Camden and Islington NHS
NHS Foundation Trust

PRESCRIBING GUIDANCE FOR SUBSTANCE MISUSE SERVICES

MAY 2019

This policy supersedes all previous policies for prescribing guidelines issued by Camden and Islington NHS Foundation Trust's Misuse Services.

Your partner in care & improvement

Policy title	Prescribing Guidance for Substance Misuse Services
Policy reference	PHA46
Policy category	Clinical
Relevant to	Clinical staff and service managers in Substance Misuse services
Date published	May 2019
Implementation date	May 2019
Date last reviewed	April 2019
Next review date	May 2022
Policy lead	Dr J Dunn, Consultant in Addiction Psychiatry Lucy Reeves, Chief Pharmacist
Contact details	Email: lucy.reeves@candi.nhs.uk
Accountable director	Dr Vincent Kirchner, Medical Director
Approved by (Group):	Drugs and Therapeutic Committee
Approved by (Committee):	Quality Committee

Document history	Date	Version	Summary of amendments
	July 2004	1	New guidance
	June 2009	2	Review and update
	Jan 2014	3	Review and update
	July 2016	4	Review: minor update
	May 2019	5	Review and update

Membership of the policy development/ review team	Dr John Dunn, Dr Bhaskar Punukollu, Dr Sarah Minot ,Dr Sivanthi Sathanandan, Ms Lucy Reeves, Mr Stuart Matousek, Mr Ruari McCallion
Consultation	SMS pharmacists, SMS clinical staff, DTC

DO NOT AMEND THIS DOCUMENT

Contents

1 Introduction

1.1.1 These guidelines are intended for use by medical prescribers, non-medical prescribers (NMP) and healthcare professionals working in the Substance Misuse Services in Camden and Islington Foundation Trust (C&I).

1.1.2 These guidelines should be read in conjunction with trust documents listed in section 30: Associated documents. Further detailed information can also be obtained from the reference documents listed in section 31: Key resources.

2 Aims and objectives

2.1.1 To ensure and promote evidence-based prescribing in line with national (including NICE and PHE) guidance and other relevant professional bodies.

2.1.2 To ensure that clients are prescribed medication that is individualised to their needs and that they are monitored and reviewed to ensure safe and appropriate use of medicines

2.1.3 To ensure adherence to the Trust Formulary to promote cost effective, evidence-based prescribing

3 Scope of the policy

3.1.1 This guidance is applicable for all healthcare professionals who keywork, prescribe or offer advice relating to medication and/or prescribing issues in Substance Misuse.

4 Duties and responsibilities

4.1.1 SMS managers are responsible for ensuring all relevant staff are made aware and are familiar with this guidance and all other relevant policy and procedures relating to the safe and secure prescribing, administration and issuing of medicines and prescriptions within Substance Misuse Services.

4.2 Medical Prescribers and Non-Medical Prescribers

(For the purpose of this guidance, the term ‘prescriber’ will refer to medical and independent non-medical prescribers)

4.2.1 All prescribers have a duty to:

- Follow these guidelines and other associated guidance, policy and procedures relating to the safe and secure prescribing, administration and issuing of medicines and prescriptions within Substance Misuse Services (refer to section 30 below for associated documents)

- Prescribe medication from the approved Trust formulary and within the licensed indication(s), unless off-label use approved by Trust and indicated in Trust formulary. Any deviations should be directed to the consultants before any final decision is made. For further detailed information refer to:

  - Trust formulary

  - Trust policy: Unlicensed Medicines & Unlicensed use of licensed medicines (off-label) policy

- Prescribe within their professional competencies. For further detailed information refer to:

  - Trust policy: Non medical prescribing policy

  - A competency framework for all Prescribers 2016. NICE accredited.
    https://www.rpharms.com/resources/frameworks/prescribers-competency-framework

- Prescribe in line with good practice standards. For further detailed information refer to:

  - Trust policy: Medicines Management policy (Prescribing of medicines, section 11).

4.3 All healthcare professionals working within Substance Misuse Services

4.3.1 Staff must have a good pharmacological understanding of the medication that is prescribed – any identified learning needs should be discussed in supervision.

4.3.2 Staff must adhere to the guidelines and where there is a valid reason for practice outside these guidelines, the request must be presented in the multi-disciplinary meeting and documented in the patient's electronic patient record.

4.3.3 Staff must follow SMS operational policy and procedures that support safe prescribing, administration of and issuing of medicines and /or prescriptions to service users. See section 31 below for list of associated documents.

5 Methadone Prescribing in Outpatients Services

5.1.1 Methadone is a synthetic opioid, widely used in the treatment of opiate dependence. Its long half-life makes it suitable for single daily dosing. The preparation of choice is Methadone oral solution 1mg/1ml sugar-free (the sugar formulation is available).

5.1.2 Some clients may be prescribed Concentrated Methadone 10mg/ml due to general health issues. However, many pharmacies and pharmacists are not used to dispensing Methadone Concentrate and may not have it readily in stock. Many drugs workers, nurses and doctors are unfamiliar with producing prescriptions for Methadone Concentrate. Due to the strength of the medication, errors could be fatal. Therefore, the decision to put a client on Methadone Concentrate needs to be risk assessed and assurances put in place that the staff initiating the medication, printing the prescriptions and dispensing the medication all have the competencies to do so.

5.1.3 Methadone tablets are not licensed for the treatment of opiate dependence due to the increased risk of diversion and injection and should only be prescribed with approval of the consultant and in line with the Trust's policy on the use of unlicensed medicines: Unlicensed medicines and unlicensed use of licensed medicines (off label) policy. Methadone tablets can be prescribed within the Trust for air travel as an exception following approval by the consultant (see section 'Holiday prescription')

5.1.4 Methadone ampoules are licensed for the treatment of opiate dependence but should only be prescribed with the approval of the consultant and in line with Drug misuse and dependence: UK guidelines on clinical management (PHE: 2017).

5.1.5 Other slow release or long-acting opioid medications, such a Morphine *MXL* and Morphine *Continus* should only be prescribed on a named patient basis and with the approval of the consultant.

5.1.6 Methadone is prescribed for the purpose of detoxification or maintenance treatment for opiate dependence in line with NICE Technology Appraisal 114 (2007).

5.1.7 A summary for management of opiate dependent hospital in-patients is available (see Appendix 1)

5.2 Aims of Methadone Prescribing

5.2.1 To stabilise the client and enable them to reduce or stop illicit opiate and other drug use and to improve physical and mental health, reduce the risks associated with drug use and to initiate and facilitate the process of social re-integration and recovery.

5.3 Inclusion Criteria

- For Camden and Kingston clients should be able to provide proof of a link with the prescribing borough. Documents which may be accepted as proof of such a link include: utility bills with the clients address, benefits documentations and for homeless clients either a CHAIN number or evidence from the Safer Streets Team (SST) that they have a connection with the borough. Registering with a local GP is no longer a valid link.

- For Islington clients do not have to be a borough resident to be eligible for treatment if they are registered with an Islington GP.

- Objective evidence from the clinical history and physical examination of opiate dependence and a current urine test that is positive for opiates, methadone or other opioids.

- A willingness and ability to co-operate with the programme, in particular, the process of assessment, examination, urine testing and review.

- Age 18 years or over and with the capacity to consent to treatment

- It is good clinical practice to inform the client's general practitioner (GP) that treatment has started. Where a client refuses consent for the prescribing service to inform their GP, the prescribing service will not normally prescribe medication for the client, but will refer them back to their GP. This is to minimise the risk of 'double-prescribing' where client may be prescribed the same medication or/and another medication that may interact with the prescribed medication. Alternatively GP Summary Care Record portal can be accessed to obtain the list of current medication prescribed by the GP.

Camden Specialist Drugs Service is now a complex needs substance misuse service and an additional set of criteria need to be met (see Appendix 2)**.** Contact the service directly on 0203 317 6000 for further information.

5.4 Exclusion Criteria

- Clients who are using opiates but are not dependent on them.

- Client providing opiate/opioid negative urines.

- Further precautions may be necessary in those patients with severe mental illness or recent head injury, acute abdominal conditions

- Clients who present intoxicated

- Under the age of 18 years will need to be referred to the local Young person's Service:

  - Camden: Forward (FWD) Drugs and Alcohol service for young people in Camden

  - Islington: Islington Young People's Drug and Alcohol Service (IYPDAS)

5.5 Initiating Methadone Prescribing

5.5.1 The decision to initiate opioid substitute prescribing on an outpatient basis is made following multi-disciplinary assessment and the development of a treatment and recovery care plan which will be formulated in collaboration with the client.

5.5.2 Methadone is usually prescribed in the form of Methadone Oral Solution 1mg/1ml Sugar-free (available in sugar formulation).

5.5.3 Dosage is determined by clinical judgement depending upon the degree of dependence and is determined by the doctor or non-medical prescriber in conjunction with feedback from the client and keyworker and within the recommended national guidelines. The dose should be estimated against present drug use, route of administration and severity of dependence, including severity of withdrawal symptoms (see Appendix 3) Short Opiate Withdrawal Scale SOW). The aim is to achieve a therapeutic dose, which is one that does not produce sedative or intoxicating effects, controls withdrawal symptoms and minimises or stops on-top heroin use. Where there is continued opiate use on top of prescribed methadone, the dose should be reviewed as evidence suggests that higher doses are associated with less heroin use.

5.5.4 The usual starting dose of methadone should be between 10 and 30mg. For heavily dependent users a first dose of up to 40mg may be used, where the prescriber/non-medical prescriber is experienced and competent. If a dose greater than 40mg is dispensed on the first day, it should be a split dose and there should be a gap of at least 2 hours between the first and second doses. The decision to give this higher dose should be agreed with a consultant beforehand and documented in the notes.

5.5.5 Dose increases should usually be between 5 and 10 mg per day and with a maximum increase of 30mg above the starting dose in the first week.

5.5.6 Dose changes must only be made after there has been discussion with a prescriber or non-medical prescriber.

5.5.7 Following the first week, doses can continue to be increased incrementally up to a total of between 60 and 120mg a day. Occasionally higher doses may be needed to achieve a level where the patient reports feeling comfortable and is no longer using illicit heroin. A key goal of opiate substitution therapy is to provide the dose that leads to complete cessation of heroin (and other illicit opioid) use, which may be higher than the dose at which the patient feels “stable”.

5.5.8 Clinicians should aim to optimise treatment interventions for patients who are not benefiting from them by intensifying support (pharmacological and psychological) rather than reducing it.

5.5.9 Clients receiving a methadone prescription will see their keyworker on a regular basis varying on the level of support that they need. This can be weekly, fortnightly or monthly. The minimum frequency that clients can be seen is monthly.

5.5.10 Clients will usually start their treatment under supervised consumption, either at a local pharmacy (supervised self-administration – SSA) or on-site (daily dispensing programme – DDP).

5.5.11 For those clients with problematic alcohol consumption, they will need to demonstrate control over their alcohol consumption. They will need to continue to demonstrate this by having their breath tested when being issued their prescription. If patients fail to maintain control of their alcohol consumption they should be returned to DDP for breathalyser monitoring and support. All new clients to the service will start their treatment either on the Daily Dispensing Programme (DDP) or the supervised self-administration programme (SSA).

5.6 Cautions

5.6.1 A significant minority of those in drug treatment drink at hazardous or harmful levels. The risks of prescribing (and supplying) opioids for heroin dependence alongside high levels of alcohol use need to be balanced against the benefits of retaining the client in and on treatment. It could be riskier for the client if they were not provided with a continued, stable dose of substitute opioid. We have developed a flow chart to aid practitioners working with this clients group (Appendix 4).

5.6.2 Methadone may prolong the QTc interval and induce torsade de pointes, with a possible dose-dependent action. Other medications which also affect the QTc interval, such as certain antidepressants and antipsychotics, can potentiate this effect. Prior to clients receiving doses at and over 100mg methadone, a baseline ECG should be performed with subsequent annual ECGs.

5.6.3 Higher doses of methadone are likely to be needed for clients on medication which increase the metabolism of methadone by enzyme induction such as anti-tubercular drugs (rifampicin) and carbamazepine. For example, full enzyme induction is reached in about 1 week after commencing rifampicin and dissipates in roughly 2 weeks after discontinuation (Neimi et al, 2003). Likewise methadone dose reduction will be required following discontinuation of such medicines. Regular liaison with the TB team is recommended for updates on any dose/medication changes.

5.6.4 Doses above 120 mg of methadone should be discussed in the multi-disciplinary meeting and require consultant agreement. Non-medical prescribers should only prescribe in doses above 120mg with the consent of the responsible consultant.

5.6.5 Caution should be exercised when prescribing methadone, so that it does not get into the hands of drug naïve individuals in whom it can cause fatal overdose, for example, children, non-opiate using adults and opiate users whose tolerance has decreased following abstinence or detoxification. Doses as small as 20mg may be fatal to an adult who has no tolerance to opiates; significantly less may be fatal for a child or a baby.

5.6.6 Clients must be given patient information leaflet (PIL). Further patient information is available on Choice and Medication website accessible via Trust website and intranet.

6 Buprenorphine Prescribing for Outpatients

6.1.1 Buprenorphine is a synthetic partial opioid agonist at μ (mu) receptors and antagonist at k (kappa) receptors. High buprenorphine doses can produce a mild, less euphoric and less sedating effect compared to high doses of heroin or methadone. However, a sufficient opioid effect is exerted to prevent/alleviate symptoms of opiate withdrawal.

6.1.2 The product is indicated for the treatment of opiate dependence in the form of detoxification and maintenance treatment in adults and children aged over 16 years. It is available in three strengths, 400mcg, 2mg, and 8mg.

6.1.3 Buprenorphine (Temgesic®) is available in the 200mcg and 400mcg strength, but it is licensed for pain management only, and should not be used for opiate substitution.

6.1.4 Currently the laboratories at UCLH, the Whittington and the Royal Free Hospitals do not have tests to confirm the presence of buprenorphine in the urine, therefore, clients need to be tested on-site using the buprenorphine test strips prior before sending the sample to the laboratories.

6.2 Inclusion Criteria

- Objective evidence of current opiate dependence. This includes information from client/other professionals and results of urine testing.

- Ability to comply with the treatment and recovery programme.

- The clients should not usually be on more than 30mg Methadone or its equivalent in heroin.

- Buprenorphine might be considered as a drug of first choice for young (over 18 years) heroin users, particularly heroin smokers, who have not been on a methadone maintenance programme before and who are aiming to become drug-free.

- Clinical experience suggests that patients presenting with dependence on codeine and dihydrocodeine preparations may benefit from buprenorphine.

- Where the side effects of methadone maintenance treatment such as sedation or euphoria are particularly troublesome.

6.3 Exclusion Criteria

- Buprenorphine maintenance would **not** usually be used in the following clinical scenarios:

- Pregnant drug user, unless they become pregnant whilst taking buprenorphine; although use during pregnancy is not contraindicated, it is not recommended (Summary of Products Characteristics 2012). This is because of the risk of

buprenorphine inducing a withdrawal state in the induction phase, which could put the pregnancy at risk.

- Clients who are taking other opioid medications for pain relief, because buprenorphine blocks other opioids from attaching to the receptors.

- Clients with severe hepatic, renal or respiratory insufficiency. Refer to the manufacturer's summary of product characteristics (SPC) for advice in less severe conditions.

- A client who is taking buprenorphine but who continues to use heroin in addition, should be switched to methadone, as long as they have been taking an optimised doses of buprenorphine: 12 to 16mg (but up to a maximum of 32mg) under supervision.

- Hypersensitivity to buprenorphine or any other component of the tablet

- Children less than 16 years of age. No data are available in children less than 16 years of age; therefore, buprenorphine should not be used in children under the age of 16.

- Acute alcoholism or delirium tremens

- Breast feeding (contraindicated in SPC although may be considered after specialist advice)

- Further precautions (which equally apply to methadone as well) may be necessary in those patients with severe mental illness or recent head injury, acute abdominal conditions

- Concurrent use of other sedating drugs

6.4 Initiating Buprenorphine Prescribing

6.4.1 Generic buprenorphine should be prescribed; clients should be reassured that branding does not change the efficacy of the medication.

6.4.2 Buprenorphine is administered sublingually and can take up to 5 minutes to dissolve completely. Clients should not swallow the tablet (due to first-pass metabolism) or drink liquid immediately afterwards.

6.4.3 Although the British National Formulary states that clients should have been opiate-free for at least 6-12 hours, our clinical experience suggests that clients should have been abstinent from any heroin use for 12 hours and from methadone use for 36 hours prior to commencing buprenorphine.

6.4.4 Dose titration should start when the client is showing objective signs of opiate withdrawal (blood pressure monitoring, SOW scale). An initial test dose of 2 to 4mg

may be given and the client reviewed after 1 hour. If the withdrawal symptoms have diminished a further dose of 2 to 4mg may be given to bring the total dose on the first day to 8mg. If the client's withdrawal symptoms worsen after the first or second dose of buprenorphine, the next dose should not be given until these symptoms have started to subside. The maximum dose recommended is 32mg. however most clients can be are stabilised on doses of 8-16mg.

6.4.5 Doses changes must only be made after there has been discussion with a prescriber or non-medical prescriber

6.4.6 When commencing treatment with buprenorphine, it is important that clients are also provided with the client information leaflet which is available in the pharmacy.

6.4.7 Clients must be given patient information leaflet (PIL). Further patient information is available on Choice and Medication website accessible via Trust website and intranet.

7 Urine Drug Testing

7.1.1 Urine drug testing is a requirement of drug treatment. It is a pre-requisite for starting treatment to confirm reported drug use and an essential tool for monitoring compliance with treatment. Prescribers and keyworkers should feel confident about asking a patient to provide a sample of urine for drug testing.

7.1.2 If a urine sample is required but a client says they are unable to provide one, they should be encouraged to drink water and wait in reception until they are able to pass urine. If a client refuses to provide a urine sample for testing this raises concern about the client's concordance with treatment and they should understand that their treatment will be reviewed. If a client is unable to pass urine, the service should have the option of using a saliva test to confirm opiate use or compliance.

7.1.3 A prescriber who suspects the veracity of the sample of urine provided, for example, the sample is cold, looks diluted, looks green in colour or has been given back in an unlabelled bottle, the sample should be repeated and later discussed in the MDT meeting. Future samples should be requested at random without the key worker giving prior warning/notification to the patient. Directly supervised samples should only be done with the client's consent and in the presence of a healthcare professional of the same gender. A saliva test would also be an option in these circumstances.

7.1.4 All clients whether they are new or established clients, should have a urine drug screen performed every 3 months and documented clearly in the progress notes of electronic patient record. The terms "urine drug screen (UDS)" or "urinalysis" should be used when writing the results on the patient's electronic record.

7.1.5 Urine results returned from the pathology lab should be uploaded into the electronic patient record immediately and not filed away separately – failure to input this investigation into the progress notes may give the impression that the client has not

had a urine drug screen for a long time. Furthermore, prior to seeing a client one may need to read the electronic progress notes to familiarise oneself with the clinical issues that need addressing in the forthcoming key-working session – failure to record the last urine result in the electronic progress or upload a laboratory results raises the concern of whether this important aspect of treatment has been done.

7.1.6 Urine drug screens that have been undertaken by the Pathology Laboratory are clinical investigations and part of that client's record of care and as such should be scanned and uploaded onto the electronic patient record. They should be uploaded as a PDF document into the document section and should have a standard document nomenclature as follows: SURNAME Forename UDS date.pdf

7.1.7 Urine samples should continue to be provided every 3 months.

8 Supervised Consumption

8.1.1 In most circumstances, it will be appropriate for new patients being prescribed methadone or buprenorphine to take their daily doses under direct supervision of a professional for a period of time to ensure compliance, minimise the risk of diversion, monitor progress and undertake a risk assessment.

8.1.2 All requests to progress to from daily supervised consumption to less restrictive regimes should be discussed with a prescriber before being actioned. The decision to stop supervised consumption is usually taken when the client has stabilised, is compliant with treatment, not at risk of diverting their medication or having it diverted and are not using illicit opiates on-top of their medication as confirmed by given opiate negative urines. Previous Orange Guidelines specified an initial 3-month supervision period but current guidelines do not talk about a specific time period but shift the focus of attention onto undertaking a risk assessment. Progression from supervised to unsupervised regimes should only occur after a risk assessment has taken place which looks at:

- Compliance with prescribed drug treatment
- Abstinence from or significant change in heroin or other drug use
- Changes in drug-taking behaviour, e.g. cessation of injecting
- Compliance with other elements of drug treatment and recovery care planning
- Risk of diversion.

8.1.3 Clients may come off supervised consumption sooner if the risk assessment suggests that significant progress has already been made. For example, long-term, daily supervised consumption would probably not be appropriate for a patient in regular, full-time employment where supervision would be a clear barrier to retention in treatment and recovery.

9 Principles of Prescribing Injectable Methadone

9.1.1 Clients should only be considered for starting a new injectable opioid prescribing plan in line with the eight key principles that were outlined in the National Treatment Agency guidance, Injectable Heroin (and Injectable Methadone): Potential Roles in Drug Treatment (NTA, 2003).

9.1.2 There is a small number of clients in receipt of unsupervised injectable opioid treatment in C&I specialist substance misuse services. Most of these clients came to us from the private sector where they had been receiving injectable treatment for many years. They will have been re-assessed by a consultant at the point of transfer back to the NHS and a new treatment plan will have been developed.

9.1.3 Injectable methadone may only be initiated in C&I Substance Misuse services by a medical doctor. Independent NMP may prescribe continuation treatment:

- for those clients already started on injectable prescriptions
- where this treatment plan has been agreed,
- the NMP has personal knowledge of the client and
- prescribing injectable methadone is within their agreed competencies.

9.1.4 For new clients being considered for injectable prescribing the following principles should be followed:

- Drug treatment comprises a range of treatment modalities which should be woven together to form integrated packages of care for individual patients.

- Substitute prescribing alone does not constitute drug treatment. Substitute prescribing requires assessment and planned care, usually with other interventions such as psycho-social interventions. It should be seen as one element or pathway within wider packages of planned and integrated drug treatment.

- Within the substitute prescribing modality, a range of prescribing options are required for heroin misusers requiring opioid maintenance. Some options may carry more inherent risks than others (for example, injectable versus oral options). Patients who do not respond to oral maintenance drug treatment should be offered other options in a series of steps. This would normally include:

    - oral methadone and buprenorphine maintenance, specifically optimized higher dose oral methadone or buprenorphine maintenance treatment, then

- Injectable methadone or injectable diamorphine maintenance treatment (perhaps in combination with oral preparations).

- Injectable maintenance options should be offered in a local area that can offer optimized oral methadone maintenance treatment including adequate doses, supervised consumption and psycho-social interventions. This is essential to ensure oral drug treatment options have been fully explored prior to a trial of injectable maintenance treatment and to ensure smooth transition back to oral treatment if required.

- Injectable and oral substitute prescribing must be supported by locally commissioned and provided mechanisms for supervised consumption. Injectable drugs may present more risk of overdose than oral preparations and have a greater value on illicit markets and hence may require greater levels of supervision.

- Injectable maintenance treatment is likely to be long-term treatment with long-term resource implications. Clinicians should consider the move from oral to a trial of injectable preparations carefully, including long-term implications for the patient and drug treatment systems and involvement of services.

- Specialist levels of clinical competence are required to prescribe injectable substitute drugs. Diamorphine prescribing also requires a license from the Department of Health.

- The skills of the clinician should be matched with good local systems of clinical governance, supervised consumption and access to a range of other drug treatment modalities.

9.2 Client Eligibility

- The client should have a protracted history (>3 years) of heroin dependence and regular daily injecting.

- The client should be age 18 or over.

- The client should be able to provide informed consent. This includes no active medical or psychiatric condition impairing the clients' capacity to provide informed consent.

- The client should be willing to comply with the conditions of injectable opiate treatment, including:

    - A treatment plan

    - Regular supervision and monitoring

    - Avoidance of persistent injecting in high-risk areas (e.g. neck or groin veins)

- Continuation of injectable treatment being conditional upon an effective response to treatment.

- Diversion of the prescribed drugs and double scripting being grounds for discontinuation of injectable treatment.

- The client should first have received optimised oral methadone maintenance treatment for an adequate period (6 months or more).

- There should be a persistence of poor treatment outcomes despite a current optimised oral maintenance treatment episode:

    - Continued frequent (daily or almost daily) injecting of illicit heroin or other opioids

    - Continuing high risk behaviour.

- Caution should be exercised in prescribing injectables to clients suffering from acute medical conditions and in clients with injection-related systemic infections.

- Caution should be exercised in clients abusing benzodiazepines and/or alcohol, and in multi-drug users.

- Caution should be exercised in pregnant drug users

9.3 Assessment Procedure

9.3.1 Assess suitability according to the above client selection criteria.

9.3.2 Agree individualised goals, e.g. what is going to change with an injectable opioid prescription? Assess injecting health (observe injecting, review by experienced nursing or medical staff).

9.3.3 General health screen, venous access and recent injecting complications should be assessed. There may be physical contra-indications to starting or continuing an injectable prescription, e.g. groin injecting in a client with a recent history of deep vein thrombosis and taking anticoagulants.

9.3.4 Agree a starting dose - this could be all in injectable form or partly in oral form.

9.3.5 Daily supervision and dispensing initially - when commencing treatment, injections should be directly supervised for at least the first three days to ensure that the client has a safe technique and to observe for the effects of intoxication.

9.3.6 Return all dispensed ampoules on dispensing/prescription days. The amount returned should be noted on the prescription sheet and discrepancies discussed at

multi-disciplinary meetings. The keyworkers are not expected to handle returned 'works' and must pay attention to their own health and safety.

9.3.7 Review progress at three months and six months, including review of injection sites. Further periods of observing injecting technique and re-titration may be necessary.

9.3.8 In July 2009 the Chief Medical Officer issued a Safety Alert Broadcast on the safe administration of parenteral opioids, highlighting the risk of respiratory depression. Clients and their carers should be warned of these risks. When injectable opioid medication is being initiated under supervised observation, on-site during the induction phase or during dose review, there should be naloxone available

9.3.9 The Misuse of Drugs (Supply to Addicts) Regulations 1997 require only medical practitioners who hold a special licence issued by the Home Office may prescribe, administer or supply diamorphine, dipipanone (Diconal®) or cocaine in the treatment of addictions. The license are individualised, therefore medical practitioners who do not have this licence are not legally allowed to sign these prescriptions.

10 Methadone (Physeptone®) Tablets

10.1.1 Methadone (Physeptone®) tablets are not licensed for the treatment of opiate dependence and should not usually be prescribed. There is an increased risk of diversion or injection of methadone tablets. When they are used, they need to be prescribed in line with the local policy on the use of "off label" medicines or under approved exception (see section 'Holiday prescription').

10.1.2 Client preference or dislike of methadone oral solution, are not indications for prescribing methadone tablets.

10.1.3 Clients who are currently on methadone tablets should be reviewed with the consultant psychiatrist. If there is no clear medical indication, such as gastro-intestinal issues for continuing the prescription, then it should be changed to methadone oral solution.

11 Benzodiazepine Dependence and Withdrawals

11.1.1 Much benzodiazepine use follows a binge pattern with irregular and non-daily consumption. Clients who are taking benzodiazepines but are not dependent on them do not need to be prescribed benzodiazepines.

11.1.2 If clients have been taking benzodiazepines on a daily basis for more than 4 weeks, they may have become dependent on these drugs. It may then be necessary for a benzodiazepine reduction to be offered, particularly if there is a previous history of fits, or withdrawal symptoms with benzodiazepines.

11.1.3 Benzodiazepines are not licensed for the treatment of benzodiazepine dependence.

11.1.4 New clients who are assessed as being dependent on benzodiazepines can be prescribed a benzodiazepine reduction regimen.

11.1.5 Clients should also be offered psychological interventions to help increase the effectiveness of the gradual dose reduction. This can be particularly helpful in clients with insomnia, anxiety and panic disorders.

11.1.6 The benzodiazepine of choice for benzodiazepine withdrawal is diazepam (5mg or 2 mg tablets). It is best if a relatively long-acting benzodiazepine is chosen for the reduction; therefore convert the dose of whatever benzodiazepine the client has been taking to the equivalent dose of diazepam. Conversion tables for different benzodiazepines to an equivalent doses of diazepam can be found in the latest BNF.

11.1.7 The Benzodiazepine and Opioid Withdrawal Service (BOWS) in primary care, where clients have been prescribed a range of different benzodiazepine, may continue to prescribe the same medication the client was previously on rather than convert to diazepam (or other standard detoxification treatment). The potential risks and benefits of each approach should be assessed on a case by case basis.

11.1.8 Clients should not normally be prescribed initial doses greater than 30 mg diazepam daily or equivalent in the management of benzodiazepine dependence. If a higher starting dose is thought to be necessary, consultant approval should be sought. In some instances inpatient management may need to be considered.

11.1.9 Diazepam should only be prescribed as 5 mg and 2 mg tablets.

11.1.10 Diazepam should initially be prescribed on a daily pick-up basis using the blue FP10(MDA) prescriptions – supervised consumption is not available. Further into the reduction, a less frequent pick-up may be negotiated if the client is stable and sticking to the reduction regimen.

11.1.11 Clients who are already on long-term benzodiazepine prescriptions should negotiate with their key-worker and doctor, a suitable reduction schedule. Normally this should not take longer than a year.

11.1.12 For opiate dependent clients who are also alcohol dependent or consuming alcohol at hazardous levels, great caution needs to be taken in prescribing benzodiazepines because of the risk of precipitating an overdose.

11.1.13 Clinicians may be faced with requests to continue a prescription for maintenance benzodiazepines. While most patients in receipt of structured drug treatment will either not require benzodiazepine replacement, or will be provided with a time-limited detoxification programme, there will be exceptional cases, following careful assessment, where individuals with dependence may be provided with longer-term prescribing of benzodiazepines. Factors such as long duration of previous benzodiazepine prescribing, clear evidence of relevant pre-existing and concurrent comorbid mental health problems, or clear deterioration following previous adequate benzodiazepine detoxification are factors that clinicians may consider are relevant in such cases.

11.1.14 There should be at least 3 positive urine results for benzodiazepines (usually from initial assessment and first medical assessment) before a prescription is offered.

11.1.15 For clients already in treatment, regular urine samples of not less than 2 weekly should be taken and also review of past urine results to demonstrate dependence prior to prescribing.

11.1.16 In the event of a subsequent negative urine result to benzodiazepines or if the client discloses continued use of illicit benzodiazepine, the keyworker should discuss this further in the multidisciplinary meeting as discontinuation of the prescription may be necessary.

11.2 Prescribing Regime of Diazepam

11.2.1 If a client has been taking benzodiazepines for less than 4 months it is often possible to successfully detoxify such a person relatively rapidly by, for instance, a reduction in daily dose every 3 or 4 days.

11.2.2 For clients whose duration of use has been greater, slower reduction over 6 to 12 months may be more appropriate. However, the duration of any reduction needs to be discussed carefully at the multidisciplinary meeting.

11.2.3 A benzodiazepine can be withdrawn in steps of one-tenth of the daily dose every fortnight, in cases of long-term use or in general a rate of 2mg every 2 weeks is recommended.

TABLE 1: Dose of Benzodiazepines equivalent to 5 mg Diazepam

BENZODIAZEPINES	**DOSE (mg)**
Chlordiazepoxide	15
Clonazepam [a]	0.5-1mg [(1)] 0.5mg (0.25-4mg) [(2)]
Loprazolam	0.5 - 1mg
Lorazepam	0.5 - 1mg
Oxazepam	15
Temazepam	10
Nitrazepam	5

Lormetazepam	0.5 - 1mg

(Ref: BNF 70)

11.2.4 Inter-patient variability and differing half-lives mean the figures can never be exact and should be interpreted using clinical and pharmaceutical knowledge. There is no equivalent dose listed in the BNF.

12 Alcohol and Substitute Opioid Prescribing

12.1.1 Refer to trust Community Alcohol Withdrawal Prescribing Guidelines for further guidance

12.1.2 Caution should be exercised when dispensing methadone or buprenorphine to clients who are under the influence of alcohol or other sedative drugs, because of the risk of precipitating an overdose. However, the risks of prescribing (and supplying) opioids for heroin dependence alongside high levels of alcohol use need to be balanced against the benefits of retaining the patient in and on treatment. It could be riskier for patients if they were not provided with continued, stable dose of opioid substitution therapy. The patient is more likely to die of an overdose if they fall out of treatment and drop off their prescription and return to illicit heroin use alongside their alcohol misuse. Specialist competencies are required to make judgements about prescribing alongside alcohol misuse and dependence.

12.1.3 In non-dependent drinkers methadone should not usually be dispensed, or a prescription issued, if the breath alcohol level is above the standard 0.35mg/L (blood alcohol level above 80mg%). Client should be advised to return back for breathalysing at a later time and advised not to drink any more alcohol.

12.1.4 In dependent drinkers methadone should not usually be dispensed, or the prescription issued, if the breath alcohol level is above 0.5mg/L. It is important to remember that requiring a patient with severe alcohol dependence to attend the service with a breathalyser level below 0.35mg/L may result in that individual going into acute alcohol withdrawal and even having a fit.

12.1.5 In some severely dependent drinkers with high levels of alcohol tolerance, the medication may be dispensed, if there is no clinical evidence of alcohol intoxication, even when the blood alcohol level is above 0.7mg/L. In this situation the client needs to be clinically reviewed and discussed with a consultant before a decision is taken. Normally the client will be asked to attend on-site on consecutive days over a week where their intoxication levels can be assessed against their reading on the breathalyser. An objective limit can then be set for the breath alcohol levels in these clients.

13 Dexamfetamine

13.1.1 The evidenced-based interventions for amphetamine and crack/cocaine use are psychological treatments. There is no evidence-base for prescribing dexamfetamine to primary cocaine or crack users. The first line treatment would be psychosocial interventions.

13.1.2 Dexamfetamine has been approved by the DTC for dexamfetamine detoxification and hence is included in the trust formulary for this indication and by consultant initiation only. This is in line with PHE guidance, Drug misuse and dependence: UK guidelines on clinical management (2017). This is an Off-label indication and therefore trust guidance on prescribing of off-label medicines must be followed (refer to trust Unlicensed medicines and unlicensed use of licensed medicines (off-label) policy)

13.1.3 Dexamfetamine may only be initiated in C&I Substance Misuse services by a Consultant. Other medical prescribers and Independent NMP may prescribe continuation treatment:

- where this is part of an agreed and documented treatment plan
- the clients has already transferred onto dexamfetamine prescriptions by C&I consultant
- the NMP has personal knowledge of the client and
- prescribing dexamfetamine is within their agreed competencies.

13.1.4 Any prescribing of dexamfetamine outside the Trust approved formulary indication must be requested on a non-formulary form in line with the Trust formulary policy.

Note: A small number of patients who have been stabilised on long-term prescriptions of dexamfetamine have recently been taken into treatment with C&I services from the private sector. All have been reviewed by a consultant and a new treatment plan developed. Many of these clients have been prescribed dexamfetamine for many years, sometimes decades, and abrupt or rapid withdrawal is likely to cause significant withdrawal effects. Some of these clients have already started to come off their dexamfetamine but for others slow reduction, sometimes over several years, may be the most realistic goal.

13.2 Inclusion Criteria

- Primary Amphetamine users.
- Injecting users or heavy dependent use for more than 3 months.
- Use of more than 1g per day on 3 or more days per week.
- Evidence of escalating use.
- Increased tolerance and craving.

13.3 Exclusion Criteria

- Polydrug use
- Mental illness which may be exacerbated by prescribing dexamfetamine.
- Pregnancy
- Cardiovascular disease, including hypertension.
- Cocaine dependence

13.4 Dexamfetamine Prescribing

13.4.1 A reducing dexamfetamine prescription will be considered for those clients who are clearly dependent on amphetamines. The rate of reduction should be discussed with the client and reflect the dose that the client is taking and the length of time that they have been on it. A reduction of 5 mg every 2 to 4 weeks may be a good starting point.

13.4.2 Dexamfetamine should be prescribed as 5mg tablets.

13.4.3 If a client is being prescribed dexamfetamine and uses cocaine or crack regularly on top of the prescription, the dexamfetamine should be tapered and stopped.

14 Naltrexone

14.1.1 Naltrexone is an opioid antagonist which, when taken regularly, blocks the effects of opioids completely. It is recommended as a treatment option in detoxified formerly opioid dependent people who are highly motivated to remain in an abstinence programme. It should be given as part of a programme of supportive care (NICE, 2007)

14.1.2 Naltrexone is an opioid antagonist and blocks the effects of opiates and opioids for up to 72 hours.

14.1.3 It is prescribed as an adjunctive therapy to help prevent relapse in opiate dependent clients who have achieved abstinence.

14.1.4 It is essential that the client should have been opiate-free when commencing treatment with naltrexone; urine to be tested for the presence of opiates – otherwise they will experience severe and sudden withdrawal symptoms. Current advice is that there should be a 3-4 days gap between buprenorphine and naltrexone, a 7 days gap between heroin and naltrexone and a 10 days gap between methadone and naltrexone before commencing this treatment.

14.1.5 If the doctor is fairly certain that the client has not used opiates and this is confirmed by opiate negative urine results, then it would be appropriate to proceed directly with a naltrexone test dose of 12.5 to 25mg.

14.1.6 Clients should be made aware that tolerance for opioids decreases and that a state of super-sensitivity for opioids can develop, therefore opiate relapse could cause a fatal overdose.

14.1.7 Liver function (LFTs) should be measured at the outset of treatment and again during treatment.

14.2 Inclusion Criteria

- Motivation for abstinence from opiates.
- Commitment to comply with naltrexone treatment.

- No evidence of liver damage

14.3 Exclusion Criteria

- Acute hepatitis or liver failure.
- Significant mental illness that may interfere with compliance or informed consent.
- Significant on-going illicit drug use.
- Clients receiving opiate analgesics or other prescribed opiates.
- Pregnant clients.

14.4 Initiating Naltrexone Prescribing

14.4.1 Clients are started on 25mg of naltrexone on the first day and then increased to 50 mg daily, depending upon side-effects.

14.4.2 Client should be given a patient information leaflet/card and to inform medical professionals that they are taking this medication.

14.4.3 Naltrexone can be prescribed three times per week if necessary - at dose of 100 mg on Monday, 100mg on Wednesday and 150mg on Fridays).

14.4.4 It should generally be prescribed for up to 3 months.

14.4.5 Naltrexone can be prescribed for further periods. Perform liver function tests monthly if naltrexone is prescribed for longer periods.

14.4.6 If a client relapses into heroin use and wishes to restart naltrexone, then if relapse occurred within 4 days of the last naltrexone dose, then it can be restarted at 12.5 mg as long as the first dose is at least 24 hours after last heroin use. The client may experience some withdrawal symptoms but these should be mild.

14.4.7 If there is a lapse of more than 4 days since the last dose of Naltrexone, then the regime will need to be re-started as with a new client.

15 Naloxone

15.1.1 Naloxone is a potentially life-saving medicine when used in settings associated with opiate overdose. Systematic reviews conclude that pre-provision of naloxone to heroin users can be helpful in reversing heroin overdose.

15.1.2 Anyone can administer naloxone for the purpose of saving a life.

15.1.3 New legislation came into force in October 2015 that permits the supply of naloxone by Substance Misuse Services to individuals, without the need for a prescription. This can include supply to service users, carers, family members, hostel staff and others who may come into contact with people at risk of overdosing on heroin.

15.1.4 The trust procedure for supplying naloxone in these circumstances must be followed. In addition there is a trust training package to explain to people how to recognise an opiate overdose and how to administer naloxone.

15.1.5 The current preparation used is *Prenoxad™ Injection,* naloxone 1mg/1mL pre-filled syringe ,.

16 Pregnant Opiate Dependent Clients

16.1.1 Drug misuse during pregnancy is associated with intra-uterine growth retardation and pre-term deliveries contribute to increased rates of low birth-weight and increased perinatal mortality rates. Higher rates of early pregnancy loss and third-trimester

placental abruptions appear to be major complications of maternal cocaine/crack use.

16.1.2 Babies born to mothers who are opiate dependent will develop neonatal abstinence syndrome (NAS). There appears to be a correlation between methadone dose and severity of NAS but this is not always the case.

16.1.3 Long-term outcomes in women who enter methadone treatment programmes during pregnancy are better in terms of their pregnancy and outcomes for the neonate.

16.1.4 This group of clients must be given priority for allocation to treatment as the management of the pregnant addict poses many additional problems and hazards for both the client and the foetus and should be seen by an experienced prescriber who has the skills and competencies to work with pregnant addicts. Late diagnosis of pregnancy and inadequate antenatal care are common.

16.1.5 The Trust policy is to make every effort to engage pregnant clients in treatment by being more flexible in relation to their treatment plan without compromising the safety of the unborn child.

16.1.6 It should be noted that severe withdrawal could produce foetal distress or even foetal death and premature labour. Methadone treatment programmes need to be individualised for each client in relation to severity of dependence, stage of pregnancy and general level of co-operation, motivations and psychological wellbeing of the mother.

16.1.7 In most cases outpatient management of the pregnant opiate dependent client is possible. The evidence base supports the use of methadone maintenance for pregnant opiate users. Methadone reduction may lead to the development of opiate withdrawal symptoms, which can be dangerous to the foetus and the risk of relapse is high following methadone detoxification. These concerns have to be balanced against the wishes of many mothers to be opiate-free before they deliver their babies

16.1.8 During the first trimester, detoxification should be discouraged due to the risk of spontaneous abortion. Detoxification during the second trimester may be undertaken in small frequent reductions of for example 2-3mg every 3-5 days as long as the client remains abstinent. During the third trimester metabolism of methadone is increased and doses may need to be increased or split. Detoxification in the third trimester is generally is not usually recommended due to the risks of foetal stress, foetal distress and even stillbirth.

16.1.9 To completely avoid opiate withdrawals in the newborn, the pregnant client may have to be drug-free for some weeks before the expected date of delivery. This may not be a realistic option for many clients because of the risk of relapse into heroin use. Low dose methadone maintenance may be an alternative in these circumstances, but only if the client is not using heroin on top of the prescription, in which case higher dose maintenance is indicated.

16.1.10 If there is a substantial risk of the client returning to continue illicit drug use before the baby is born, then the client should be encouraged to remain on maintenance treatment at an appropriate dose of methadone until the delivery date.

16.1.11 Active liaison with the antenatal clinic, the hospital social work department and local child and family social services are important to ensure proper antenatal care. The keyworker needs to encourage the client to attend antenatal appointments – this may include accompanying clients to such appointments. The pre-delivery planning meeting should be attended by the keyworker.

16.1.12 In certain cases, statutory case conferences are convened by the social services and must be attended by the keyworker. If the keyworker is unable to attend such a meeting, a written report should be made available to the social worker. The content of the report should be approved by a senior clinician.

16.1.13 Neither methadone nor buprenorphine are specifically licensed for use in pregnancy. There is some evidence that buprenorphine may be associated with shorter periods of neonatal withdrawal symptoms. However, some clients experience withdrawal symptoms on starting buprenorphine, which would be undesirable during pregnancy.

16.1.14 Breastfeeding should be encouraged, even if the mother continues to use drugs, except where she uses cocaine or crack cocaine, or a very high dose of benzodiazepines. Specialist advice should be sought if she is HIV positive or hepatitis C positive. Methadone treatment is not a contraindication to breastfeeding but the dose should be kept as low as possible, while maintaining stability and the infant monitored to avoid sedation.

16.1.15 Contact the UK Teratology Information Service for further general information on drug in pregnancy and breast-feeding http://www.uktis.org/

17 Dispensing Arrangements

17.1.1 Refer to policy: Partnership Working with Community Pharmacies and Supervised Self Administration (SSA) for Methadone and Buprenorphine in Substance Misuse Policy for further guidance.

17.1.2 Where available, clients of concern should be placed on the Daily Dispensing Programme (DDP) until there is a period of stability.

17.1.3 Outpatient methadone prescriptions are dispensed on the blue FP10(MDA) prescriptions when there is instalment prescribing for any Controlled Drugs Schedule 2 of the Misuse of Drugs Regulations 2001 (as amended) and also includes diazepam and buprenorphine.

17.1.4 Single dose/supply should be dispensed on the green FP10(HNC) prescriptions.

17.1.5 Clients usually begin prescribed treatment on the Daily Dispensing Programme (DDP) or the supervised self-administration programme (SSA). Only accredited pharmacies can take part in the SSA scheme – an up-to-date list is available at each service and can be checked with the SMS pharmacist.

17.1.6 Clients cannot access SSA chemists outside the borough where their prescribing service is located without prior consent from Camden or Islington SSA co-ordinators.

17.1.7 Clients needing to access a chemist that is out of borough needs to be discussed with the SMS pharmacist/clinical pathway managers. No changes should be made until written confirmation from SSA co-ordinators has been received.

17.1.8 Most pharmacies are open 6 days a week, therefore allowing a take-away dose for Sunday. Consider a 7 days chemist if there are concerns about safe storage, compliance and diversion.

17.1.9 A letter of introduction (see Appendix 5) needs to be provided to the client for the identified pharmacy that they will be attending. A telephone call should be made to the pharmacy to check whether there is a space available.

17.1.10 How long a client remains on SSA is individualised to their recovery care plan and also on their illicit drug use.

17.1.11 Clients can remain or be placed back on SSA if they fall under one or more of the following categories:

- A service user has a child at home and there are no safe storage facilities
- A service user is at risk of suicide, especially risk of an overdose
- There is an on-going risk of diversion
- A service user has a drug using partner who is not in treatment and there is a risk of coercion or diversion.
- A service user is in a hostel dwelling or is homeless and cannot guarantee safe storage of methadone or there is risk of intimidation.

- A service user has acute/on-going mental health issues of concern
- There are concerns about compliance
- A service user has relapsed on illicit drugs/disengaged from treatment

The above list is not exhaustive and the decision to remain or remove SSA should be based on the client's individual care plan and risk assessment

17.1.12 Once the client has spent time on unsupervised daily dispensing and has continued to be stable, he or she can move to less frequent pick-ups after discussion in multidisciplinary meetings. This is usually done gradually from daily dispensing to 3 times per week dispensing to twice weekly and finally weekly dispensing. No client in treatment at the specialist prescribing service should be picking up their medication any less frequently than once per week. The frequency of the pick-up should be reviewed regularly.

17.1.13 If a client misses one or two consecutive days of dispensing, then they may be given their normal dose on the third day. If three or more consecutive days are missed then the client will need to be reviewed before dispensing can take place as per national guidelines. The reassessment should consist of a recent drug history, an instant urine test to confirm the self-report and a discussion with a doctor or non-medic prescriber to agree a re-titration plan. Clients who drop out of treatment will be placed back on SSA to ensure compliance and a level of stability should be demonstrated before any further changes made.

17.1.14 For clients on custom pick-ups, it may be beneficial to have one day SSA to ensure compliance. Clients who pick up their medication less frequently than daily can have the following wording which allows part instalment to be collected if they miss the specified collection day:

17.1.15 "*If an instalment prescription covers more than one day and is not collected on the specified day; the total amount prescribed less the amount prescribed for the days missed may be supplied."*

17.1.16 It is illegal for the pharmacist to dispense methadone except in accordance with the dispensing instructions on the prescription, hence we cannot authorise an advance collection of methadone by letter or telephone.

17.1.17 A client must be seen by a clinical member of staff before a prescription is issued. An entry should be made in the client's notes and clients must sign for their prescription (s) on the prescription record sheet.

17.1.18 If a client is unable to attend to collect their prescription, they will need to contact the service to nominate another person to collect it on their behalf. This person should ideally be known to the service and have a letter of authorisation from the client and identification. If the service has concerns about handing the prescription to this person, they may refuse to do so. The person collecting the prescription or the medication must be an adult.

17.1.19 If a client fails to take their opioid prescription for more than 3 days, they are at risk of losing their tolerance to opioids. In this situation their prescription should be

stopped at the pharmacy and the client reassessed. The reassessment should consist of a recent drug history, an instant urine test to confirm the self-report and a face-to-face discussion with a doctor or non-medical prescriber and the client to agree a re-titration plan.

17.1.20 If a prescription needs to be cancelled, the chemist should be contacted by telephone.

18 Recording Prescriptions

18.1.1 Individual prescription numbers are recorded on the client's prescription record sheet. This should include the name of the drug, the formulation, the daily dose and total amount being dispensed and the date of commencement and termination of the prescription along with any other dispensing instructions.

18.1.2 The name of the dispensing chemist should be written on each prescription.

18.1.3 Instructions and corrections written on the prescription should be made by the prescriber or non-medical prescriber. Alterations made by another prescriber/non-medical prescriber also need to signed and dated.

18.1.4 Non-medical prescribers should stamp the prescription with their PIN/registration number or write these details on the prescription.

18.1.5 The prescription record sheet must be presented with a prescription before the latter can be signed by a prescriber.

18.1.6 Any changes to the prescribing plan must be discussed with a doctor/non-medical prescriber either individually or at the multi-disciplinary meeting. Changes to the prescribing plan must be documented in the electronic client's notes.

18.1.7 The Misuse of Drugs Act Regulations 2001 applies to the prescribing arrangements for controlled drugs (further guidance is available in the latest edition of the BNF).

18.1.8 Pharmacist can legally amend prescriptions for Schedule 2 and 3 Controlled Drugs where the prescription does not comply with the following CD prescription requirements:

- Minor spelling mistakes
- Minor typographical mistakes (this may include, for example, a number being substituted for a letter or two letters being inverted but where the prescriber's intention is still clear)
- Where the total quantity of the CD/number of dosage units is specified in either words or figures but not both, a pharmacist can add either the missing words or figures as required (but not both)

18.1.9 It is illegal for pharmacists to correct/amend prescriptions where there is a missing/wrong date, incorrect dose, form or strength of medication. In such cases they will contact the service for a replacement prescription.

18.1.10 In exceptional circumstances prescriptions can be posted or delivered to the chemist via recorded delivery. The record on the prescription sheet should be annotated that the prescription was posted. Ensure that the prescription is posted sufficiently far in advance, so that it arrives before the date it is due to start.

18.1.11 Under exceptional circumstances a named person can collect methadone from the pharmacist for a client. This must be arranged by the service and the named person must produce identification to the pharmacist. This should not be a regular occurrence. The person should present a letter from the client authorising the pick-up. The named person collecting the medication must be an adult.

19 Destruction of Prescriptions

19.1.1 Refer to trust FP10MDA Prescription Form standard operating procedure (SMS) for further detail

19.1.2 Prescription should be destroyed by drawing a line across it and writing 'void' or 'cancelled'. Tick the 'void' section on the prescription record sheet next to the prescription serial number.

19.1.3 Voided prescriptions can be destroyed in the presence of 2 healthcare professionals (one of which must be a nurse or pharmacist) who will then sign next to the prescription serial number(s) that they have done so.

20 Communication with General Practitioners (GP)

20.1.1 When a client starts prescribed treatment, he or she should be encouraged to sign an information sharing protocol allowing the prescriber to communicate with that client's GP and other relevant healthcare professionals. Where a client who requires prescribing will not consent for the Specialist Prescribing Service to inform their GP when they commence such treatment the Prescribing Service may decide not to prescribe medication for that client, but will refer them to their GP. This is to minimise the risk that the client may be also prescribed the same medication to the client or another medication that may interact with the prescribed medication. The prescriber may decline to initiate prescribed treatment but can still offer non-pharmacological interventions.

20.1.2 All clients current medication prescribed by their GP may be viewed via the National Summary Care Record portal. The icon to access this and the standard operating procedure is on desktop .

20.1.3 There should be regular and timely communication with the GP in relation to a client's treatment particularly at points where such communication is of high importance:

- At the start of treatment

- At treatment review
- When treatment is changed, e.g. new medication is started
- When the service wishes the GP to take over a specific treatment
- When a referral has been made to another treatment service
- When treatment has ended
- When client reports FP10 prescription lost or missing (to ensure GP does not issue at client's request)

20.1.4 The system for writing to GPs has changed from paper letters to either the electronic portal known as DOCMAN or e-mail using nhs.net accounts.

21 Safe Storage of Prescribed Medication

21.1.1 All clients must be aware of their responsibility for the safe storage of their medication. Under no circumstances should clients administer their medication to any other individual. In case of accidental use, the child/adult concerned should be taken to the nearest A & E department immediately or an ambulance called.

21.1.2 Clients need to be aware that as little as 20mg may be lethal to a non-tolerant individual and much less than this can kill a child or baby.

21.1.3 All clients should be advised to store their methadone/buprenorphine and any other medication out of the reach of children - ideally in a lockable cabinet. All clients should be given information on safe storage of medication, which should be signed (see Appendix 6).

21.1.4 A health visitor, a social worker or trust staff can check that safe storage facilities are available to parents with children, before a decision is made to take a client off SSA or DDP.

21.1.5 Adequate risk assessment should be carried out and discussed in the multi-disciplinary team.

21.1.6 For hostel residents there may be a high risk of unsupervised doses of medication being stolen because of a lack of safe storage facilities and shared accommodation, therefore hostel residents should be allocated a 7 days SSA chemist.

22 Lost medication, Double-scripting, Theft and Fraud

22.1.1 Once the community pharmacist has dispensed methadone to the client, it becomes the client's property and it is his/her responsibility to take appropriate care of it. The clinic will not normally replace methadone/buprenorphine that has been lost or stolen. If the client should drop the methadone in the presence of the pharmacist, and this

has been confirmed a supplementary prescription can be issued. The community pharmacist should not dispense the methadone until the replacement prescription has been re-issued.

22.1.2 If the client has lost his/her prescription or it has been stolen, he/she should contact the service. Staff will initiate the lost prescription cascade as detailed in the FP10 (HNC) Prescription Policy and a Trust incident form completed.

22.1.3 Obtaining a crime number is no longer available from the police, therefore clients should be asked to record the events leading to the loss.

22.1.4 Clients should also be made explicitly aware that if their prescribed medication is taken by someone else and that person dies, the client may be charged with manslaughter.

22.1.5 Replacing lost medication involves a risk. If the pharmacist or staff at the drug treatment service have witnessed the loss – e.g. dropped methadone bottle which spills on the floor, then it may be reasonable to replace the lost dose. Otherwise lost medication is not usually replaced because of the risk that it may have already been taken or diverted. Therefore, the decision to replace lost medication should only be taken after discussion with a prescriber and these risks have been taken into consideration.

22.1.6 If it becomes known to the service that a client has been double-scripted, immediate cancellation of the community prescription is warranted. Clients should be asked to return to the centre for a general review and advice provided on the signs of overdose. The situation should be discussed in the MDT meeting and client advised of the agreed consequence if there is a repeat situation.

23 Stopping or cancelling medication

23.1.1 Medication should not be stopped or withheld unless it has been discussed and agreed with a prescriber and there is clear clinical reason for example, intoxication or evidence of double scripting. Stopping medication abruptly can be dangerous and cause serious physical complications, e.g. withdrawal fits from abrupt cessation of benzodiazepines. Medication is usually stopped as part of a planned and structured reduction regimen.

23.1.2 If a client is late for an appointment, medication should not be withheld.

23.1.3 If a client misses an appointment when the prescription is due, attempts should be made to contact the client. Where feasible the prescription may be sent direct to the pharmacy.

23.1.4 If a keyworker takes the decision to stop prescribed medication without discussing this with the prescriber they could be in breach of professional conduct guidelines and the individual could face disciplinary action under Trust Disciplinary Procedures.

23.1.5 If a prescription needs to be cancelled, for example the client has been admitted to hospital, detained in prison or has died, the community pharmacist must be contacted and notified.

24 Driving and Drugs

24.1.1 Check the DVLA website for up-to-date information on drug and drink driving. The *At A Glance* document is reviewed regularly and can be found at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/233964/At_a_glance.pdf

24.1.2 Clients must be informed of the following :

- It is illegal to drive if either:
  - You are unfit to do so because you're on legal or illegal drugs
  - you have certain levels of illegal drugs in your blood (even if they have not affected your driving)
- Legal drugs are prescription or over-the-counter medicines. If you're taking them and not sure if you should drive, talk to your doctor, pharmacist or healthcare professional.
- The police can stop you and make you do a 'field impairment assessment' if they think you're on drugs. This is a series of tests, e.g. asking you to walk in a straight line. They can also use a roadside drug kit to screen for cannabis and cocaine.
- If they think you're unfit to drive because of taking drugs, you'll be arrested and will have to take a blood or urine test at a police station.
- You could be charged with a crime if the test shows you've taken drugs.

24.2 Prescription medicines

24.2.1 It is illegal in England and Wales to drive with legal drugs in your body if it impairs your driving.

24.2.2 It is an offence to drive if you have over the specified limits of certain drugs in your blood and you haven't been prescribed them.

24.2.3 Clients must be advised about driving if they have been prescribed any of the following medicines:

- amphetamine, e.g. dexamfetamine or selegiline
- clonazepam
- diazepam
- flunitrazepam
- lorazepam
- methadone
- morphine or opiate and opioid-based drugs, e.g. codeine, tramadol or fentanyl
- oxazepam

- temazepam

You can drive after taking these drugs if:

- you've been prescribed them and followed advice on how to take them by a healthcare professional
- they aren't causing you to be unfit to drive even if you're above the specified limits

24.2.4 DVLA state that persistent use of illicit substances, confirmed by their independent medical enquiry, will lead to licence revocation or refusal for a period depending upon the drug used and upon group 1 or group 2 entitlements.

24.2.5 Drivers on methadone may be licensed subject to annual medical review and favourable assessment.

24.2.6 It is the client's responsibility to inform the medical section of the DVLA regarding their medication and drug use. The medical section of the DVLA will then make decision about their suitability for driving.

24.2.7 Keyworkers and doctors working in drug services need to be satisfied that the client has made such a contact and may request to see a copy of their letter to the DVLA about their current drug use and medication.

24.2.8 At assessment and at the review all clients should be asked whether they are driving and advised to contact DVLA. If there are on-going concerns that a client is still driving, staff have a responsibility to contact and inform the DVLA.

24.2.9 If a client is driving a public service vehicle or a heavy goods vehicle staff must inform DVLA.

25 Holiday Prescription

25.1.1 Clients requesting a holiday prescription need to give at least 2 weeks' notice and provide proof of travel. The holiday request will be discussed at the MDT meeting.

25.1.2 Normally only 28 days' supply of medication will be provided, unless there are special circumstances.

25.1.3 For clients travelling for 3 months or more, or carrying a supply of controlled medication lasting 3 months or more, an export licence will be needed and this can be requested from the Home Office. If the client is a non-UK EU national they may be able to obtain their medication from a local drug service in their home country.

25.1.4 To obtain this licence from the Home Office a special request form must be filled in at least 10 days in advance. Further information is available at: (https://www.gov.uk/travelling-controlled-drugs)

25.1.5 Prescriptions for diamorphine falls outside the above protocol and it is prohibited in most countries (this includes prescribed diamorphine). As much notice as possible is needed by the Home Office to export diamorphine and permission will need to be granted by the visiting country before diamorphine can be taken on holiday abroad.

25.1.6 Different countries have different constraints regarding the importation of controlled drugs. This information should be verified with the Embassy or Consulate to ensure that it is up-to-date (https://www.gov.uk/government/publications/foreign-embassies-in-the-uk)

25.1.7 Provide a covering letter stating that the person is in treatment with the service and the dose of medication prescribed. This holds whether the person is going overseas or travelling locally

25.1.8 Methadone tablets may be used for clients going on holidays, particularly on airplanes where there is a restriction on taking fluids in hand luggage and where the bottle is a risk of leaking if put in luggage in the hold. For clients on high doses of methadone, it may be impracticable to take large volumes of methadone. These decisions should be agreed at the multidisciplinary team meeting.

25.1.9 Clients need to be informed that in certain countries methadone and buprenorphine are prohibited. Therefore it is their responsibility to check with the relevant embassy about the consequences of taking opioids into the country. In such cases, client may need to attend the drug service in the country or agree to a detoxification prescription.

25.2 Holiday in UK

25.2.1 If holidaying in the UK it should usually be possible to find a local chemist willing to dispense. Agree the pick-up date with the client (daily dispensing may not be the most ideal arrangement over a holiday period).

25.2.2 Methadone tablets should not be considered for UK holidays unless there is a flight involved.

26 Dissemination and implementation arrangements

26.1.1 These guidelines will be circulated to all consultants and service managers who will be required to cascade the availability of this document to members of the team. Guidelines will be available on the Trust intranet. The policy lead can be contacted for clarification or support in the implementation of the policy.

27 Training requirements

27.1.1 Staff should attend relevant training and CPD as per Trust policy and professional body.

27.1.2 Any training needs identified should be discussed during clinical supervision

28 Monitoring and audit arrangements

28.1.1 The Trust Accountable Officer for Controlled Drugs (CDAO) is responsible for monitoring the prescribing of controlled drugs in the organisation. The CDAO for the trust is the Chief Pharmacist.

28.1.2 New policies or changes to existing policies on controlled drugs must be agreed with the CDAO. All doctors and non-medical prescribers involved in the prescribing of controlled drugs should be willing and able to explain and justify their prescribing if called on to do so by the CDAO

28.1.3 Prescribing practice should be routinely monitored in the service or locality. This is to include regular checking and monitoring of FP10 prescribing using ePACT data. Such audits should be undertaken in conjunction with local clinical governance mechanisms.

Elements to be monitored	Lead	How trust will monitor compliance	Frequency	Reporting arrangements	Acting on recommendations and Lead(s)	Change in practice and lessons to be shared
Prescribing within the Trust formulary	Chief Pharmacist	ePACT data	Quarterly	Emailed to the service line consultants for cascading	Required actions will be identified and completed in a specified timeframe	Required changes to practice will be identified and actioned within a specific time frame. A lead member of the team will be identified to take each change forward where appropriate. Lessons will be shared with all the relevant stakeholders
Prescribing Incidents	Chief Pharmacist/Service Consultant	Datix	Ongoing	Drugs and Therapeutic Group		

29 Review of the policy

This guidance shall be reviewed every three years or earlier should new national/regional guidance be published.

30 Associated documents

This guideline should be cross referenced and read in conjunction with the following trust documents. All documents are accessible on trustnet.

- Medicines Management Policy
- Controlled Drug Policy and Procedures

- Non medical prescribing policy
- Trust Medicines Formulary and Policy
- Unlicensed medicines & unlicensed use of licensed medicines (off-label) policy
- Off-label indications for formulary medicines
- FP10 (HNC) Prescription Policy
- FP10MDA Prescription Form standard operating procedure (SMS)
- SMS Keyworkers' Handbook
- SMS Daily Dispensing Programme standard operating procedure
- Protocol for Urine Drug Screening and Prescribing Regime in Substance Misuse Services
- Supervised Self Administration (SSA) of methadone and buprenorphine in substance misuse policy
- Community Alcohol Withdrawal Guidelines
- Managing opioid addiction – hospital inpatients

31 References and Key Resources

Key Resources

NICE guidance (www.nice.org.uk)

- Methadone and buprenorphine for the management of opioid dependence. Technology Appraisal No. 114. January 2007 (www.nice.org.uk/guidance/index.jsp?action=byID&o=11606)
- Naltrexone for the management of opioid dependence. Technology Appraisal No. 115. January 2007 (www.nice.org.uk/guidance/index.jsp?action=byID&o=11604)
- Drug misuse: psychosocial interventions. Clinical Guideline No. 51. July 2007(www.nice.org.uk/guidance/index.jsp?action=byID&o=11604)
- Drug misuse: opioid detoxification. Clinical Guideline No. 52. July 2007 (www.nice.org.uk/guidance/index.jsp?action=byID&o=11813)
- Community-based interventions to reduce substance misuse among vulnerable and disadvantaged children and young people. Public Health Intervention Guidance No. 4. March 2007 (www.nice.org.uk/guidance/index.jsp?action=byID&o=11379)
- Alcohol use disorders. Clinical Guidance 115. 2001. (http://guidance.nice.org.uk/CG115)

NICE Medicines and Prescribing Centre (formerly National Prescribing Centre)

(http://pathways.nice.org.uk/pathways/drug-misuse)

- Provides easy access to source or related NICE guidance to drug misuse

Public Health England(https://www.gov.uk/government/organisations/public-health-england)

The National Treatment Agency joined Public Health England on 01 April 2013

A wide range of commissioning, national reports and practice guides are available including:

- Drug Misuse and Dependence: UK Guidelines on Clinical Management. July 2017 (the 'Orange book') https://www.gov.uk/government/publications/drug-misuse-and-dependence-uk-guidelines-on-clinical-management
- Commissioning for Recovery: Drug treatment, reintegration and recovery in the community and prison: a Guide for drug partnership

- (http://www.nta.nhs.uk/uploads/commissioning_for_recovery_january_2010.pdf)

Royal College of General Practitioners (RCGP) (www.smmgp.org.uk)

The RCGP has produced several guidance documents related to substance misuse which are available on the Substance Misuse Management in General Practice (SMMGP) website, including:

- Guidance for the use of methadone for the treatment of opioid dependence in primary care. September 2005 (www.smmgp.org.uk/download/guidance/guidance015.pdf)
- Guidance for the use of buprenorphine for the treatment of opioid dependence in primary care. October 2004 (www.smmgp.org.uk/download/guidance/guidance010.pdf)

The General Pharmaceutical Council (http://www.pharmacyregulation.org/)
The GPhC has produced a range of guides and factsheets on all aspects of the management of controlled drugs (http://www.pharmacyregulation.org/search/site/controlled%20drugs)

Department of Health (www.dh.gov.uk/controlleddrugs)
Information on the post Shipman changes to the legal framework around the use and management of controlled drugs is available via this link. Users are also signposted to relevant legislation and guidance from Government, professional bodies and other agencies.

Home Office (http://drugs.homeoffice.gov.uk/)
This website provides professionals working with drug misusers with the latest news and guidance from Government about the Drugs Strategy.

British Association for Psychopharmacology (BAP) (http://www.bap.org.uk/)

The BAP was founded in 1974 with the general intention of bringing together those from academia, the health service and the pharmaceutical industry who are involved in the study of psychopharmacology. Evidence-based guidelines are available

- Evidence-based guidelines for the pharmacological management of substance misuse, harmful use , addiction and comorbidity: recommendations from BAP http://www.bap.org.uk/pdfs/BAPaddictionEBG_2012.pdf

Appendix 1

Camden and Islington NHS
NHS Foundation Trust

OPIOID ADDICTION – MANAGEMENT OF HOSPITAL IN-PATIENTS (PHA60)

This summary should only be used as part of the immediate assessment and management of patients

During normal hours contact the Substance Misuse Service (SMS) - see next page

PATIENT HISTORY

- Establish current opiate use:
  - What drug(s), amount, frequency, duration of use, last use, withdrawal symptoms and cautions / contra-indications to methadone prescribing.
  - Is the patient currently in possession of drug(s) or substitute medication?
- Enquire about other substance misuse especially alcohol and benzodiazepines
- Enquire about Hep C, Hep B and HIV status.

EXAMINATION

- Evidence of drug use (e.g. needle marks, thrombosed veins, cellulitis and old scars)
- Observe for signs of opioid intoxication or withdrawal (see next page)
- Urine dipsticks testing for opiates (morphine) and/or methadone if available
- Request 'urine drugs of abuse screen' from **clinical biochemistry.**
  Note: Buprenorphine urine assays are not readily available at UCLH or RFH

Urine dipstick positive for opiates or methadone

Has the patient been on a regular methadone prescription administered within 3 days pre-admission?

Do not rely on patient's answers – check with SMS and/or community pharmacy

Yes

Continue with previously prescribed dose if confirmed and clinically safe.
NB: Check when patient last had a dose of methadone / buprenorphine / illicit opiates.

- If on methadone, initially give as divided dose
- If on sublingual buprenorphine (Subutex®) give once daily
- Cancel community prescription to avoid double scripting
- Inform Substance Misuse Service (SMS)
- Inform GP

Yes

Urine dipstick negative for opiates

Has the patient been on a regular buprenorphine (Subutex®) script administered within 3 days pre-admission?
NB: Buprenorphine does not show up on a routine drug screen.

Do not rely on patient's answers – check with SMS and/or community pharmacy.

No

No

Are there objective signs of opiate withdrawal? *(see next page)*

Yes

Methadone liquid (1mg/ml) 10mg up to QDS

- Monitor for opiate toxicity for at least 2 hours after dose
- Monitor for opiate withdrawal and assess 4 hourly
- If withdrawing at 4 hours, prescribe 5-10mg STAT
- Maximum of 40mg in first 24hours in divided doses.
- Once maintenance dose established give once daily

No

DO NOT PRESCRIBE OPIATES

Observe for withdrawals using Short Opiate Withdrawal Scale (page 3)

- Always write on drug chart '***OMIT IF SEDATED OR INTOXICATED***'
- Divided doses of methadone should be TWICE a day or up to FOUR times a day. **Avoid doses after 18.00hrs**
- Only prescribe **methadone oral solution (1mg/ml)** – do not prescribe tablets or injection
- Prescribe **all methadone and buprenorphine dose & frequency** in **WORDS & FIGURES**
- Ensure there is immediate access to **Naloxone**
- Fatal respiratory depression can occur with methadone doses of 30mg or lower in non-tolerant individuals or if combined with other opiates, alcohol or benzodiazepines (e.g. chlordiazepoxide, diazepam). Buprenorphine can similarly cause respiratory depression if used with these agents.

General Management:

- The treatment of opiate addiction is a specialist area. Existing treatment regimens should be continued if clinically indicated. New treatment episodes should be initiated with specialist advice. In emergencies and out-of-hours the aim is to minimise withdrawal symptoms so that the primary health problem can be treated**.** Whenever possible, get confirmation from the responsible prescriber or pharmacist in relation to substitute opioid prescribing

- **Opiate withdrawal:** Opiate withdrawal symptoms are unpleasant and can be very uncomfortable but are not life-threatening. Mild or early features are often subjective: restless, agitation and subjective discomfort; **Objective signs**: Sweating, yawning, running nose (rhinorrhoea), runny eyes (lacrimation), feeling hot and cold, anorexia and abdominal cramps, nausea, vomiting and diarrhoea, tremor, insomnia and restlessness, muscle aches and pains, increased pulse rate (tachycardia), increased blood pressure (hypertension), gooseflesh (piloerection), dilated pupils (mydriasis), increased bowel sounds.

- **Opiate Intoxication:** signs and symptoms: Constricted pupils (miosis), drowsy, intermittent dozing off with eyes closing, orthostatic hypotension, loud snoring, leading to cyanosis and respiratory depression.

- A **POSITIVE urine result** for **OPIATES** means that heroin, morphine, codeine-based opiates and/or their metabolites have been identified (note: prescribed or OTC analgesics may contain opiates).

  A **POSITIVE urine result** for **METHADONE** means that the parent compound methadone has been identified.

  A **NEGATIVE urine result** means that it is unlikely that the patient has taken opiates recently. Note that buprenorphine is not tested for in the clinical biochemistry urine drug analysis, so the result will come back as negative. Specific urine dip sticks are available for buprenorphine.

- Methadone has a long half-life, so if discontinued withdrawal symptoms may not occur for up to 36hrs.

The medication of choice to manage opiate withdrawal is Methadone oral solution (1mg/1ml). **It should not be prescribed or administered to a patient who appears**

intoxicated, whether with drugs or alcohol. Do **not** prescribe it for patients who are usually on buprenorphine.

- To avoid illicit drug use on the ward: ingestion of medication should be observed. Be aware of visitors who may bring drugs or medication onto the ward (Ref. local drugs and alcohol policy). Regular urine drug screens should be undertaken.

- Ensure clear documentation of advice/recommendations; other staff may need to refer to your notes.

- Pain relief: Opiate dependent patients will be tolerant to their daily intake and may require additional opiates for pain relief, however, these should be prescribed only if clinically indicated and for short term. Consider referral to the local pain management team.

Discharge

- When planning discharge involve the keyworker or duty worker from the local drug service who will be able to advise on management and link with follow-up agencies.

- **Methadone/buprenorphine should not be given as a TTA**.

- If necessary patients should return to the ward over weekends to receive daily supervised doses of methadone/buprenorphine. During weekdays the drug treatment service will aim to pick up prescribing as soon as the patient is discharged. The hospital should make arrangements for the client to attend over the weekend if discharged after midday on Friday. They should also inform the substitute prescriber.

- If the patient has no GP and medical follow-up is required please refer to the Camden Health Improvement Pathway (CHIP).

Contact Points

- Camden - The Margarete Centre (Camden Specialist Drug Service), 108 Hampstead Rd, NW1 2LS Tel: 0203 317 6000. Integrated Camden Alcohol Service (CSATS): Tel 0203 227 4950

- Islington - Better Lives, 99-101 Seven Sisters Road, N7 7QP,Tel: 020 3317 6099 or 309 Grays Inn Road, London, WC1X 8QF, Tel: 020 3317 6650

- Camden Health Improvement Pathway (CHIP): 108 Hampstead Road, NW1 Tel: 020 3182 4200

Appendix 2 – Complexity Criteria for Camden Specialist Drug Service

General Eligibility Criteria: Camden resident, 18 years of age or over, problematic drug use, has a connection with Camden (chain number, benefits in Camden)

Complexity Criteria

Comorbid mental health problem of moderate-severe intensity	Severe and enduring mental health condition Under a Mental health team Under CPA Requires mental health assessment
Severe personality disorder	Formal ICD-10 diagnosis Under personality disorder service
Pregnancy	Confirmed pregnancy test
Comorbid alcohol dependence	Confirmed diagnosis of alcohol dependence
Complex polydrug dependence	Dependence on multiple substances such as: opiate, with benzodiazepine, alcohol, NPS, etc
Chronic and severe physical health problem that impacts on clinical management	TB HIV End stage liver failure Renal failure Pain management Referrals from hospital liaison, frequent attenders or homeless pathways discharge planning service
Learning disability	Formal diagnosis in place Under LD team
Complex substitute prescribing	Injectable opioids/Diamorphine Physeptone tablets Methadone dose greater than 120mg on case by case basis Benzodiazepine prescribing Dexamfetamine prescribing

High risk injecting	Groin or neck injecting
Hard to engage, chaotic clients who have formed a therapeutic relationship with the service	

Appendix 3: Short Opiate Withdrawal Scale

Assessment for dose titration/retitration

1. Current script - drugs, dose, when was last dose increase?

2. Attendance at DDP/chemist - for last 1/52, when was last dose?

3. Illicit drug use - what and when?

4. Alcohol - frequency, amount, dependence, BAC limit?

5. Withdrawal symptoms - what (complete opiate withdrawal chart) and any currently, how many hours to develop after dose?

6. Intoxication - any sedation after dose, currently present?

7. Recent urine results and current drug screen.

8. Document all information in notes, file opiate withdrawal scale and bring with DDP chart/script record sheet to discuss with prescriber.

9. Prescriber may request a dose titration appointment.

10. Before commencing detox discuss at team meeting.

Example of opiate withdrawal scale

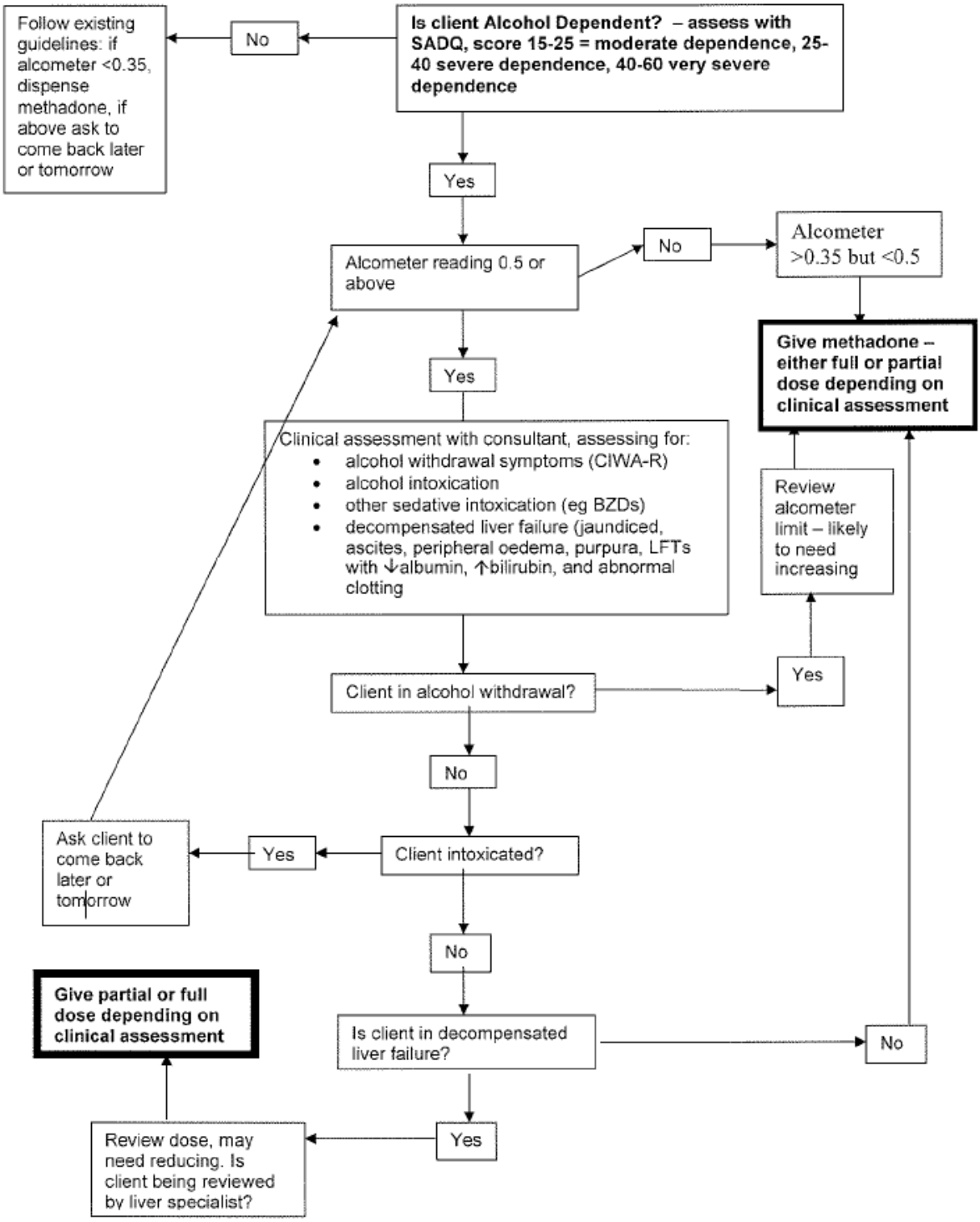
Date
Time
For completion by staff:
Pulse (bpm)
Blood Pressure
Pupil size (mm)

Short Opiate Withdrawal Scale (SOWS)1 Please rate whether any of the following have been experienced in the last 24hours: None = 0, Mild = 1, Moderate = 2, Severe = 3
Feeling Sick
Stomach Cramps
Muscle spasms/Twitching
Feelings of Coldness
Heart Pounding
Muscular Tension
Aches and Pains
Yawning
Runny Eyes
Insomnia/ problems sleeping

[1] Gossop, M., The developments of a Short Opiate Withdrawal Scale (SOWS). Addictive Behaviours, Vol. 15, pp. 487-490, 1990.

Appendix 4 – Alcohol and Methadone

Alcohol Dependence and Methadone or Buprenorphine Maintenance Flow Chart



Appendix 5: Letter of Introduction for Community Pharmacist

Camden and Islington NHS
NHS Foundation Trust

(Insert appropriate service address and details)

Pharmacy Address:

Pharmacy telephone/contact:

Date: ……..…..

Dear Pharmacist,

RE: ...……..……..... DOB: ……

Address: ……....

…….....

Thank you for agreeing to dispense to the above service user.

We are prescribing methadone 1mg/ml / buprenorphine (**delete as appropriate**)

Daily dose:……(figure)……..(words) milligrams

Start date:……..…….

Please note that our service user has signed up to a service care agreement which applies equally when they are attending your pharmacy. Enclosed is a copy for your records.

Please do not hesitate to contact ……(Keyworker), if you require any further information.

Yours faithfully,

Appendix 6: Safe Storage Letter

RESPONSIBILITIES AND SAFETY IN RELATION TO CONTROLLED DRUG PRESCRIPTIONS

- Methadone can be a dangerous drug and can kill.

- Methadone is very dangerous when swallowed by children. Children have no tolerance to the drug and even a tiny amount can kill.

- When you collect your Methadone from the chemist, ensure that it is in a bottle with a child-proof lid.

- Keep all controlled medication (e.g. Methadone, Buprenorphine, Diazepam) in a locked cabinet out of reach of children. If you have children at home, or who visit regularly, staff may wish to visit your home to check that you are using a lockable cabinet. If Social Services are involved, they may randomly visit to check that you are using a lockable cabinet.

- If you suspect that your child or anyone else has swallowed any Methadone or Buprenorphine by accident, call 999 for an ambulance - do not wait to see if they are OK – call immediately.

- Return empty bottles of Methadone to the locked cabinet. Rinse out empties before throwing them in the waste or return them to the pharmacy.

- Prescribed medication is for your use only. Giving or selling your medication to anyone else is a criminal offence. The dose you are taking may be fine for you, but it could kill someone else. If someone dies as a result of taking your medication, you risk being charged by the police with manslaughter.

- It is dangerous for you to take more than the prescribed dose or to take it in combination with non-prescribed drugs and/or alcohol.

- It is an offence to obtain a controlled drug, such as Methadone, Buprenorphine, or Diazepam from more than one prescriber at the same time. You must inform the prescriber or clinic staff if you are already getting such medication from another source.

- If you miss picking up your medication or prescription for 3 or more days, your prescription will be stopped automatically at the chemist. You will need to return to the treatment centre for re-assessment before a new prescription can be issued.

- Once the prescription has been issued or your medication dispensed, it is your property and your responsibility to look after it. Lost or stolen prescriptions or medication may not be replaced. Lost prescriptions or medication should be reported to the police and a crime or incident number obtained. If someone else takes medication that you have lost but have not reported, and if that person were to die of an overdose, you risk being charged by the police with manslaughter.

- Your chemist is prohibited by law from dispensing your medication on any days other than the exact dates specified on the prescription. Please do not ask your chemist to dispense medication in advance or for days that you have missed.

- We do not issue prescriptions scripts to clients who are intoxicated with drugs or alcohol. If you appear intoxicated we will ask to breathalyse you. If you appear intoxicated at the chemist, they may refuse to give you your Methadone, Buprenorphine or Diazepam and ask you to come back later.

- If you are travelling you need to give us two weeks' notice in order to discuss the request at the team meeting, arrange holiday prescriptions, identify local chemists or obtain export licenses from the Home Office if required. If you are going abroad, it is your responsibility to check whether the country of destination allows you to bring a prescribed controlled drug with you. In some countries it is illegal to do so. It is your responsibility to check this. Proof of travel will be requested. The clinic will need to make an assessment of the risks of prescribing medication to take-away.

- It is a criminal offence to drive under the influence of drugs or alcohol. If you are currently addicted to drugs or alcohol, you are obliged to inform the DVLA of your condition. They may allow you to continue to drive if you are stable on a prescription of Methadone or Buprenorphine and are not using illicit drugs on top. If you are driving a HGV or a Public Service Vehicle, we will need proof that you have informed DVLA. If you are unable to do this and continue to drive, we will be obliged to inform DVLA.

- If you are a healthcare professional or work with children or vulnerable adults, we may need to assess you fitness to practice and obtain proof that you have informed your employer, occupational health department or professional body of your problem. If we have concerns about your fitness to practice or to work, we may need to inform your professional body or your employer.

I, _____, have read and understood the above.

Client:

Signature: Print Name: Date:

Staff:

Signature: Print Name: Date:

Equality Impact Assessment Tool

		Yes/No	Comments
1.	**Does the policy/guidance affect one group less or more favourably than another on the basis of:**		
	Race	No	
	Ethnic origins (including gypsies and travellers)	No	
	Nationality	No	
	Gender	No	
	Culture	No	
	Religion or belief	No	
	Sexual orientation including lesbian, gay and bisexual people	No	
	Age	No	
	Disability - learning disabilities, physical disability, sensory impairment and mental health problems	No	
2.	**Is there any evidence that some groups are affected differently?**	No	
3.	**If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?**	N/A	
4.	**Is the impact of the policy/guidance likely to be negative?**	No	

		Yes/No	Comments
5.	**If so can the impact be avoided?**	NA	
6.	**What alternatives are there to achieving the policy/guidance without the impact?**	NA	
7.	**Can we reduce the impact by taking different action?**	NA	