risk behaviours as a result. Treatment staff must be certain that it is a necessary intervention on the basis that the risks of continuing the prescription are greater than the risks of stopping it.

The patient should be aware of exactly what the rate of detoxification will be before the prescription is terminated. Abrupt cessation of opiates is not fatal in people who are otherwise healthy. The rate of reduction therefore usually seeks to strike a balance between continuance of the prescribing programme under a new guise, and a rate of reduction, which gives the individual some chance of achieving abstinence should they decide to.

As a very rapid detoxification, the following regime can be used when methadone mixture is the substitute agent: 10 mg reduction in the daily dose every day until the patient is receiving 30 mg daily, then 5 mg reduction in the daily dose each day with two days on 2 mg at the end. This should be used in extreme cases for the rapid termination of prescribing.

Patients with a long history of methadone maintenance (spanning more than 18 months) will need much greater consideration in terms of the rationale for prescription termination and the rate of withdrawal needs to be much slower. Medical/psychiatric supervision from Turning Point would be indicated in such cases (see below).

Direct specialist supervision

- Specialist review can take place by the patient having direct medical/psychiatric consultation at Turning Point. This would be particularly relevant if the patient's course of treatment were to become problematic and there were concerns about the viability and the safety of continuing treatment under Shared Care arrangements. This option may also be considered in circumstances where the GP requires extra support.
- The key worker will receive supervision through individual supervision and through attendance at specialist multidisciplinary team meetings.
- The GP can seek support from Turning Point or a GPwSI.

Benzodiazepines (see Appendix 9)

The evidence for the value of methadone maintenance prescribing is overwhelming while there is none for benzodiazepines. Despite this fact many doctors feel more comfortable prescribing them rather than methadone. There are also concerns that GP prescriptions may become diverted onto the illicit market particularly into the hands of opiate users (around 30% co-use). Illicit benzodiazepine dealers and internet pharmacies are also responsible for availability.

There is no licence to use benzodiazepines to treat dependency, unlike methadone. Users will often stockpile tablets for bigger effect. Evidence suggests that high dose long-term use is associated with cognitive impairment and neurological damage.

Withdrawal symptoms are more severe the longer the drug is used. It is a difficult drug to work with in a treatment programme as it cannot be given once daily by supervised consumption

Please note that zopiclone has been used as a drug of abuse and for practical purposes should be grouped in with benzodiazepines.

The philosophy of benzodiazepine prescribing regimes should be:

- Convert to diazepam as it is the most long-acting and gives less euphoria than shorter acting drugs, e.g. temazepam. There is no indication for using two benzodiazepines.
- Use conversion charts in the BNF.
- Changes should be made with the patient's agreement when possible.
- The prescriber should not force the pace but prescribe for as short a period as possible: < 6 months.
- Set clear targets with patients and include brief rests if this helps. Usually 30 mg is adequate (rarely up to 60 mg then rapid reduction). Start low and work up to a dose that prevents withdrawal symptoms.
- Daily dispensing. Diazepam may be dispensed in daily instalments on an FP10MDA.
- **ALL BENZODIAZEPINE SCRIPTS SHOULD BE REDUCING.**

Appendices

Appendices 1 – 16

Appendices.pdf

Appendix 5

RCGP Buprenorphine Guidelines.pdf

Appendix 14

RCGP Guidance Hep A and B.pdf

LES Shared Care Misuse

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Practice Templates for Substance Misuse

Initial Template.pdf

Follow up Template.pdf

Primary Prevention of Hepatitis C Among Injecting Drug Users

Primary Prevention of Hepatatis C Among

Somerset guidelines for Shared Care endorsed by:

Somerset

Somerset Drug and Alcohol Action Team

Somerset

Somerset Local Medical Committee