# Respiratory Disease in Drug & Alcohol Treatment Services: Clinical Pathway

This pathway has been developed by members of the Northwest Drug & Alcohol Related Death Comorbidities Task & Finish Working Group 2023.

# A clinical pathway designed for the population of Service Users in Drug & Alcohol Treatment Services

**Evidence:**

- There is evidence that heroin smokers have high rates of hospital admissions and respiratory morbidity, and mortality(i)
- Most common causes of drug related deaths, that were not from overdose, were deaths from alcoholic liver disease followed by COPD/Emphysema/Respiratory Failure (ii)
- A Lancet paper reported that past-year smoking prevalence was 63% among drinkers at risk of alcohol dependence (iii)

**Rationale:**

- Individuals with drug and alcohol problems suffer from stigmatisation in the healthcare system, whether real or perceived. This can lead to avoidance of interacting with traditional treatment services
- The drug and alcohol treatment service may be the only service individuals attend, and it is a golden opportunity to offer primary and secondary prevention of respiratory disease, diagnosis, and treatment.
- In addition to the personal cost to individuals with respiratory disease in terms of increased morbidity and mortality, there is a cost to society in terms of frequent hospital admissions.


- Nightingale R., Mortimer K., Giorgi E., Walker P., Stolbrink M., Byrne T., Marwood K., Morrison-Griffiths S., Renwick S., Rylance J and Burhan, H. Screening Heroin Smokers Attending Community Drug Clinics for Change in Lung Function: A Cohort Study. Chest 2020;157(3):558-65
- Whitfield M. and Reed H. Cheshire & Merseyside Drug Related Deaths & intreatment mortality Annual Report 2021
- Garnett C., Oldham M., Shahab L., Tattan-Birch H. and Cox S. Characterising smoking and smoking cessation attempts by risk of alcohol dependence: A representative, cross-sectional study of adults in England between 20142021. The Lancet Regional Health - Europe 2022;18: 100418

# Development of the Clinical Pathway

- This pathway was developed by members of the Northwest Drug & Alcohol Related Death Comorbidities Task & Finish Working Group 2023.
- The membership of the Working Group is comprised of health care professionals and managers working within drug and alcohol treatment services and commissioners of these services.
- The group met every 6 weeks in 2023 to discuss how respiratory disease was addressed within our services and what more could be done to address the unmet need of severe respiratory morbidity and mortality .in this service user population
- The outcome was the production of the Clinical Pathway and it is being launched nationally with the aim of raising awareness and improving the treatment provision for service users of Drug & Alcohol Treatment Services.

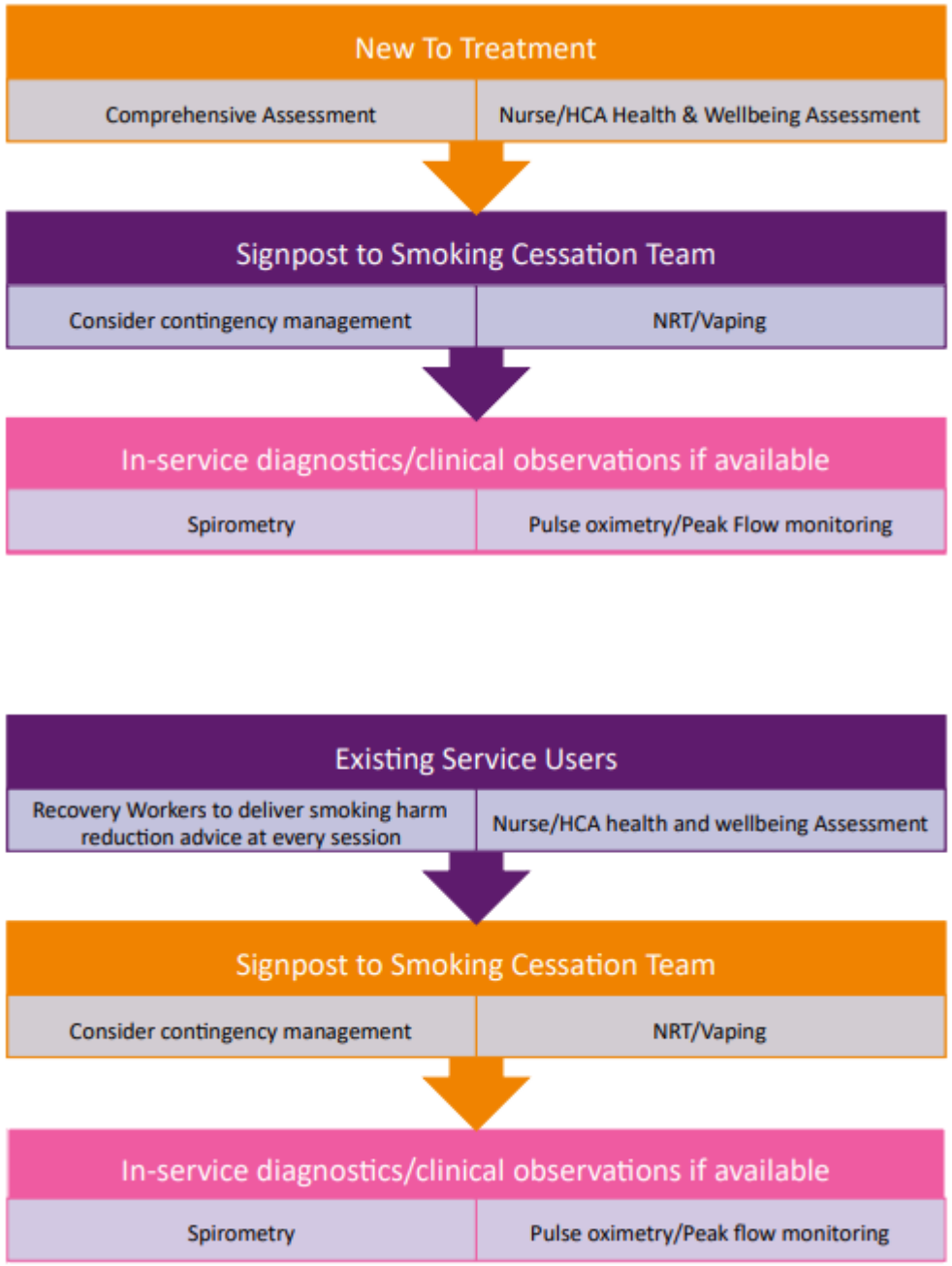
# How will the pathway be used?

- This pathway can be made available to the whole workforce to encourage a team approach to improving the respiratory health of drug and alcohol users.
- As services are designed and commissioned in different ways, some aspects of the pathway may not be suitable for every service.
- It is designed as a guide that can be adapted to work within the resources available in different organisations

# Clinical Evidence and Guidelines Incorporated into the Pathway

1. CLeaR Local Tobacco Control Assessment - GOV.UK (www.gov.uk)
2. NICE guidelines NG 115 Overview | Chronic obstructive pulmonary disease in over 16s: diagnosis and management | Guidance | NICE
3. NICE guidelines NG 209 Overview | Tobacco: preventing uptake, promoting quitting and treating dependence | Guidance | NICE
4. RightCare Pathway: COPD NHS RightCare Pathways: COPD (england.nhs.uk)
5. MRC Breathlessness Scale
6. Right Breath Website
7. National Centre for Smoking Cessation and Training (NCSCT) website
8. The COPD Assessment Test (CAT)

# Clinical Pathway for Smoking Cessation/Reducing Risk of Smoking-related Respiratory Disease




**COMMISSIONERS**

1. Support the Drug & Alcohol services that you commission to provide staff training to enable them to follow the clinical pathway.
2. Liaise with commissioners of primary and secondary care respiratory services to encourage and facilitate a multidisciplinary and collaborative approach to the prevention, diagnosis and treatment of respiratory disease in drug & alcohol services.
3. Consider commissioning in-service smoking cessation service within drug & alcohol services.
4. Undertake the CLeaR Local Tobacco Control Assessment if appropriate for the service

**SERVICE MANAGERS**

1. Ensure all staff are trained in offering harm reduction advice for tobacco in addition to drugs and alcohol – see NCSCT website.
2. Provide access to smoking cessation and support to staff as well as service users.
3. Undertake the CLeaR Local Tobacco Control Assessment with commissioner if appropriate for your service.
4. Work closely with commissioners to encourage collaborative working with community respiratory health teams and secondary care.
5. Consider setting up an 'Opt Out' Smoking Cessation Service if available.
6. Consider carbon monoxide screening at assessment.

**ASSESSMENT TEAM**

A. Ask the questions:

1. Do you have a diagnosed respiratory disease like asthma or COPD?
2. Do you smoke tobacco?
3. Do you smoke cannabis?
4. Do you smoke heroin?
5. Do you smoke crack cocaine?
6. Do you ever have any of the following symptoms?
   - Breathlessness on exercise or walking upstairs
   - A persistent cough
   - A wheezing sound in your chest

B. If the answer to any of the above is yes, book in with the nurse for a health and wellbeing assessment (if this service is available)

C. If the answer to any of the above is yes, offer brief smoking cessation advice (as per NCSCT guidelines) and if indicated, offer signposting to Smoking Cessation Service.

**NURSING TEAM**

For any service users with a suspicion of or at risk of respiratory disease:

1. Take a full history of respiratory symptoms including number of hospital admissions in the past year, seasonal influenza vaccination, pneumococcal vaccination, any treatment.
2. Establish if the service user has got a diagnosis of COPD or other respiratory disease.
3. Check the service user's understanding of COPD and explain risks.
4. Ask if the service user gets 'Rescue Packs' from the GP and check understanding of when to use them (and how many times they have used in the past year).
5. Refer directly for spirometry if available.
6. Pulse oximetry/PEFR measurement and routine observations.
7. Weight and BMI – including any history of weight loss.
8. MRC Breathlessness scale.
9. Offer seasonal influenza vaccination if available in your service or signpost to GP/pharmacy.
10. Signpost to GP for Pneumococcal and COVID19 vaccinations
11. Support inhaler technique if prescribed – see 'Rightbreath' website.

**PRECRIBING TEAM**

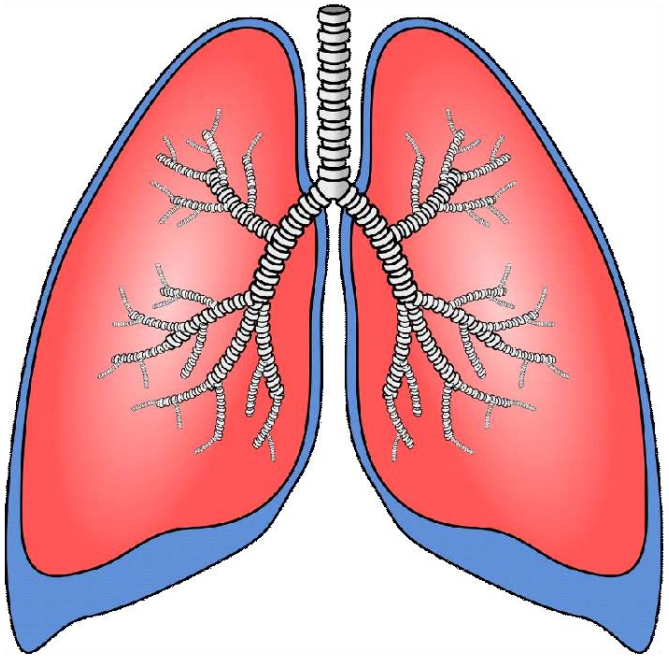
1. Include physical health assessment as part of prescriber assessments and reviews.
2. If OST is to be prescribed, consider Buprenorphine as first line in COPD and other respiratory disease.
3. If Methadone is the choice of the service user, start on a low dose and titrate more cautiously if there is a known respiratory disease.
4. Letter to GP after assessment and at each review.
5. Request GP to consider spirometry of service user is over 35 and COPD or Asthma is suspected and no diagnosis (or referral in-service spirometry if available in your service).
6. If service user has diagnosis of COPD or Asthma, advise to attend their regular Practice Nurse reviews.

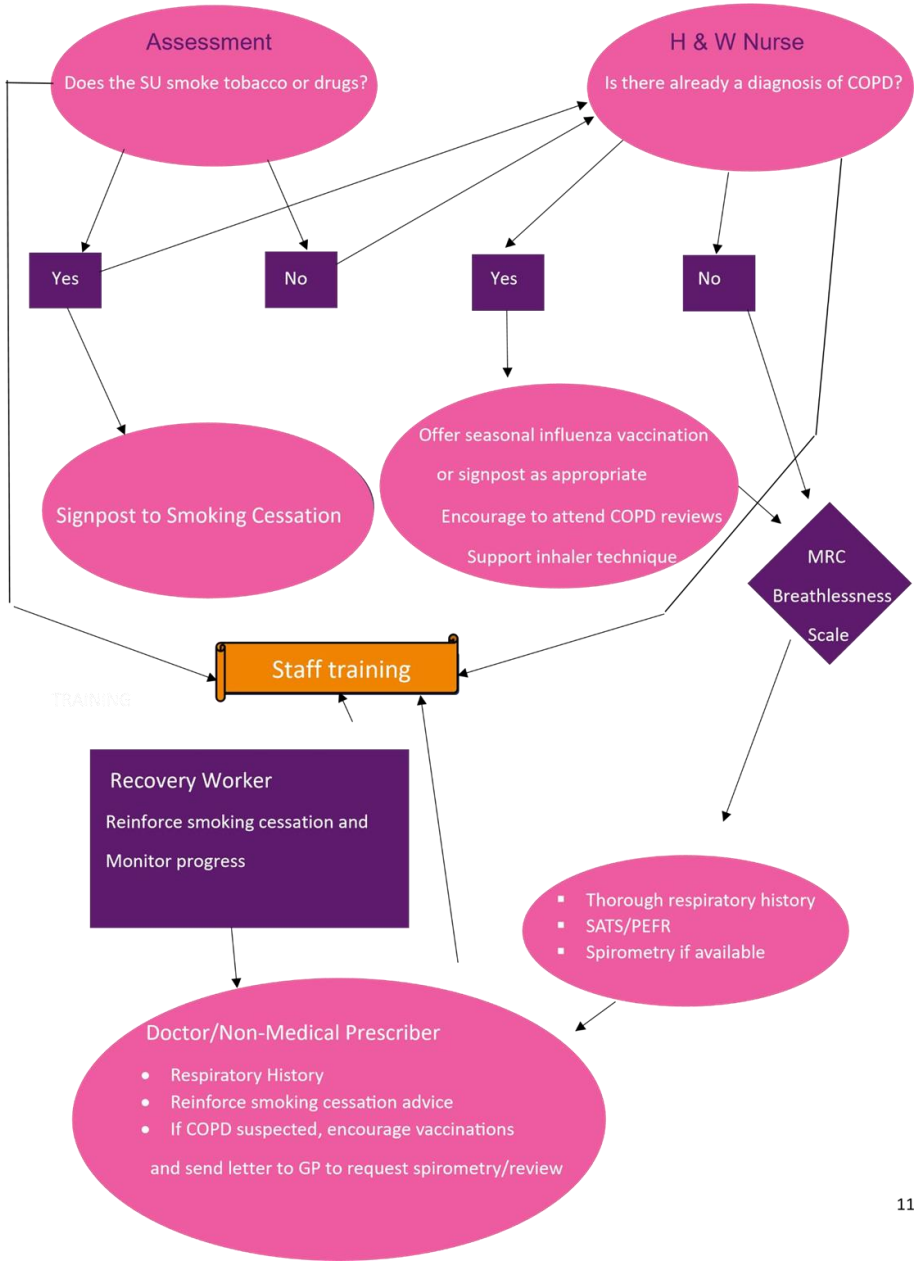
**RECOVERY WORKERS**

1. Attend training on smoking cessation.
2. Include smoking cessation advice with harm reduction advice for drugs and alcohol use.
3. Continue to offer signposting to smoking cessation service where necessary ('Opt Out' Service if available)
4. Report any physical health concerns to clinical team.

# Respiratory Disease in Drug & Alcohol Treatment Services:

## Clinical Pathway













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# For further information

Contact: S.MorrisonGriffiths@cgl.org.uk
elizabeth.booth@wearewithyou.org.uk
ariella.williams@wearewithyou.org.uk