3rd Edition 2010

Guidance for Primary Care Drug Misuse

3rd Edition 2010

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Published October 2010

Introduction

This is the 3rd edition of guidance for the treatment of drug misuse in opiate dependent patients. The guidance has been developed by the Shared Care Management Group (SCMG) which oversees the delivery and monitoring of opiate substitution therapy (OST) in primary care.

The Shared Care Management Group is represented by:

- Oxfordshire DAAT (specialist commissioners for drug services within NHS Oxfordshire)
- NHS Oxfordshire (the county's Primary Care Trust)
- Oxfordshire User Team (OUT)
- Specialist Community Addiction Service (SCAS), Oxfordshire & Buckinghamshire Mental Health NHS Foundation Trust
- Community Drug and Alcohol Service (CDAS), SMART
- Local Pharmaceutical Committee (LPC)
- GP representative

The guidance is produced for the key professionals, GPs, addiction nurses and community pharmacists who make up the Shared Care Team, providing the clinical element of treatment to patients with opiate dependency. This guidance may also be used as a resource for other drug-related services that have contact with patients in the Shared Care Scheme.

N.B Prescribing of opiate substitution therapy (OST) is only part of a package of care to successfully treat and manage opiate dependency.

Shared Care: The Model

The model for delivering drug treatment to opiate dependent patients in primary care in Oxfordshire is known within the drug treatment services as 'Shared Care'. This model allows patients to access drug treatment at their own GP practice. An addictions nurse from the Specialist Community Addictions Service (SCAS) provides specialist input in collaboration with the GP, to provide opiate substitute therapy (OST), for patients with an opiate dependency and is also supported by a local pharmacy.

Shared Care is part of a package of care which may also include the Oxfordshire Community Drug and Alcohol Service, Restart Plus (Aftercare), Counselling Service, The Women's Service, NHS Salaried Dentists and the Probation Substance Misuse Team as well as more peripheral services e.g. housing.

Shared Care has been running for eight years across Oxfordshire and is now commissioned by Oxfordshire DAAT and NHS Oxfordshire through a local enhanced service for GPs and Pharmacists. Patients in Shared Care will normally be stable and maintained on a prescription of methadone or buprenorphine.

The model is voluntary with fifty GP practices and ninety-two pharmacies participating in the scheme through the Drug Misuse Local Enhanced Service (LES). The Shared Care scheme is directly supported by SCAS Specialist Care which under the Consultants in Addiction sees the unstable, chaotic drug user not suitable for Shared Care.

Each GP practice providing Shared Care will have an allocated addictions nurse from SCAS and provide a level of service as set out in the LES, determined by the following;

- Nursing time availability
- GP availability
- GP competence/Banding of service
- Patient numbers & complexity
- Local needs
- Consulting room availability
- DAAT/PCT Funding

The experience and competencies of GPs will vary from practice to practice, but each practice should have one GP who has successfully completed the RCGP Part 1 Certificate in the Management of Drug Misuse.

Patients should be allowed to choose their preferred pharmacy from the list of pharmacies providing the LES (see appendix 4); collaboration between the pharmacist, GP, addictions nurse and the patient is fundamental to the service.

Patients whose GP practice does not provide a Drug Misuse Service are seen in Drug Treatment Clinics (formerly known as Resource Centres). There are currently four Drug Treatment Clinics (DTCs) operating across Oxfordshire, and since June 2010 have been provided by OBMH.

Sites for Drug Treatment Clinics include:

- Abingdon
- Didcot
- Witney
- Oxford City

Patients identified with complex or more chaotic needs, or patients whose condition worsens will be referred into Specialist Care; the secondary care arm of the Specialist Community Addiction Service, led by a team of Consultants in Addiction Psychiatry.

Eligibility

- All patients aged 18 years and older
- All patients with an Oxfordshire GP practice
- All patients with a confirmed dependence for opiates

Excluding

- Patients registered with an Oxfordshire GP practice who are in a residential unit for substance misuse
- Patients who are temporary residents

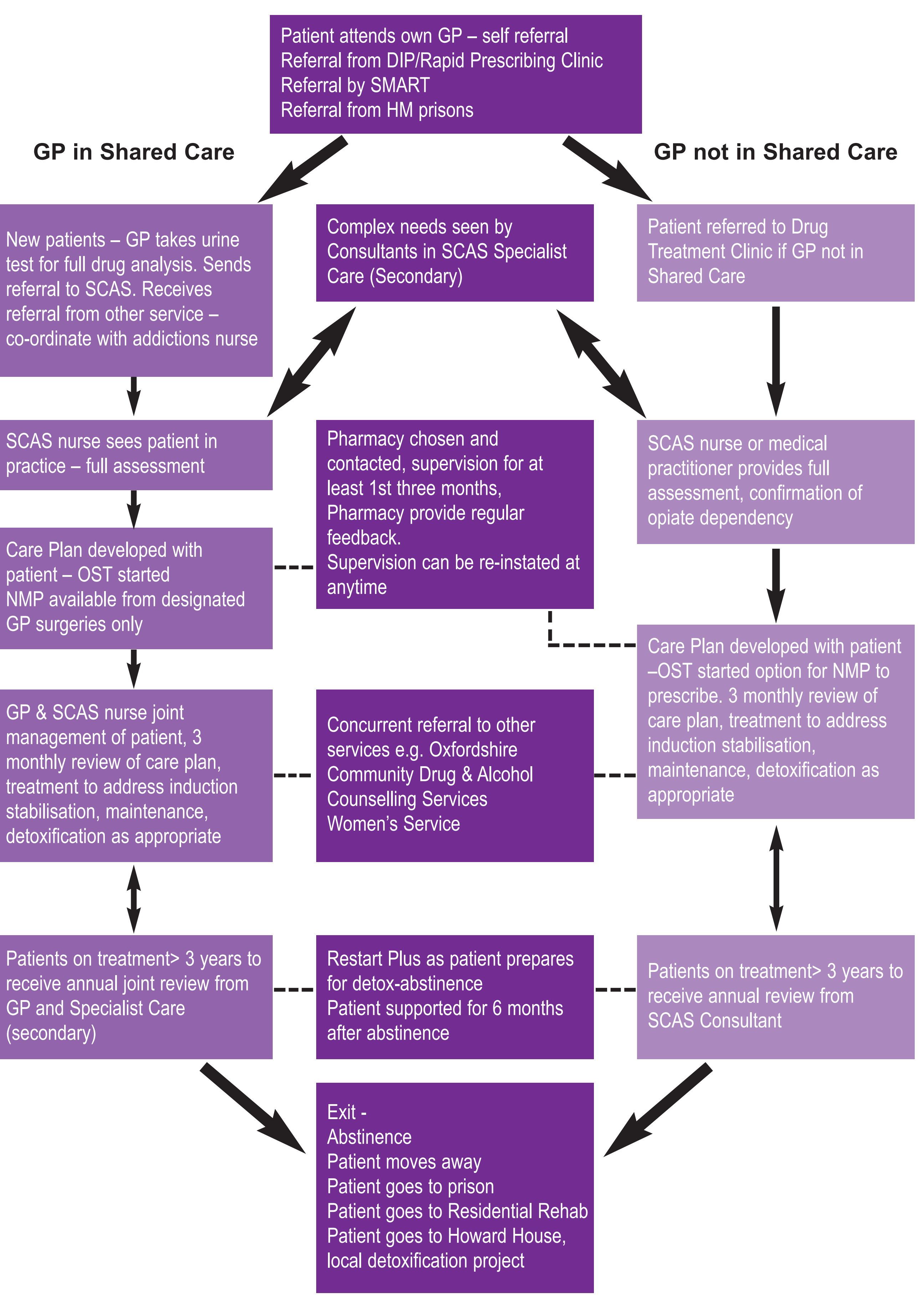
Referral

All patients consulting with a GP for opiate dependence should be referred to SCAS in the first instant (Referral form Appendix 1). Patients will be allocated to an addictions nurse, and managed collaboratively with a GP at the practice.

Under 18s

Patients under 18 years old with drug or alcohol problems should be referred to Young Addaction Oxfordshire, 62 Stert Street, Abingdon, OX14 3JU. Tel: 01865 815476.

Shared Care Pathway



GPs: Roles & Responsibilites for Shared Care

The level of service from GP practices is met by different banding:

Band One GP Practice will:

- Identify a minimum of one GP in the practice who will have completed the RCGP part 1 Certificate in the Management of Drug Misuse
- Provide a consistent service 52 weeks of the year
- Offer a written copy of the care plan to the patient (see Appendix 9)
- Make available a consulting room for the addictions nurse and access to a practice computer system and internet connection
- Provide general medical care to the patients including BBV screening and vaccination
- Maintain standard operating procedures for the safer management of controlled drugs, ordering and use of FP10MDA prescription forms, and the delivery of the enhanced service
- Participate in audit, both national and local, as required
- Maintain a current register of drug users in treatment
- Provide DAAT with data as requested, through a monthly reporting system for;
    - Data submission to the National Drug Treatment Monitoring System (NDTMS)
    - Payment of LES.

Band One GP will:

- Be competent to prescribe opiate substitution therapy for largely stable opiate dependents in maintenance, as per the GP Roles for an enhanced service[1] (See Appendix 2)
- Encourage and support detoxification as part of a planned intervention with the addictions nurse and other related services
- Only start prescribing in collaboration with the nurse after a full assessment has been undertaken
- Develop a care plan in collaboration with the nurse and patient
- Meet and discuss regularly with the addictions nurse the caseload and individual treatment plans
- Review patients care plan in collaboration with the addictions nurse every 3 months[2,3]
- Provide an independent prescriber role for supplementary non-medical prescribers (subject to agreement with the Shared Care Management Group)
- Participate in a joint annual review with Specialist Care for patients on maintenance treatment for longer than three years.
- Review prescribed dose if a patient is reported (by pharmacist) to have missed 3 consecutive daily doses, or attends erratically and re-issue prescription as necessary
- Provide written information on the prescribed opiate substitute therapy[4,5]
- Provide HIV, hepatitis C screening, hepatitis A & B immunisation and tetanus for patient and family/carers as relevant

continued ...

[1] Roles and responsibilities of doctors in the provision of treatment for drug and alcohol misusers Royal College of Psychiatrists and RCGP 2005
[2] Drug misuse and dependence UK guidelines on clinical management DH 2007
[3] Guidance for the use of methadone for the treatment of opioid dependence in primary care RCGP 2005
[4] Methadone Replacement for Heroin http://www.patient.co.uk/pdf/pilsL571.pdf Appendix Five
[5] Buprenorphine Replacement for Heroin http://www.patient.co.uk/pdf/pilsL588.pdf Appendix Six

- Advise and provide information on Safer Injecting and harms associated with drug use
- Provide basic and minimal interventions for co-incidental alcohol or tobacco use
- Ensure that prescribing is only a part of the treatment and management of opiate dependent patients with referral to psychosocial interventions and other supporting services as required
- Promote and encourage the uptake of dental care, sexual health and general medical services
- Adhere to the Safeguarding Children guidance from the Oxfordshire Safeguarding Children Board (OSCB) http://www.oscb.org.uk/; regularly documenting any change for patients' regarding access to children and supporting appropriately.

Content of Review

Review should include:

- Treatment Outcome Profile form-carried out by addiction nurse
- Consent to Information Sharing
- Risk assessment

To link closely with:

- Original full assessment
- Current Care Plan
- Prescribing record
- Drug Screen record

Band Two/Three GP and Practice will in addition to the above:

- Have a GP who has completed the RCGP Certificate in the Management of Drug Misuse Part 1 and 2 or equivalent training
- Meet and maintain the competencies identified for GPs providing a special interest[6] (see Appendix 2)
- Be competent to undertake full assessment for new patients
- Be competent to offer a methadone contingency plan[7] (see Appendix 3)
- Initiate prescribing and changes in accordance with clinical guidelines
- Be available on a weekly basis to see patients
- Initiate both Detoxification and 'Short Detoxification' (see Chapter on Detoxification) subject to a planned intervention with the consenting patient, the addictions nurse and Restart Plus
- Be available to provide advice and training to colleagues and other healthcare professionals
- Oversee with the SCAS nurse, the regular treatment and management of a minimum of 10 patients, rising for Band 3 GPs to a minimum of 40 patients.

GPs may become involved in Shared Care at varying steps reflecting the individuals experience knowledge and competencies. Care should only be delivered as part of a shared case load with the addictions nurse.

❖ GPs should work within their level of competency.

[6] Roles and responsibilities of doctors in the provision of treatment for drug and alcohol misusers Royal College of Psychiatrists and RCGP 2006

[7] Specialist Community Addictions Service Prescribing Guidelines OBMH 2009

Maintenance Prescribing

Prescribing

This guidance is based on the following publications:

- *Drug Misuse and Dependence UK guidelines on clinical management* DH 2007
- *British National Formulary* BMJ Group and RPS Publishing, (current edition)
- TA114 *Methadone and buprenorphine for the management of opioid dependence* NICE 2007.

Opiate substitution therapy (OST) should only be started after a full or comprehensive assessment and the following considered;

- Opiate dependence has been confirmed through drug screening, evidence of recent injection, observed withdrawal symptoms (see Appendix 7)
- Patients are motivated to change at least some aspect of their drug misuse
- Opiates are taken on a regular daily basis
- The patient is not already receiving a prescription
- The patient has the capacity to comply with the prescribing regimen
- The patient understands that when maintenance is the treatment option it is likely to be long-term and for several years.

Prescribing is only part of the treatment for opiate dependency; the patient should be referred for psychosocial interventions to Oxfordshire Community Drug and Alcohol Service (provided by SMART) and other supportive mechanisms according to need.

*SMART, The Old Music Hall, 106-108 Cowley Rd, OX4 1JE. Tel 01865 403151. Email: oxford.admin@smartcjs.org.uk

Before initiating a script the following must be undertaken:

- Assess recent (last month) and current use
- Assess the history of money spent daily on heroin
- Assess weight of drug used daily (smoked heroin may need less oral substitution than injected to maintain stability)
- Assess prescribed drugs, alcohol and street drugs used
- Confirm any recent OST with prescribing service.

Choosing an opiate substitution therapy for maintenance

Methadone 1mg /ml solution or **Buprenorphine s/l tablets**
Both are recommended *by NICE[8] for maintenance therapy in the management of opioid dependence*.

When selecting a treatment consider:

- Level of opioid of misuse: buprenorphine is better suited for patients with moderate opioid dependence, which can include patients who smoke heroin, or for patients who do not have a long history of opiate dependence
- Risk of diversion
- Risk of accidental overdose
- Patient's past & current prescribed/illicit medications
- Patient preference

continued ...

[8] TA114 *Methadone and buprenorphine for the management of opioid dependence* NICE 2007.

- Prescriber's experience with methadone or buprenorphine
- Evidence suggests that methadone is more likely to retain patients in treatment
- Buprenorphine is less sedating than methadone, this may be a positive or negative for different patients
- Methadone 1mg/ml solution is less expensive than buprenorphine, Subutex®.

❖ **Selection should be made on a case by case basis but methadone should be prescribed if both drugs are equally suited.**

A decision should be made between the patient and practitioner as to whether the treatment is maintenance or detoxification, before starting prescribing.

Methadone

Methadone is an opioid agonist used to treat and manage opiate addiction with a view to stabilisation and maintenance from illicit heroin.

Methadone oral solution 1mg/ml should be prescribed as part of the Shared Care Scheme.

Methadone tablets should not be prescribed and are not licensed for the treatment of opiate addictions.

Titration

Titration from street heroin to methadone is started if **maintenance** is the identified goal of treatment:

- When titrating a patient from street heroin to methadone for maintenance always **START LOW, GO SLOW**
- Patients will usually continue to use illicit drugs 'on top' in the first week/s of treatment until an adequate dose is reached whereby there are no withdrawal symptoms present
- The patient's daily spend and frequency of use of street heroin can only act as a guide for a starting point for methadone
- Start on a low dose no higher than 30ml of methadone 1mg/ml solution a day, with an increase of 5-10ml every three days until stabilisation is achieved. A total weekly increase should not usually exceed 30ml above the starting day's dose. If tolerance is uncertain or other drugs are being misused e.g. benzodiazepines, alcohol, initiate doses no higher than 20ml daily for the first few days.
- All prescriptions for methadone should be supervised for the first 12 weeks of treatment; this is usually for 6 days with a take home dose for one day. (**NB there are several pharmacies in Oxfordshire that are now open on a Sunday where 7-day supervisions may be accessed** see Appendix 4).
- Methadone may cause QT prolongation and torsades de pointes. Higher doses, concomitant QT interval-prolonging agents and the presence of other risk factors for QT prolongation may predispose patients to the development of potentially fatal arrhythmias with methadone. ECG monitoring is recommended with methadone doses >100mg/day and in patients with either risk factors for QT prolongation or symptoms that may be attributable to arrhythmia[9].

continued ...

[9] Roden DM. Drug-induced prolongation of the QT interval. *New England Journal of Medicine* 2004;350(10):1013-1022.

- Induction should be monitored by a doctor or trained nurse
- Provide written information on methadone treatment (see Appendix 5).

There is an increased risk of death during titration, patients and carers should be alerted to the early signs of overdose.
Extra care should be taken if the patient is also taking benzodiazepines, anti-depressants or alcohol.

Maintenance with methadone 1mg/1ml solution

- Doses for maintenance can be increased incrementally up to a total of between 60ml-120ml; it may take several weeks to reach this dose, with several days between each increment
- Higher doses >120ml should only be prescribed under the supervision of Specialist Care (secondary care) which should be documented in the patient's notes
- Collaboration and review should included the GP, nurse and patient as well as the pharmacist who will have had daily contact with the patient
- The maintenance dose will vary across patients according to the degree of dependence and pharmacokinetics of the individual.

Buprenorphine S/L tablets

Buprenorphine is a partial agonist and alternative to methadone in the treatment of opiate dependency. As buprenorphine can result in precipitated withdrawal it is not suited for patients on high doses of opioids. Buprenorphine is available as a sub-lingual tablet in dosages of 400mcg, 2mg and 8mg. It is available as a generic and brand name ™Subutex, prescribers should use generic prescribing.

- Patients should not have used heroin within 4 hours of taking the first dose and should be exhibiting signs of withdrawal (see Appendix 7)
- A dose of 8mg should be started with a rapid increase to a 12mg-16mg range, and thereafter increase the dose more slowly if necessary, maximum 32mg a day
- Patients should be supervised in the first 3 months of treatment as above
- Patients switched from methadone to buprenorphine should be on a methadone dose of 30mg or less
- Patients should be provided with information about precipitated withdrawal and informed they can switch to methadone
- Service users should have regular liver function tests whilst on buprenorphine.

Maintenance with buprenorphine

- Doses are usually around 12-24mg range but may go as high as 32mg daily
- Collaboration and review should include the GP/addictions nurse, patient and pharmacist who will have had daily contact with the patient
- Provide written information on buprenorphine treatment (see Appendix 6).

Supervision of opiate substitution therapy

- Patients should normally be supervised in the first three months of treatment
- Stopping supervision should be based on a risk assessment (see Appendix 11) involving the patient
- Daily pickups can be initiated and progress to less frequent pickups as determined by the level of risk and patient compliance
- Supervision should only be relaxed if the prescriber has good reason to believe that compliance will be maintained
- A request for 'crushed buprenorphine' can be made if there is concern of diversion of buprenorphine. (Pharmacies must work within the NPA protocol or equivalent)
- If children are known to be in the household, a safety 'methadone holding' box should be provided (facilitated by SCAS nurse and subject to availability) before take home doses are allowed
- Supervision should be re-started after a break or when there is a significant increase in the methadone daily dose or when there is loss of compliance
- Take home doses of methadone should be dispensed in individual daily containers, prescribers should include the text **'dispense in daily dose containers in advance'** or equivalent, when taking home more than one days treatment
- Take home doses should not be for longer than one week's treatment.

❖ **Prescribing is only part of the treatment for opiate dependency; the patient should be referred for psychosocial interventions to Oxfordshire Community Drug and Alcohol Service (provided by SMART*) and other supportive mechanisms according to need.**

*SMART, The Old Music Hall, 106-108 Cowley Rd, OX4 1JE. Tel 01865 403151. Email: oxford.admin@smartcjs.org.uk

Maintenance with methadone and buprenorphine

Most patients require the support of OST for longer than a few months. The patient should be involved in the decision for long-term prescribing as part of a care plan that involves psychosocial interventions and social support.

- The dose of maintenance OST should be reviewed regularly (usually at least every 3 months), by the GP and addictions nurse with the patient, as part of goal setting within an agreed care plan
- Dosing should remain flexible and seek to 'hold' the patient without withdrawal symptoms or the need to use on top
- Patients may need to be seen fortnightly initially and then less frequently if stable and achieving goals
- Random urine testing should be carried out, at least twice a year
- Patients on maintenance for longer than 3 years should have a joint review with Specialist Care (secondary care).

Writing a Prescription

Guidance for Issuing Scripts

Legal Requirements

Prescriptions can be printed including the date, but must be indelible and include:

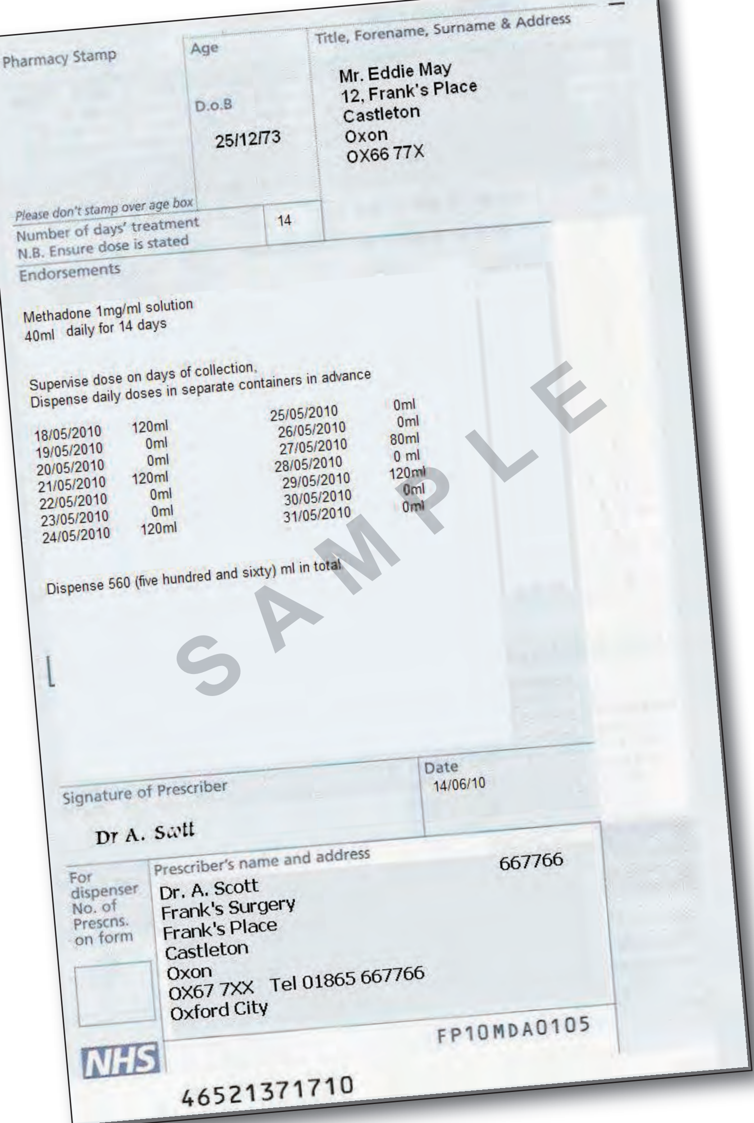
- Patient's full name , address and, where appropriate age
- The form and strength of the preparation
- The dose to be taken (Home Office has advised that quantities of liquid preparations should be written in millilitres e.g. 70ml of methadone 1mg/ml solution)
- An instalment prescription must have both a dose and an instalment amount on the prescription
- The total quantity of the preparation or the number of dose units in both words and figures
- A hand written signature of the prescriber who has written/printed the prescription
- The date of signing by the prescriber
- For a quantity intended to be dispensed by instalments, contain a direction specifying the amount of the instalments which may be supplied and the intervals to be observed when supplying
- Instalment prescriptions must have **both** a dose **and** an instalment amount on the prescription i.e. they both have to be specified separately.[10]

Practical Points

- All instalment prescriptions should be written using the blue FP10 (MDA) form and can only be authorised for up to 14 days supply
- Always include a **start date** for the prescriptions (this can be more than 28 days from the date of signing/issuing)
- It is not a legal requirement for a starting date to be specified, but where one is given it must be complied with
- Specify the dispensing instructions e.g. daily dispensing, supervised consumption as appropriate
- Include the Prescriber's NHS identifier
- Include instalments for Sunday/ Bank Holidays
- Supply of take home medicine should not normally exceed one week's supply
- Controlled Drug prescriptions are valid for 28 days from the date of issue unless a later start date is included
- Full details on how to write a Controlled Drug prescription can be accessed from the British National Formulary (BNF)
- If a third person is collecting an instalment a covering letter should be provided and noted in the patient's care plan
- Take home doses of methadone should be supplied in pre-measured doses, with the words ***Dispense daily doses in separate containers in advance***.

[10] Medicines, Ethics & Practice A Guide for Pharmacists and Pharmacy Technicians 33 RPSGB 2009.

Sample Prescription



Pharmacy Stamp | Age | Title, Forename, Surname & Address

D.o.B
25/12/73

Mr. Eddie May
12, Frank's Place
Castleton
Oxon
OX66 77X

Please don't stamp over age box
Number of days' treatment
N.B. Ensure dose is stated
14

Endorsements

Methadone 1mg/ml solution
40ml daily for 14 days

Supervise dose on days of collection.
Dispense daily doses in separate containers in advance

18/05/2010	120ml	25/05/2010	0ml
19/05/2010	0ml	26/05/2010	0ml
20/05/2010	0ml	27/05/2010	80ml
21/05/2010	120ml	28/05/2010	0 ml
22/05/2010	0ml	29/05/2010	120ml
23/05/2010	0ml	30/05/2010	0ml
24/05/2010	120ml	31/05/2010	0ml

Dispense 560 (five hundred and sixty) ml in total

SAMPLE

Signature of Prescriber
Dr A. Scott

Date
14/06/10

For dispenser No. of Prescns. on form

Prescriber's name and address
Dr. A. Scott
Frank's Surgery
Frank's Place
Castleton
Oxon
OX67 7XX Tel 01865 667766
Oxford City

667766

NHS

FP10MDA0105

46521371710

Home Office ruling on missed collections of instalments[11]

There is now an option to include the following text on a prescription as appropriate:

For supervised consumption
"Instalment prescriptions covering more than one day should be collected on the specified day; if this collection is missed the remainder of the instalment (i.e., the instalment less the amount prescribed for the day(s) missed may be supplied."

For unsupervised consumption
"Instalment prescriptions covering more than one day should be collected on the specified day; if this collection is missed the remainder of the instalment (i.e., the instalment less the amount prescribed for the days(s) missed may be supplied."

[11] Medicines, Ethics & Practice A Guide for Pharmacists and Pharmacy Technicians 33 RPSGB 2009.

If the prescription does not reflect such wording, the Regulations only permit the supply to be in accordance with the prescriber's instalment direction.

Other Home Office wording for when the pharmacy is closed:

"Instalments due on days when the pharmacy is closed should be dispensed on the day immediately prior to closure".

Technical/ errors/ omissions

Pharmacists can still supply scripts for methadone or buprenorphine if:

- The prescription contains a minor typographical error or spelling mistake
- The total quantity of the preparation or the number of dosage units (as the case may be) is specified on the prescription in either words or figures, but not both.

Travel

Holidays/out of area trips

Patients planning to go on holiday should receive a planned assessment of the risks associated to their ongoing current treatment and prescribing of CDs, at least two to three weeks in advance of a holiday. Many issues are raised when a holiday prescription is requested - this is particularly relevant to people travelling overseas and those holidaying as opposed to going out of area for other reasons. It is accepted that risk behaviours may well increase during a holiday period, particularly with the use of alcohol and illicit drugs. The following points should be considered for holiday prescriptions:

- Only stabilised patients should be considered
- Written confirmation/booking of the holiday should be provided by the patient
- Length of holiday prescription should not normally exceed two weeks
- Supervised patients should continue to be supervised if possible
- Safe storage arrangements for travelling with CDs must be ensured throughout the period of holiday.

Methadone 1mg/ml solution can be carried safely in patient's luggage and can be wrapped in protective packaging. Methadone 5mg tablets should not be prescribed.

Holidays/trips in the UK

Patients holidaying or going out of area for a short period in this country should be maintained on their usual script and arrangements made in advance with a destination pharmacy for dispensing and supervision as relevant.

Holidays abroad

From January 1st 2008 patients travelling abroad carrying CDs in Schedules 1, 2, 3 and 4 Part 1 for any period up to and including three months no longer require a Home Office licence regardless of the drug(s) and amount(s) being carried[12]. The Home Office still advise the carriage of a letter issued by the prescribing doctor or drug worker. The letter should contain:

- Patient's name
- Patient's address
- Patient's date of birth
- Outward and return dates of travel
- Destination country for visiting
- A list of the drugs being carried, including dosages and total amounts.

This letter should be carried in the patient's hand-held luggage.

Controlled Drugs should be:

- Carried in original packaging
- Carried in hand luggage (BAA/Airline regulations permitting)
- Carried with a valid personal import/export if travelling for periods greater than 3 months.

Patients requiring a Home Office licence can download an application form on:
http://drugs.homeoffice.gov.uk/drugs-laws/licensing/personal/

It is the responsibility of the patient to check the export and import regulations for travel as well as airline regulations as relevant.

Note: BAA regulations advise people to carry only medicines necessary for the trip. Essential medicines should fit in a clear, litre sized re-sealable bag and must be in containers of less than 100ml supported by documentation from a relevant qualified medical professional. Passengers may be permitted to take quantities in larger quantities above the 100ml but must have obtained prior agreement of the airline with which they are travelling and departure airport. There are no restrictions by airline regulations on the quantities of tablets that can be transported. Current for June 2010.

[12] Drugs Licensing, Home Office. *Letter outlining arrangements for personal licences: Persons travelling to or from the United Kingdom carrying controlled drugs.* 2008. Available from: drugs.homeoffice.gov.uk (accessed 25 June 2010).

Community Detoxification

Detoxification

The following guidance is based on *Nice Clinical Guideline Number 52 Drug misuse: opioid detoxification 2007:*

Detoxification should be a readily available treatment option for people who are opioid dependent and have expressed an informed choice to become abstinent.

Detoxification should only be attempted after careful planning involving the GP, addictions Nurse, Restart Plus* and the patient.

*Restart Plus –An Aftercare Service provided by SMART Tel. 01865 403 151 email:oxford.admin@smartcjs.org.uk

Abstinence may be one of the long-term goals for patients with an opiate addiction. Detoxification is a key stage in achieving abstinence, with pharmacological methods the primary treatment option, supported by psychosocial interventions. The addictions nurse will act as the key co-ordinator to the patient centred care for achieving abstinence using OST.

Detoxification should be a ready available option in the community for patients who express an informed consent to become abstinent.

Detoxification should not be associated with a slow reduction and should aim to take place over a period of approximately 12 weeks.

To make informed consent patients should receive detailed information on:

- The physical and psychological aspects of opioid withdrawal, including the duration and the intensity of symptoms and how these may be managed
- The use of non-pharmacological approaches to manage or cope with opioid withdrawal symptoms
- The loss of opioid tolerance following detoxification, and the ensuing increased risk of overdose and death from illicit drug use that may be potentiated by the use of alcohol or benzodiazepines
- The importance of continued support, as well as psychosocial and appropriate pharmacological interventions, to maintain abstinence and treat co-morbid mental health problems as appropriate.

A clinical assessment for detoxification should be undertaken prior to starting treatment

Methadone or buprenorphine should be used first line for opioid detoxification in the community (recommended by NICE[13])

The medicine used in maintenance should be the drug used in detoxification.

[13] Nice Clinical Guideline Number 52 Drug misuse: opioid detoxification 2007.

Detoxification from maintenance

- Detoxification on methadone can be offered with a view to abstinence over 12 weeks
- Doses should be reduced weekly, fortnightly, going slow and in agreement with the patient, reductions should not exceed a 5ml reduction per week and regular reviews should be held with the patient
- The patient should be referred to Restart Plus (an Aftercare Service provided by SMART) as part of a wider package of support to achieve and maintain abstinence
- A short detoxification using methadone is not recommended
- Patients who have successfully reduced to a dose of 30mg of methadone daily can be switched to buprenorphine for a more quick detoxification see below
- Patients on buprenorphine can be reduced initially by 2mg every two weeks or so with final reductions by 400 micrograms
- All patients starting a detoxification should be referred to Restart Plus for further support
- Patients with concurrent benzodiazepine and alcohol misuse issues may need to be referred to Secondary Care SCAS for specialist support.

Patients must be warned that their tolerance to opioids will be reduced and that they are at greater risk of overdose should they take any opioids on top of the detoxing regimen.

Short Detoxification

Detoxification using buprenorphine can be achieved over a shorter time period of between 14-28 days and may be more appropriate for patients seeking detoxification from heroin.

A short detoxification using buprenorphine can be offered to:

- Patients on methadone doses no greater than 30mg/ml daily
- Patients on heroin
- Patients on buprenorphine maintenance.

NB Short Detoxification should only be attempted after careful planning involving the GP, addictions nurse, Restart Plus and the patient.

Example

Day 1

- Mild opiate withdrawal symptoms should be observed (see Appendix 7)
- Prescribe 4mg of buprenorphine at least 24 hours after the last dose of methadone or 4 hours after heroin
- Assess patient two hours or so later administer a further 4mg of buprenorphine.

- Follow the Example below:

Example Buprenorphine Detoxification Schedule

Day	Period	Buprenorphine Dose
-5	Induction	8mg
-4	"	12 mg
-3	"	16 mg
-2	Stabilisation*	16 mg
-1	"	16 mg
0	"	16 mg
1	Detoxification	14 mg
2	"	12 mg
3	"	10 mg
4	"	8 mg
5	"	6 mg
6	"	4 mg
7	"	2 mg
8	"	1.2mg
9	"	0.8mg
10	"	0.4 mg

SCAS-OBMH Prescribing Guidelines 2009

Adjunctive Medication

- **Use only when clinically indicated**
- **Use the minimum effective dosage and number of drugs needed to manage symptoms**

Abdominal cramps	Hyoscine butylbromide 20mg qds Alverine citrate 60-120mg tds
Diarrhoea	Loperamide 4mg initially followed by 2mg with each loose stool
Muscle and joint pain	Ibuprofen 400mg-600mg tds

Following successful detoxification:

❖ **All patients should be offered continued treatment, support and monitoring designed to maintain abstinence. This should normally be for a period of at least 6 months, in conjunction with Restart Plus (Aftercare Service).**

Care Planning

Care planning is an integral part of providing treatment. Each patient should be involved in the development of their care plan and offered a written copy. This will be updated as part of the ongoing review of treatment as goals are achieved and new ones set. It is good practice to share a copy with the pharmacist who plays a vital role in the treatment of patients in addictions (see Appendix 9).

Residential Detoxification

For some patients community detoxification may not be appropriate. Patients may be referred onto an out of county residential detoxification through an assessment by the SCAS residential placement team.

From November 1st 2010, GPs will be able to refer patients for assessment for detoxification into Howard House in Oxford; a new drug and alcohol detoxification project for Oxfordshire residents provided by SMART*

* **SMART:** The Old Music Hall, 106-108 Cowley Rd, Oxford OX4 1JE
Tel 01865 403151 www.smartcjs.org.uk email: oxford.admin@smartcjs.org.uk

Residential Rehabilitation

For some patients community rehabilitation may not be successful. For those patients there is the opportunity to be assessed for suitability for an out of county residential rehabilitation placement through an assessment by the SCAS residential placement team.

Benzodiazepine Misuse

Benzodiazepine Prescribing

This guidance does not support substitution prescribing for benzodiazepines.

❖ The decision to prescribe should only be considered following a comprehensive assessment by the Specialist Care (secondary) Team and the following demonstrated:

- The patient takes benzodiazepines on a daily basis
- There is convincing evidence of dependence e.g. screening, withdrawal symptoms, see Appendix 8
- The service user is motivated to stabilise and reduce their drug use.

NB: Illicit street 'benzos' are readily available, particularly through the internet. Strengths of illicit benzodiazepines should be considered dubious as well as potentially counterfeit and should not be directly compared to pharmaceutical products.

The following should be considered:

- Benzodiazepines should only be prescribed as diazepam - See Conversion chart below
- Prescribing should be for **a reducing regime only** on doses not higher than 30mg daily
- Benzodiazepines must not be prescribed long–term
- Diazepam can be prescribed by instalment on the FP10 MDA form
- Avoid prescribing large quantities of diazepam for take home
- There is no requirement for 'immediately necessary treatment' with benzodiazepines
- GPs should only prescribe and treat at levels which they feel competent and for which they have received adequate training and support from Specialist Care.

Diazepam Conversion Chart[14]

Benzodiazepine	Equivalent dose of Diazepam 5mg
Chordiazepoxide	15mg
Loprazolam	0.5mg-1mg
Lormetazepam	500mcg
Nitrazepam	5mg
Oxazepam	15mg
Temazepam	10mg

[14] British National Formulary 59 BMJ Group RPS Publishing 2010.

For further information

Withdrawal of a benzodiazepine should be gradual because abrupt withdrawal may produce confusion, toxic psychosis, convulsions, or a condition resembling delirium tremens.

The benzodiazepine withdrawal syndrome may develop at any time up to 3 weeks after stopping a long-acting benzodiazepine, but may occur within a day in the case of a short-acting one. It is characterised by insomnia, anxiety, loss of appetite and/or low body-weight, tremor, perspiration, tinnitus, and perceptual disturbances. Some symptoms may be similar to the original complaint and encourage further prescribing; some symptoms may continue for weeks or months after stopping benzodiazepines.

Pharmacists: Roles & Responsibilities for Shared Care

Community Pharmacist

Pharmacists have been regarded as an essential part of the Shared Care Team in Oxfordshire since the start of the service. The pharmacist's role has also been acknowledged in National Guidelines;

Community Pharmacist(s) provide a significant point of contact as part of primary health care services and have regular (often daily) contact with the patient. Hence their role in the care of drug misusers is crucial, and communication in both directions between pharmacists and other health care professionals should be encouraged.[15]

Participation by community pharmacists in the LES remains voluntary.

Drug Misuse Local Enhanced Service

Pharmacists provide Shared Care for patients within the scope of the Drug Misuse LES, when a prescriber requests supervision of consumption for either methadone or buprenorphine within the following criteria:

- On a daily basis, minimum 6 days of treatment
- On collection of a regular prescription for take home with a minimum supervision of once a week at point of dispensing.

The prescriber should be:

- A GP from a Shared Care practice
- A supplementary prescriber working within a GP shared care practice
- A prescriber from SCAS (supplementary and medical prescribers)
- A prescriber from the Rapid Prescribing Clinic/ DIP Clinic
- A prescriber from a Drug Treatment Clinic (supplementary and medical prescribers).

There are two levels of service within the LES that a pharmacist may provide.

Band One Pharmacist will:

- Develop and maintain standard operating procedures for the delivery of Shared Care
- Provide the patient with both written and verbal information about their medicines
- Provide information on the safe storage of medicines
- Supervise either methadone or buprenorphine as requested at the point of dispensing (see Appendix 14)
- Refer and collaborate with the GP and or addictions nurse, where appropriate, on a need to know basis. Pharmacists are encouraged to ask patients to sign a consent form (see Appendix 12)

continued ...

[15] *"Drug Misuse and Dependence - Guidelines on Clinical Management"*, Department of Health 2007 London, HMSO.

- Review and feedback on the patient's progress at the request of the GP or addiction nurse,
- Provide a valuable link when a patient transfers from one service to another
- Provide written information on harm reduction, and sexual health (subject to availability)
- Promote the uptake of hepatitis A and hepatitis B vaccination and screening for hepatitis B, C and HIV
- Promote, advise and signpost on general health issues, dental care
- Signpost and provide information on drug related services
- Provide a continuous service when locum cover is used
- Adhere to the Safeguarding Children guidance from the Oxfordshire Safeguarding Children Board (OSCB) http://www.oscb.org.uk/; identifying any change for patients' regarding access to children and supporting appropriately.

Band Two

A Band Two pharmacy will be determined by need, as agreed by the Oxfordshire DAAT and NHS Oxfordshire partnership but the following criteria must be met:-

- A Band Two pharmacy will have a pharmacist who has completed the RCGP Certificate Management of Drug Misuse Parts One and Two
- The pharmacy premises are accredited by the PCT for advanced services
- The pharmacy will be routinely supervising a minimum of twenty patients.

Band Two pharmacists/pharmacies will provide the same service as for Band One and the following:

- Act as a resource for other pharmacists and healthcare professionals, to share knowledge and experience and offer support
- Advise healthcare professionals on medicines management for patients receiving substitute prescribing and other medicines
- Provide both verbal and written advice on harm reduction methods, for a wide range of drug users
- Be willing to develop or pilot a specialist role subject to agreed negotiation
- Offer training at a local level for healthcare professionals or frontline staff as required
- Liaise with the GP/SCAS worker on recommended doses for individual patients
- Refer for vaccination and testing for BBVs and HIV.

Contacting the GP or Addictions Nurse

Pharmacists will contact either the prescriber or addictions nurse when:

- The patient fails to turn up for a collection or supervision
- The patient turns up after an absence of three days or more
- The patient continually misses odd days of treatment
- The patient exhibits unacceptable behaviour (based on the pharmacist's professional judgement), which may result in a ban
- The patient presents in an intoxicated state and treatment is withheld
- The pharmacist is concerned at the observed deterioration in the health of a patient
- The pharmacist believes the patient may benefit from a dose alteration or increased/ decreased rate of supervision
- The pharmacist is concerned about possible drug interactions with the patient's other prescribed drug therapies
- The pharmacist believes there may be a concordance issue with other prescribed drugs
- The patient indicates to the pharmacist that he/she, and maybe their family, would like to be vaccinated for hepatitis A and B or screened for hepatitis C
- The pharmacist suspects the supervised client has not consumed the whole dose
- A patient or carer requests supervision
- The pharmacist believes the patient may have additional social problems that affect compliance (e.g. client has been made homeless)
- The pharmacist is informed by the patient that he/she is leaving treatment or changing pharmacies.

Standard operating procedures should be in place in each pharmacy and all staff, including locums, should be made aware of them.

The procedures should address:

- New patient entering Shared Care; new either to dispensing or to the pharmacy
- Patients on regular scripts
- Feedback to the clinical Shared Care team
- Referral and/or signposting
- Maintenance of records including patient medication records
- Legality of prescription
- Details for preparation of daily doses
- Supervised consumption procedure
- Missed doses
- Discreet and efficient supervision by the pharmacist

continued ...

- Withholding a dose
- Disposal of waste
- Doses to be collected to cover days when the pharmacy is closed
- Safe storage for 'take homes'
- Confidentiality
- Behaviour in and around the pharmacy
- Safeguarding Children as per OSCB guidance.

SWOP needle-exchange is a confidential service that can be provided alongside the Shared Care service. It is accepted that patients will continue to inject at the start of treatment and that as a relapsing condition this can happen at any point during treatment. There should be no exchange of information between the two services.

Addictions Nurses and Non-Medical Prescribers: Roles and Responsibilities in Shared Care

The Specialist Care Addiction Service (SCAS) addictions nurse

The addictions nurse will support the provision of the Drug Misuse LES in the GP practice through regular sessions at the GP practice. Where patients present with more chaotic behaviour or show instability they will be referred to the Specialist Service for treatment and management.

The addictions nurse will:

- After referral and caseload allocation: undertake either triage, brief or comprehensive assessment and reassessment
- Formulate a care plan in agreement with the GP and patient, which will include the patient's treatment and goals and will be subject to change according to patient needs.

A written copy of the care plan will be offered to the patient and shared with the pharmacist

- Carry out regular reviews with the patient and the GP at three monthly intervals and updating the care plan
- Participate in a joint annual review with the GP and Specialist Care for patients on maintenance treatment for longer than three years
- Advise on and monitor substitute prescribing
- Act as a resource for the management of all drug users within the GP practice in accordance with clinical guidelines
- Liaise with the community pharmacist prior to a patient starting a substitute prescription and then on an ongoing basis
- Provide written information on the prescribed opiate substitute therapy[16,17]
- Ensure a smooth transition for patients coming from Specialist Care back to Shared Care and refer the patient back to Specialist Care if a greater intervention is needed
- Record all patient consultations using appropriate Read Codes on to the practice computer
- Collaborate with the GP on a review of a prescribed dose for patients missing more than three daily consecutive pickups; as referred by the pharmacist
- Promote/ provide (according to training) uptake of hepatitis A and hepatitis B vaccination and hepatitis B, C and HIV screening from the practice
- Offer Dried Blood Spot testing for injecting drug users who cannot or will not provide a blood sample for testing
- Refer patients to other services as appropriate and document in the care plan e.g. to attend a Structured Group or One to One Session
- Advise and provide information on Safer Injecting and harms associated with this activity
- Be available to advise and support practice staff
- Work within the SCAS/OBMH protocols, reporting to the Clinical Lead for SCAS, OBMH
- Facilitate the provision of a Safe Storage ' methadone box' to patients (subject to availability)
- Offer education and training both formally and informally
- Ensure that prescribing is only a part of the treatment and management of opiate dependent patients with referral to psychosocial interventions and other supporting services as required

continued ...

[16] Methadone Replacement for Heroin http://www.patient.co.uk/pdf/pilsL571.pdf Appendix Five
[17] Buprenorphine Replacement for Heroin http://www.patient.co.uk/pdf/pilsL588.pdf Appendix Six

- Complete the Treatment Outcome Profile (TOP) form for each patient as per the National Treatment Agency requirement, (see Appendix 13)
- Maintain documentation to support the GP clinical governance requirements and Oxfordshire DAAT data requirements
- Manage a caseload in collaboration with the GP practice that is safe and effective.

Non-Medical Prescriber-Supplementary Prescriber

Where a surgery has been agreed by the SCMG to receive supplementary prescribing the non-medical prescriber will:

- Provide a prescribing role for opiate dependent patients who have consented to be prescribed for by a supplementary prescriber
- Work within the scope of an agreed Care Management Plan
- Work within a governance framework for supplementary prescribers as per OBMH protocols
- Continue to provide a role as described for addictions nurses
- Collaborate on a regular basis with the GP at least every 3 months for all patients
- See no more than 75% of the practice's caseload in a supplementary prescribing role.

Blood Borne Viruses

Vaccination and Screening for Injecting Drug Users

GP surgeries should provide testing and vaccination as part of the general medical services for patients, hepatitis B is considered an essential component for the drug using patients.

Opiate dependent patients should be:

- Offered hepatitis B vaccination[18,19]
  - Use an accelerated regime, 0, 7 and 21 days
- Offered hepatitis A vaccination (injecting drug users)
- Offered screening for hepatitis C[20,21]*
- Encourage screening for HIV
- Check tetanus status, vaccinate as appropriate (Injecting drug users in the past have been exposed to tetanus in batches of illicit drugs. Checking the tetanus status of current injecting drug users and administering a booster dose are recommended as appropriate)
- Vaccination and testing should be encouraged for families, carers as appropriate.

*Patients who cannot or will not provide a blood sample for hepatitis C testing can be offered a dried blood spot test by the addictions nurse.

[18] Guidance for Hepatitis A and B vaccination of drug users in primary care and criteria for audit London: RCGP 2005
[19] Management of viral hepatitis BASHH 2008
[20] Hepatitis B and Hepatitis C Strategy for Oxfordshire 2010-2014
[21] Guidance for the prevention, testing, treatment and management of hepatitis C in primary care. *London:* RCGP; 2007

Psychosocial Interventions

Psychosocial interventions are recommended in the treatment of people who misuse opioids, stimulants and cannabis in the healthcare and criminal justice systems[22].

Opioid misuse is often characterised as a long-term, chronic condition with periods of remission and relapse. Although abstinence may be one of the long-term goals of treatment, it is not always achieved. Pharmacological approaches are the primary treatment option for opioid misuse, with psychosocial interventions providing an important element of the overall treatment package.

Psychosocial Interventions - What are they?

A range of formal psychosocial interventions are effective in the treatment of drug misuse; these include contingency management and behavioural couples therapy for drug-specific problems and a range of evidence-based psychological interventions, such as cognitive behavioural therapy, for common co-morbid mental health problems, coping skills and relapse prevention approaches.

Psychosocial interventions are provided as one to one structured support that gives the patient the time and the space to address their drug use in order to reduce harm and improve health and wellbeing. The patient will be expected to attend regular appointments either weekly or fortnightly depending on need.

Who should be referred for Psychosocial Interventions?

Patients with opiate misuse should be referred following a full assessment or review, where a benefit to attending has been identified. This will normally be undertaken by the addictions nurse.

Who provides Psychosocial Interventions?

Oxfordshire Community Drug and Alcohol Services
SMART, The Old Music Hall, 106-108 Cowley Rd, Oxford OX4 1JE
Tel 01865 403151 www.smartcjs.org.uk
Services are available at Oxford, Banbury, Witney, Bicester, Abingdon & Didcot, as well as a mobile treatment centre that covers smaller towns and villages.

The Women's Service
Cranstoun Drug Services, Hooper House, 3 Collins Street, Cowley Rd, Oxford, OX4 1XS
Tel 01865 793880 www.cranstoun.org

Counselling Services
SMART, The Annexe, The Old Music Hall, 54a Marston Street, Oxford, OX4 1JU
Tel 01865 403210 www.smartcjs.org.uk

Group Work
People often find treatment within in a group setting beneficial, this may be incorporated into an individual's treatment package. In Oxfordshire a range of group work modules are available in various locations across the county, provided by SMART and The Women's Service, **see contact details above**.

[22] NICE Clinical Guideline 51 – Drug Misuse Psychosocial Interventions 2007

Appendix 1

Specialist Community Addiction Service (SCAS) Referral Form

OXFORDSHIRE COUNTY COUNCIL
www.oxfordshire.gov.uk
Working for you

Specialist Community Addiction Service (SCAS) Referral Form

Oxfordshire and Buckinghamshire Mental Health NHS Foundation Trust

GP Name & Practice:	
Practice Address:	**Telephone No:**
	Fax No:
Patient's Name	**DOB:**
Patient's Address:	**Telephone No:**
	NHS No:
Reason for Referral:	
Brief History:	
Risk Factors (including mental health issues):	

Substances currently used (please tick all that apply)

Heroin ☐

Crack/Cocaine ☐

Amphetamines ☐

Benzodiazepines ☐

Ketamine ☐

Cannabis ☐

Alcohol ☐

Is the patient drinking to a physically dependant level? ☐

Other (please provide details) ☐

____

____

Have you explained to the patient that we may pass their information onto another agency working in substance misuse, and do they consent to this?

Yes ☐ No ☐

GP: ____________________________ Date: ____________

11 Appendices

Appendix 2

Roles and Responsibilities of doctors in the provision of treatment for drug and alcohol misusers adapted from *'Roles and responsibilities of doctors in the provision of treatment for drug and alcohol misusers'* Royal College of Psychiatrists and RCGP 2006

	GP providing core services	GP providing enhanced services Band 1	GP with a special clinical interest Band 2/3
ADVICE			
Provide information and advice to patients and carers on the harms and risks of using drugs	✓	✓	✓
Develop drug education and prevention materials			✓
Provide advice to patients on reducing the harm associated with their drug use		✓	✓
Provide support and advice to GPs and others on harm reduction			✓
Provide support and advice to GPwSIs and others, e.g. hospital doctors on harm reduction		✓	✓
IDENTIFICATION			
Identify own patients with drug problems	✓	✓	✓
Provide support and advice to GPs and other members of the primary health care team in identifying patients with drug problems			✓
Act upon immediate risk of danger to drug misusers	✓	✓	✓
Assess immediate risk and refer appropriately	✓	✓	✓
Assess uncomplicated patients' drug misuse needs	✓	✓	✓
Provide support and advice to GPs and others in assessing patients with uncomplicated drug misuse needs			✓
Refer patients with uncomplicated drug misuse needs to GPwSIs or specialist drug services	✓	✓	
Recognise the physical signs of drug misuse and related complications on physical examination (e.g. HIV)	✓	✓	✓
Undertake biological tests for substance use and interpret them to form a management plan and assist in referral		✓	✓
Provide full assessment for all patients with a range of drug misuse problems, including full physical and mental state examination		✓	✓
Be aware of relationship between offending and substance use	✓	✓	✓
Ascertain patient's status in the criminal justice system.			
Assess impact of drug misuse on offending		✓	✓
Be aware of the relationship between mental health and substance misuse	✓	✓	✓
Refer patients with complex drug misuse needs to consultants in addiction psychiatry		✓	✓
Provide care to drug misusers in prison		✓	✓
PATIENT MANAGEMENT			
Liaise with local prison on individual client issues. When appropriately commissioned, be involved in the treatment of substance misusers in prison. Be involved in managing through care and aftercare. Assist in developing local prison treatment protocols			✓

Advocate for individual substance misuse patients		✓	✓
Provide continued general health care to drug misusers referred to GPwSIs and specialist day services	✓	✓	
Provide continued health care to drug misusers referred to specialist day services and to own patients	✓	✓	✓
Be aware of and take account of the needs of relatives and carers	✓	✓	✓
Be able to provide continuing care to drug users who have been assessed by and had a treatment plan defined by a GPwSI or specialist services as part of a local shared care arrangement	✓	✓	
Plan to meet drug misuse needs of patients with simple drug misuse needs in collaboration with consultants in addiction and other specialist services (e.g. counselling, psychotherapy, housing, employment, training)		✓	✓
Be aware of and refer to the full range of treatment models available, including day programmes, in-patient care and residential treatment			✓
Provide support and advice to GPs and others in planning, managing and reviewing care for patients with simple drug misuse needs			✓
Liaise with other specialist services, both voluntary and statutory, e.g. counselling, psychotherapy, pharmacy, housing, employment and training)			✓
Be aware of the needs of special groups such as young people, older adults and pregnant women			✓
Prescribe substitute medication for patients with uncomplicated drug misuse needs in line with national and local guidelines		✓	✓
Assess dependence and tolerance test when treatment is initiated			✓
Review the care plans of patients with uncomplicated drug misuse needs in collaboration with consultants in substance misuse and other services		✓	✓
Develop, and monitor concordance with, GP practice guidelines for the care of patients with drug misuse needs, in line with local guidelines			✓
Work within a clinical governance framework of evidence-based treatment and competence		✓	✓
TRAINING, SUPERVISION AND TEACHING			
Participate in training and professional supervision of others in the primary care team who are involved in planning, managing, delivering and reviewing care for patients with simple drug misuse needs		✓	
Participate in the education of GP registrars		✓	
Contribute to local medical student teaching programmes			✓
RESEARCH AND AUDIT			
Be aware of research findings and use them to implement evidence based practice		✓	✓
Participate in local audits	✓	✓	✓
Participate in audits of prescribing practice. Participate in clinical audits of caring for patients with drug misuse needs		✓	✓
MANAGEMENT AND SERVICE DEVELOPMENT			
Develop and manage the general practice	✓	✓	✓
Work with the primary care organisation to support the commissioning of local primary care drug services			✓

Appendix 3

Methadone Contingency Plan – from *SCAS Prescribing Guidelines OBMH 2009*

Methadone Contingency Plan-
Methadone prescriptions can be made contingent upon certain behaviours to maximise the therapeutic potential. Survey research on methadone patients picking up daily prescriptions (eg. Stitzer et. Al, 1977; Chutape, Silverman, and Stitzer 1998) points to "take homes" of methadone as the most highly desired privilege in contingency plans. The requirement for a daily journey (except Sunday) to a community pharmacist to pick up daily methadone dose is viewed as irksome by most patients. Therefore the possibility of picking up scripts less often than daily, i.e. being given "take homes" or "days off" is potentially appealing. The SCAS contingency plan offers the client "take homes", and thus "days off" from the daily chore of visiting the community pharmacist in return for drug free laboratory samples.

- The SCAS Methadone Contingency Plan offers patients "days off" daily methadone dispensing in exchange for drug free laboratory results. Patients signing up for the plan must sign the consent /information sheet (appendix 3.14).
- The SCAS Methadone Contingency Plan should be discussed with all maintenance patients before starting methadone. All patients who have been on a stable methadone maintenance script for at least six months are eligible for the plan.
- Any patient producing laboratory samples, which are consistently negative for illicit drugs, should be allowed one "day off" per week from the routine of daily dispensing. Their methadone script should be altered accordingly (see new/ change to community script form – appendix 2.4) for "day off" methadone to be dispensed the following Monday e.g. A patient taking 50 mg/day who produces a drug free laboratory test will on the following Monday pick Monday and Tuesday's methadone up (i.e. 100mg) up together, thus avoiding a journey to the pharmacist on Tuesday, the next day. This earned privilege continues unless positive laboratory samples, injecting or other problems arise.
- Further reductions in the frequency of dispensing can be considered every six weeks.
- Nobody should normally collect their prescription less frequently than twice.
- The following will lead to cancellation of all "day off" privileges: -
    - failure to provide a sample
    - laboratory tests testing positive for illicit drugs
    - failure to attend clinic
    - intoxication at appointment
- If "day off" privileges are cancelled patients can continue in the scheme. They simply start again by providing drug free samples.

Appendix 4

List of Shared Care Pharmacies

Name of Pharmacy	Road	Town	City	Postcode	Tel	Open 7 days	SWOP
Barton Pharmacy	Barton	Oxford	Oxon	OX3 9LU	01865 763106		✓
Berinsfield Pharmacy	Berinsfield Health Centre	Fane Drive	Berinsfield	OX10 7NE	01865 341114		✓
Bliep Pharmacy	190 Abingdon Rd	Oxford	Oxon	OX1 1RA	01865 244468		
Bloxham Pharmacy	High Street	Bloxham	Oxon	OX15 4LU	01295 722169		
Boots The Chemist	33-35 Sheep Street	Bicester	Oxon	OX26 6JJ	01869 252030		
Boots The Chemist	12-14 Castle Quay	Banbury	Oxon	OX16 5UH	01295 262015	✓	
Boots The Chemist	18, High Street	Chipping Norton	Oxon	OX7 5AD	01608 642523	✓	✓
Boots The Chemist	96, London Road	Headington	Oxford	OX3 9AJ	01865 762518		
Boots The Chemist	151a Cowley Road	Oxford	Oxon	OX4 1UT	01865 243633	✓	
Boots The Chemist	6-8 Cornmarket Street	Oxford	Oxon	OX1 3HL	01865 247461	✓	✓
Boots The Chemist	221, Banbury Road	Summer-town	Oxford	OX2 7HQ	01865 556852	✓	
Boots The Chemist	Unit 4, Oxford Retail Park, Ambassador Ave	Cowley	Oxford	OX4 6XJ	01865 717699	✓	✓
Boots The Chemist	5-7 Bell St	Henley on Thames		RG9 2BA	01491 574132	✓	✓
Boots The Chemist	7/8 Market Place	Wallingford	Oxon	OX10 0EG	01491 839061		
Boots The Chemist	27 Bury Street	Abingdon	Oxon	OX14 3QT	01235 520056		
Boots The Chemist	130b The Broadway	Didcot	Oxon	OX11 8RG	01235 813107		
Boots The Chemist	50/51 Market Place	Wantage	Oxon	OX12 8AW	01235 765227		
Boots The Chemist	2-8 High Street	Witney	Oxon	OX28 6HA	01993 702213		
Boots The Chemist	The Heath Centre	East Street	Thame	OX9 3JZ	01844 218248		
Boots Uk	17, Market Place	Faringdon	Oxon	SN7 7HR	01367 240505		
Boots Uk Ltd	West Lane, off West Street	Henley-On-thames	Oxon	RG9 2DZ	01491 573211		✓
Boots Uk Ltd	5 Lostock Place, Ladygrove	Didcot	Oxon	OX11 7XT	01235 811728		
Boots Uk Ltd	3 Edington Square	Witney	Oxon	OX28 5YP	01993 706765		
Boots Uk Ltd	The Pharmacy, Bury Knowle Health Centre London Rd	Headington	Oxon	OX3 9JA	01865 765559		✓
Boswells	1-4 Broad Street	Oxford	Oxon	OX1 3AG	01865 255509		
Bretts Ltd	11-12 Millbrook Square	Grove	Oxon	OX12 7JZ	01235 763941		✓
Chalgrove Pharmacy	60 High Street	Chalgrove	Oxon	OX44 7SS	01865 890587		✓
Cleggs Manimoss	Unit 3, Kings Walk, Limborough Rd	Wantage	Oxon	OX12 9AJ	01235 763046		

Consult Pharmacy	11 Spring Road	Abingdon	oxon	OX14 1AA	01235 530302		
Cox & Robinson Pharmacy	South Bar House,	South Bar	Banbury	OX16 9Ab	01295 262039	✓	
Cross Pharmacy	10 Horsefair	Banbury	Oxon	OX16 0AH	01295 263058		
Frosts /Jessica's Chemist	Hardwick Shopping Centre	Ferriston	Banbury	OX16 1XE	01295 272432		
H Carson Ltd	19b Wood Lane	Sonning Common	nr Reading	RG4 9SJ	0118 9722306		
Jardines	2, Nightingale Place, Langford Village	Bicester	Oxon	OX26 6XX	01869 323008		
Jenners Chemist	East Oxford Health Centre, 2 Manzil Way	Oxford	Oxon	OX4 1GE	01865 725612	✓	✓
Knights Chemist	Unit 2 Burchester Place	Banbury	Oxon	OX16 3WT	01295 278281		✓
Lloyds Pharmacy	23 High St	Benson	Oxon	OX10 6RP	01491 838686		
Lloyds Pharmacy	20-21 Market Pl	Wallingford	Oxon	OX10 0AD	01491 836206		✓
Lloyds Pharmacy	High Street	Goring on Thames	Berks	RG8 9AT	01491 872124		
Lloyds Pharmacy	28, Church Road	Chinnor	Oxon	Ox39 4PG	01844 351340		
Lloyds Pharmacy	3-4 The Square	Botley	Oxford	OX2 9LH	01865 247023		
Lloyds Pharmacy	158, Oxford Rd	Cowley	Oxon	OX4 2LA	01865 777278		
Lloyds Pharmacy	64, Acre End Street	Eynsham	Oxon	OX29 4PD	01865 881283		
Lloyds Pharmacy	116 Walton Street	Oxford	Oxon	OX2 6AJ	01865 557219		✓
Lloyds Pharmacy	7, Burford Road	Carterton	Oxon	OX18 1JA	01993 842572		✓
Lloyds Pharmacy	19 Bury Street	Abingdon	Oxon	OX14 3QT	01232 521456		✓
Lloyds Pharmacy	4 Stretfield House,	Alvescott Road	Carterton	Ox18 3jw	01993 844442		
Lloyds Pharmacy	The Heath Centre Mably Way	Grove	Oxon	OX12 9BN	01235 763028		
Lloyds Pharmacy	24-26 High Street	Witney	Oxon	OX28 6HB	01993 705644		
Lloyds Pharmacy	34, Sheep Street	Bicester	Oxon	OX26 6LG	01869 248335		✓
Lloyds Pharmacy	Britwell Road	Didcot	Oxon	OX11 7JH	01235 812116		✓
Lloyds Pharmacy	Cogges Surgery	Cogges Hill Road	Witney	OX28 3FP	01993 706498		
Lloyds Pharmacy	The Old Barn, Coker Close	Bicester	Oxon	OX26 6DR	01869 240972		
Lloyds Pharmacy	100, Blackbird Leys Road	Blackbird Leys	Oxford	OX4 5HS	01865 778729		✓
Lloyds Pharmacy	25, Oxford Road	Kidlington	Oxon	OX5 2BP	01865 373174		
Lloyds Pharmacy	18, The Parade	Kidlington	Oxford	OX5 1DB	01865 373333		✓
Lloyds Pharmacy	7,Peachcroft Centre	Abingdon	Oxon	OX14 2NA	01235 530599		✓
Lloyds Pharmacy	Leys Health Centre, Dunnock Way	Oxford	Oxon	OX4 7EX	01865 770713		
Manimoss	25, Bell Street	Henley	Oxon	RG9 2BA	01491 574142		
Manor Pharmacy (Rowlands)	57, Osler Road	Headington	Oxford	OX3 9BH	01865 762979		

Marston Pharmacy	11, Old Marston Road	Oxford	Oxon	OX3 0JR	01865 243824		
Mid Counties Co-op	Market Street	Charlbury	Oxon	OX7 3PL	01608 810315		
Mid Counties Co-op	6a High Street	Chipping Norton	Oxon	OX7 5AD	01608 642731		
Mid Counties Co-op Pharmacy	39, High Street	Wheatley	Oxon	OX33 1XX	01865 874047		
Mid counties Co-op Pharmacy	Unit 5	Barberry Place	Bicester	OX26 3HA	01869 324965		✓
Northway Pharmacy	53, Westlands Drive	Headington	Oxford	OX3 9QS	01865 763706		✓
Roundway Pharmacy	3, The Roundway, Green Road Roundabout	Headington	Oxford	OX3 8DH	01865 766994		
Rowlands Pharmacy	The Nuffield Health Centre,	Welch Way	Witney	OX28 6JQ	01993 702191		✓
Rowlands Pharmacy	58 Orchard Way	Banbury	Oxon	OX16 0EN	01242 523270		
Rowlands Pharmacy	17 Ivy Close	Oxford	Oxon	OX4 2NB	01865 777089		
Rowlands Pharmacy	1, The Pond	Cholsey	Wallingford	OX10 9NS	01491 652392		
Rowlands Pharmacy	13, Atkyns Road	Oxford	Oxon	OX3 8RA	01865 766978		✓
Rowlands Pharmacy 1386	1 Henley Avenue	Oxford	Oxon	OX4 4DH	01865 711722		✓
S&C Reavley	124, High Street	Burford	Oxon	OX18 4QR	01993 823144		✓
Sainsburys	Oxford Road	Kidlington	Oxon	OX5 2PE	01865 847606	✓	
Sainsbury's Pharmacy	Oxford Road	Banbury	Oxon	OX16 9XA	01295 253445	✓	
Sainsbury's Pharmacy	Heyford Hill Lane, Heyford Hill	Littlemore	Oxford	OX4 4XR	01865 777663	✓	
Faringdon Pharmacy	28a London St	Faringdon		SN7 7AA	01367 244632	✓	✓
Superdrug	39, Sheep Street	Bicester	Oxon	OX26 6JJ	01869 248822		✓
Superdrug	Unit 5, Templars Square	Cowley	Oxford	OX4 3UZ	01865 779299		✓
Superdrug	34-35 Castle Quay	Banbury	Oxon	OX16 8EA	01295 269318		
Tesco Pharmacy	359 Reading Road	Henley	Oxon	RG9 4HA	01491 579946	✓	
Tesco Pharmacy	Marcham Road	Abingdon	Oxon	OX13 6QL	01235 550332	✓	✓
Tesco Pharmacy ref2413	Wallingford Road	Didcot	Oxon	OX11 9BZ	01235 707549	✓	✓
The Leys Pharmacy	Spar, Dunnock Way,	Greater Leys	Oxford	OX4 7EX	01865 401430	✓	✓
The Leys Pharmacy	220 Cowley Rd	Oxford	Oxon	OX4 1UQ	01865 236515	✓	✓
The Leys Pharmacy Rosehill	6a Courtland Road	Rosehill	Oxford	OX4 4JA	01865 777836		✓
Watlington Pharmacy	Market Place	Watlington	Oxon	OX49 5PU	01491 612248		
(Westlake) Pharmacy Rowlands	267 Banbury Road	Summer-town	Oxford	OX2 7HZ	01865 554999		
(Westlake) Pharmacy Rowlands	227 Banbury Rd	Summer-town	Oxford	OX2 7HQ	01865 558348		
Woodlands Pharmacy	74 Botley Road	Oxford	Oxon	OX2 0BU	01865 242649		
Woodstock Pharmacy	24 High Street	Woodstock	Oxon	OX20 1TF	01993 811492		

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Appendix 5

http://www.patient.co.uk/pdf/pilsL571.pdf

Methadone Replacement for Heroin

If you stop taking heroin, methadone can prevent or reduce the unpleasant withdrawal symptoms. Many people stay on methadone long-term, but some people gradually reduce the dose and come off drugs altogether. You should not take any street drugs or much alcohol when you are taking methadone.

What is heroin addiction?

If you are addicted to heroin it means that you develop withdrawal symptoms within a day or so of the last dose. Therefore, if you are addicted to heroin you need a regular dose to feel 'normal'.

Withdrawal symptoms can include: sweating, feeling hot and cold, runny eyes and nose, yawning, being off food, stomach cramps, feeling sick or vomiting, diarrhoea, tremor, poor sleep, restlessness, general aches and pains, and just feeling awful. Withdrawal symptoms tend to ease and go within five days. However, you may then have persistent craving for heroin, remain tired, and have poor sleep for quite some time afterwards.

What is methadone?

Methadone is a drug that is similar to heroin, although it lasts a lot longer in the body. It can be prescribed. If you take methadone, you are unlikely to get withdrawal symptoms if you stop heroin (or the withdrawal symptoms are much less severe). If you take methadone under supervision from a doctor instead of street heroin, you are:

- More likely to be able to get away from the street 'drug scene'.
- Likely to feel better in yourself.
- More likely to be able to get off drugs for good.

Who prescribes methadone, and when?

A typical plan
Most GPs will refer you to a community drug team to be assessed. Following assessment, a member of the community drug team will usually contact your GP quite quickly to recommend a dose of methadone, and a plan for follow-up. Some GPs who are specially trained may assess some cases and prescribe without the need for referral.

Assessment usually includes:

- Taking details of your health and social circumstances.
- Taking details of your past and current drug taking, and whether methadone is needed or appropriate.
- An examination.
- A urine test (or a mouth swab test) to confirm the drugs you are taking.
- An assessment of what you think you need at this present time.

If you have been injecting drugs such as heroin, it is also common to advise:

- A blood test which includes testing for HIV, checking the health of your liver (liver function tests), and checking for hepatitis A, B and C.
- Immunisation against hepatitis A, hepatitis B, and tetanus (if not previously immunised).
- If appropriate, immunisation against hepatitis B for your partner and children.
- About the dangers of injecting, of using shared needles and syringes, and on other ways to reduce harm to yourself.

Starting off with methadone
Methadone is usually started some time after assessment when the results of the urine test are back. An initial dose is chosen. The aim is to prevent withdrawal symptoms. However, methadone can cause serious harm, or death, in overdose. Therefore, at first your doctor will prescribe a low-ish dose to 'play safe' and see you frequently to adjust the dose. Be patient, this early stage is very important. The initial dose is usually gradually increased to a regular maintenance dose. But note:

- Methadone takes 2-4 hours to reach peak effect.
- Methadone accumulates in your body. So, you will feel a greater effect of the drug over a few days even without increasing the dose.
- It may take a few weeks to get to the correct dose which prevents all withdrawal symptoms.

Try to accept that you may have some, or partial, withdrawal symptoms until the correct dose is found. The correct dose varies from person to person depending on how much heroin you were using and how your body deals with (metabolises) the methadone. You should not take any street drugs or much alcohol when you are on methadone.

Maintenance and coming off ('detox')
Once established on a regular dose, most people stay on methadone for a long time or even long-term. This is called maintenance and helps you to keep off street drugs. Some people gradually reduce the dose and come off it. This is called detoxification or 'detox'. However, it usually takes months, and sometimes years, before most people are ready to consider detox. It is often safer to stay on methadone then to detox before you are ready.

Taking methadone

Methadone is usually prescribed as a once-daily dose in liquid form. You will usually be asked to take it under the supervision of the pharmacist who dispenses the methadone to you. This means there can be no doubt about how much methadone you take at each dose. This supervision may be relaxed after a few months of your taking a regular maintenance dose.

Some other points about taking methadone

- **You are more likely to succeed** in staying off heroin if you have support and counselling during this difficult time. This may be from a local drug community team (or similar). Self-help groups or other agencies may also be of help. It is much harder to 'do it alone' - so do go for counselling and help if it is available in your area.
- **Some prescribed medicines** may interfere with methadone. For example, some used to treat TB and epilepsy. Tell the doctor who prescribes methadone if you are taking any other medicines. However, most prescribed medicines can be taken in the normal way.
- **Other street drugs** such as benzodiazepines ('benzos'), and alcohol can affect methadone. It is best not to take any other drugs, and don't drink too much alcohol.
- **You will be asked to give a urine sample** from time to time by your doctor.
- **Driving**. If you use heroin, methadone or similar drugs, you should tell the DVLA. You are likely to be banned from driving. However, if you are on a supervised methadone programme, you may be allowed to drive again subject to an annual medical review.
- **Keep methadone and any other drugs out of reach of children.**

Further help and support

Frank
Tel: 0800 77 66 00 Web: www.talktofrank.com
National website and 24 hour helpline for people with concerns over drugs and addiction.

The Alliance
Helpline: 0845 122 8608 Web: www.m-alliance.org.uk
The Alliance is a user-led organisation which provides advocacy, training and helpline services to those currently in drug treatment, those who have accessed drug treatment in the past and those who may access drug treatment in the future.

Self-help and support groups
Web: www.patient.co.uk/display/16777380/
A listing of the many groups and organisations that provide information, help and support to people who use drugs, and for their families and carers.

References

- Opioid dependence, Clinical Knowledge Summaries (January 2008)
- Drug Misuse and Dependence - UK Guidelines on Clinical Management, Department of Health (September 2007)
- Mattick RP, Breen C, Kimber J, et al; Methadone maintenance therapy versus no opioid replacement therapy for opioid dependence. Cochrane Database Syst Rev. 2009 Jul 8;(3):CD002209. [abstract]

Comprehensive patient resources are available at www.patient.co.uk

Disclaimer: This article is for information only and should not be used for the diagnosis or treatment of medical conditions. EMIS has used all reasonable care in compiling the information but make no warranty as to its accuracy. Consult a doctor or other health care professional for diagnosis and treatment of medical conditions. For details see our conditions.
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Appendix 6

http://www.patient.co.uk/pdf/pilsL588.pdf

Buprenorphine Replacement for Heroin

If you stop taking heroin, buprenorphine can prevent or reduce the unpleasant withdrawal symptoms. Many people stay on buprenorphine long-term, but some people gradually reduce the dose and come off drugs altogether. You should not take any street drugs or much alcohol when you are taking buprenorphine.

What is heroin addiction?

If you are addicted to heroin it means that you develop withdrawal symptoms within a day or so of the last dose. So, if you are addicted to heroin you need a regular dose to feel 'normal'.

Withdrawal symptoms can include: sweating, feeling hot and cold, runny eyes and nose, yawning, being off food, stomach cramps, feeling sick or vomiting, diarrhoea, tremor, poor sleep, restlessness, general aches and pains, and just feeling awful. Withdrawal symptoms tend to ease and go within five days. However, you may then have persistent craving for heroin, remain tired, and have poor sleep for quite some time afterwards.

What is buprenorphine?

Buprenorphine (trade name Subutex®) is an opioid drug that is similar to heroin. It can be prescribed. If you take buprenorphine, you are unlikely to get withdrawal symptoms if you stop heroin (or the withdrawal symptoms are much less severe). It also helps to reduce cravings for heroin. The drug most commonly prescribed as a substitute for heroin is methadone. On average, methadone tends to work better than buprenorphine helping people keep off heroin. However, buprenorphine is still a good treatment and some people prefer it because:

- Some people feel more 'clear-headed' with buprenorphine than with methadone.
- Some people have difficulties using methadone.
- Buprenorphine tends to be easier to come off (detox) than methadone. Some people take methadone long-term for 'maintenance', but switch to buprenorphine if they decide to 'detox'.
- Buprenorphine is possibly safer if taken in overdose than methadone.

If you take buprenorphine (or methadone) under supervision from a doctor instead of street heroin, you are:

- More likely to be able to get away from the street 'drug scene'.
- Are likely to feel better in yourself.
- Are more likely to be able to get off drugs for good.

Who prescribes buprenorphine, and when?

Many GPs will refer you to a community drug team to be assessed. Following assessment, the community drug team may prescribe buprenorphine. Some GPs work in a 'shared care' arrangement and will prescribe whatever is recommended for you by a community drug team. Some GPs who are specially trained may assess and prescribe buprenorphine without the need for referral.

Assessment usually includes:

- Taking details of your health and social circumstances.
- Taking details of your past and current drug taking, and whether buprenorphine is needed or appropriate.

- An examination.
- A urine test (or a mouth swab test) to confirm the drugs you are taking.
- An assessment of what you think you need at this present time.

If you have been injecting drugs such as heroin, it is also common to advise:

- A blood test which includes testing for HIV, checking the health of your liver (liver function tests) and checking for hepatitis A, B and C.
- Immunisation against hepatitis A, hepatitis B, and tetanus (if not previously immunised).
- If appropriate, immunisation against hepatitis B for your partner and children.
- About the dangers of injecting, of using shared needles and syringes, and on other ways to reduce harm to yourself.

Starting off with buprenorphine
Buprenorphine is usually started some time after assessment when the results of the urine test are back. An initial dose is chosen, depending on current usage of heroin (or methadone).

Taking buprenorphine

Buprenorphine is a tablet which you put under your tongue. The tablet dissolves over 3-7 minutes and is absorbed straight into the bloodstream from your mouth. (The tablets do not work if you swallow them into the stomach.) It is usually prescribed as a once-daily dose. You will usually be asked to take it under the supervision of the pharmacist who dispenses the buprenorphine to you. This means there can be no doubt about how much you take at each dose. This supervision may be relaxed after a few months if you are taking a regular maintenance dose. The taste of buprenorphine can be quite bitter.

The first dose
The timing of the first dose is important.

- If you are taking heroin - you take the first dose of buprenorphine at least eight hours after taking your last dose of heroin.
- If you are taking methadone - you take the first dose of buprenorphine between 24 and 36 hours after your last dose of methadone.

The reason for these timings is because, for buprenorphine to work well, you need to take it when your body has low levels of heroin or methadone. So, the aim is to take the first dose only when you feel some withdrawal symptoms starting. This tends to be about eight hours after the last dose of heroin, and longer after the last dose of methadone. If you take buprenorphine sooner, it can actually cause withdrawal symptoms suddenly to develop.

Getting to the right dose
The initial dose will usually need to be increased. You will usually be given a higher dose on the second and third days, by which time you should not be feeling any withdrawal symptoms. It is very important that you do not take any heroin or methadone during this time as this will cause you to feel ill - as though you are withdrawing. Your dose may need to be increased again to prevent symptoms of craving but most people feel they have the correct dose within the first week.

Maintenance and coming off ('detox')
Once established on a regular dose, most people stay on buprenorphine for a long period of time or even long-term. This is called maintenance and helps you to keep off street drugs. Some people gradually reduce the dose and come off it. This is called detoxification or 'detox'. However, it usually takes several months, and sometimes years, before most people are ready to consider detox. It is often safer to stay on buprenorphine then to detox before you are ready.

Some other points about taking buprenorphine

- **Some people feel uncomfortable during the first 2 to 3 days.** Do not be tempted to take heroin on top.
- **Some other medicines** may interfere with buprenorphine. For example, some antidepressants. Tell the doctor who prescribes buprenorphine if you are taking any other medicines. However, most prescribed medicines can be taken in the normal way.
- **You are more likely to succeed** in staying off heroin if you have support and counselling in addition to taking buprenorphine or methadone. This may be from a local drug community team (or similar). Self-help groups or other agencies may also be of help. It is much harder to 'do it alone' - so do go for counselling and help if it is available in your area.
- **You will be asked to give a urine sample** from time to time by the prescribing doctor.
- **Other street drugs** such as benzodiazepines ('benzos'), and alcohol can also affect buprenorphine. So, it is best not to take any other drugs, and don't drink too much alcohol.
- **Driving**. If you use heroin or other opiates such as buprenorphine, you should inform the DVLA. You are likely to be banned from driving. However, if you are on a supervised buprenorphine programme, you may be allowed to drive again subject to an annual review.
- **Keep buprenorphine and any other drugs out of reach of children.**

Further help and support

The Alliance
Helpline: 0845 122 8608 Web: www.m-alliance.org.uk
The Alliance is a user-led organisation which provides advocacy, training and helpline services to those currently in drug treatment, those who have accessed drug treatment in the past and those who may access drug treatment in the future.

Frank
Tel: 0800 77 66 00 Web: www.talktofrank.com
National website and 24-hour helpline for people with concerns over drugs and addiction.

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Web: www.patient.co.uk/display/16777380/
A listing of the many groups and organisations that provide information, help and support to people who use drugs, and for their families and carers.

References

- Opioid dependence, Clinical Knowledge Summaries (January 2008)
- Drug Misuse and Dependence - UK Guidelines on Clinical Management, Department of Health (September 2007)
- Mattick RP, Kimber J, Breen C, et al; Buprenorphine maintenance versus placebo or methadone maintenance for opioid dependence. Cochrane Database Syst Rev. 2008 Apr 16;(2):CD002207. [abstract]

Comprehensive patient resources are available at www.patient.co.uk

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Appendix 7

Clinical Opiate Withdrawal Scale (COWS)

5-12 = mild; 13-24 = moderate; 25-36 = moderately severe; more than 36 = severe withdrawal

Resting Pulse Rate: (record beats per minute) *Measured after patient is sitting or lying for one minute* 0 pulse rate 80 or below 1 pulse rate 81-100 2 pulse rate 101-120 4 pulse rate greater than 120		**Runny nose or tearing** *Not accounted for by cold symptoms or allergies* 0 not present 1 nasal stuffiness or unusually moist eyes 2 nose running or tearing 4 nose constantly running or tears streaming down cheeks	
Sweating: *over past ½ hour not accounted for by room* *temperature or patient activity.* 0 no report of chills or flushing 1 subjective report of chills or flushing 2 flushed or observable moistness on face 3 beads of sweat on brow or face 4 sweat streaming off face		**GI Upset:** over last ½ hour 0 no GI symptoms 1 stomach cramps 2 nausea or loose stool 3 vomiting or diarrhea 5 Multiple episodes of diarrhea or vomiting	
Restlessness *Observation during assessment* 0 able to sit still 1 reports difficulty sitting still, but is able to do so 3 frequent shifting or extraneous movements of legs/arms 5 Unable to sit still for more than a few seconds		**Tremor** *observation of outstretched hands* 0 No tremor 1 tremor can be felt, but not observed 2 slight tremor observable 4 gross tremor or muscle twitching	
Pupil size 0 pupils pinned or normal size for room light 1 pupils possibly larger than normal for room light 2 pupils moderately dilated 5 pupils so dilated that only the rim of the iris is visible		**Yawning** *Observation during assessment* 0 no yawning 1 yawning once or twice during assessment 2 yawning three or more times during assessment 4 yawning several times/minute	
Bone or Joint aches *If patient was having pain previously, only the additional component attributed to opiates withdrawal is scored* 0 not present 1 mild diffuse discomfort 2 patient reports severe diffuse aching of joints/ muscles 4 patient is rubbing joints or muscles and is unable to sit still because of discomfort		**Anxiety or Irritability** 0 none 1 patient reports increasing irritability or anxiousness 2 patient obviously irritable anxious 4 patient so irritable or anxious that participation in the assessment is difficult	
Gooseflesh skin 0 skin is smooth 3 piloerection of skin can be felt or hairs standing up on arms 5 prominent piloerection		**TOTAL SCORE:**	

continued ...

Short opiate withdrawal scale (SOW) (Gossop, 1990)

Severe = 3
Moderate = 2
Mild = 1
Nil = 0

DAY	1	2	3	4	5	6	7	8	9	10
Feeling sick										
Stomach cramps										
Muscle spasms										
Feeling cold/gooseflesh										
Sweating										
Heart pounding										
Muscular tension										
Aches and pains										
Weakness										
Yawning										
Runny eyes										
Difficulty sleeping										
TOTAL SCORE										

Appendix 8

Benzodiazepine Withdrawal Scale[23]

NAME: ______________________________ CASE No: _________ SHEET No: _______

STARTING DATE: ____ / ____ / ____ = DAY 1

Severe = 3
Moderate = 2
Mild = 1
Nil = 0

DAY	1	2	3	4	5	6	7	8	9	10
Dizziness										
Difficulty concentrating										
Feeling faint										
No energy										
Drowsiness										
Headache										
Dry mouth										
TOTAL										

[23] Prescribing Guidelines SCAS OBMH 2009

Appendix 9

Example Care Plan from SCAS

OXFORDSHIRE COUNTY COUNCIL

SCAS CARE PLAN

Oxfordshire and Buckinghamshire Mental Health NHS

NHS NUMBER	SWIFT NUMBER	PCIS NUMBER

TITLE	FORENAME	SURNAME	DOB

A copy of the care plan has been offered to the service user **YES** **NO** DATE

YOUR NEEDS	YOUR GOALS	ACTIONS (PERSON RESPONSIBLE)	PROGRESS (DATE)
Drug/Alcohol Use			
Physical Health (incl. Injecting, Sexual activity)			
Mental Health			
Social and Crime COMMUNICATIONS INDIVIDUAL CULTURAL OR SPIRITUAL NEEDS TRANSLATION OR INTERPRETING SERVICE			

KEEPING IN CONTACT

Use these details you need to contact your worker:	We will use these details if we need to contact you:
Worker:	
Mobile:	
The Specialist Community Addictions Service (SCAS) **The Rectory Centre** **Rectory Road** **Oxford OX4 1BU** ☎ **01865 455614**	
You can contact your worker between 9:00hrs to 17:00hrs Monday – Friday.	☎

The following are involved in your care and may be sent a copy of the Care Plan. You may find it helpful to include your next of kin or significant other in this list.

NAME	DESIGNATION/ROLE	CONTACT NUMBER

If you leave or drop out of treatment we will inform the following people

OUT ADVOCACY SERVICE CAN BE ACCESSED VIA OXFORDSHIRE USER TEAM 01865 209111

There is also an OUT Service User Charter and User involvement programme please contact the above number or ask for information from key worker.

Advocacy and advice can also be found on Oxfordshire County Council Website or Oxfordshire Advocacy development Group 01865 741200 or Oxfordshire Carers Forum 01993 706543.

There is also a PATIENT ADVICE AND LIAISON SERVICE (PALS) which aims to Listen to your concerns, suggestions and queries,

As part of Oxfordshire and Buckinghamshire Mental Health NHS Foundation Trust for advice,information,help resolving a concern or compliant to make a compliment, comment or suggestion ; Contact Pals Free on 0800 3287971

I HAVE BEEN ADVISED ON ADVOCACY AND PALS SERVICE.

SIGNATURE

I have read the care plan and I am agreeable to relevant personal information being shared with the designated agencies: **YES** **NO** SIGNATURE PRINT NAME

DATE COMPLETED AND/OR REVIEWED	WORKER SIGNATURE	PRINT NAME

Care Plan revised 21 July 2009

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Appendix 10

Example Full Assessment from SCAS

OXFORDSHIRE COUNTY COUNCIL

FULL ASSESSMENT

Oxfordshire and Buckinghamshire Mental Health NHS

NHS NUMBER | SWIFT NUMBER | PCIS NUMBER

TITLE | FORENAME | SURNAME | DOB

ADDRESS

POST CODE | TEL/MOBILE | ETHNICITY / NATIONALITY

GP

ASSESSOR | DESIGNATION

ASSESSMENT START DATE | TEAM

REFERRAL DATE | DATE 1ST APPOINTMENT OFFERED

REASON FOR REFERRAL

SERVICE USERS VIEW OF CURRENT DIFFICULTIES

SECTION 1: DRUG AND ALCOHOL USE

PROBLEM SUBSTANCE NUMBER 1: | DAYS USED IN LAST 28:

ROUTE OF ADMINISTRATION OF SUBSTANCE NUMBER 1:

AGE OF FIRST USE SUBSTANCE NUMBER 1:

INJECTING STATUS | previously | currently | never | Ever Shared?

PROBLEM SUBSTANCE NUMBER 2:

PROBLEM SUBSTANCE NUMBER 3:

UNITS OF ALCOHOL (on a typical drinking day, in previous month): | NUMBER OF DRINKING DAYS IN LAST 28:

OTHER PROBLEM SUBSTANCES (note smoking):

NOTE SYMPTOMS DEPENDENCE; (salience, tolerance, compulsion, withdrawal, narrow repertoire reinstatement, relief use)

PRESCRIBED AND OVER-THE-COUNTER MEDICATION:

ALLERGY:

SECTION 2. PHYSICAL HEALTH

HEP C TEST DATE AND RESULT: | HEP B IMMUNIZATION RECORD: | 1 | 2 | 3 | Course Completed

START DATE:

HEP C INTERVENTION STATUS:

Offered and Accepted / Offered and Refused / Not Offered /

Assessed as not appropriate to offer

HEP B INTERVENTION STATUS:

Offered and Accepted / Offered and Refused / Not Offered /

Assessed as not appropriate to offer /

Immunised already / Acquired Immunity

CONTRACEPTION: | LAST SMEAR DATE | PREGNANT?

SEX WORK?:

STI HISTORY:

PHYSICAL PROBLEMS: (abscess, thrombosis, dentition, track marks, weight loss, fits, blackouts, chest problems)

OPERATIONS AND CHRONIC ILLNESSES: (Referred hepatology Y/N)

DRUG OVERDOSES?:

OBSERVE: IV sites or areas of concern

SECTION 3. MENTAL STATE AND PSYCHOLOGICAL HEALTH

CURRENT PSYCHOLOGICAL SYMPTOMS: (NOTE SELF HARM THOUGHTS or ACTS)

PAST PSYCHIATRIC TREATMENT:

DUAL DIAGNOSIS?

OBSERVE: signs of intoxication or withdrawal /withdrawal scale, notable on MSE

Appendix 10 *continued*

SECTION 4. SOCIAL FUNCTIONING AND CRIME

ACCOMMODATION:	STATUS:
	NFA – Urgent Housing problem
	Housing problem
	No Housing problem

EMPLOYMENT AND EDUCATION:

EMPLOYMENT STATUS:	PARENTAL STATUS:
Regular Employment	All children live with client
Pupil/Student	Some of the children live with client
Economically Inactive	None of the children live with client
Unemployed	Not a parent
Other	Client declined to answer
Not Known	

CHILDREN (NOTE CARED FOR BY CLIENT – include number):

ANY OFFENCES: (CURRENT AND RELEVANT PAST OFFENCES):

SECTION 5. ESSENCE OF CARE

PATIENTS' SPIRITUAL AND CULTURAL NEEDS

PATIENTS' PRINCIPAL CARER

NEED FOR TRANSLATION OR INTERPRETING SERVICES OR OTHER COOMUNICATION NEEDS

SECTION 6. SOCIAL FUNCTIONING AND CRIME

Summary

Plan

NTDTMS CONFIDENTIALITY FORM EXPLAINED **YES NO**	HAS **OUT** LITERATURE BEEN OFFERED **YES NO**

TREATMENT MODALITY:

Specialist prescribing / GP prescribing / Structured Psychosocial Intervention / Inpatient Detox / Aftercare

Structured Day Programme / Residential Rehab / Needle Exchange / Outreach / Advise and Information

Other Structured Intervention

ALC-Community Prescribing / ALC-Inpatient treatment / ALC- Structured Psychosocial Intervention

ALC-Brief Intervention / ALC-Residential Rehab / ALC- Structured Day Programme / ALC-Other Structured Treatment

RISK ASSESSMENT COMPLETED YES NO	CARE PLAN COMPLETED YES NO	TOP COMPLETED YES NO

CONFIDENTIALITY FORM COMPLETED YES NO	CONSENT FOR NDTMS YES NO

DATE COMPLETED	ASSESSOR	SIGNED

Dr Gail Critchlow, Catherine Morsli and Mark Stevens 1/110/09

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Appendix 11
Example Risk Screening Tool from SCAS

OXFORDSHIRE COUNTY COUNCIL www.oxfordshire.gov.uk Working for you

SCAS RISK SCREENING TOOL

Oxfordshire and Buckinghamshire NHS Mental Health NHS Foundation Trust

RISKS IDENTIFIED Please rate risk as: **LOW (L) – MEDIUM (M) – HIGH (H)**						DATE
Fill in both the stable and unstable boxes with the appropriate risk rating.	Stable Rating	Unstable Rating	***Fill in both the stable and unstable boxes with the appropriate risk rating.***	Stable Rating	Unstable Rating	
AGGRESSION AND VIOLENCE TO OTHERS			RISK TO DEPENDENT CHILDREN			
AGGRESSION AND VIOLENCE TO SELF			RISK TO OTHERS			
SUICIDE RISK			UNSAFE STORAGE OF DRUGS AND DRUG USING EQUIPMENT.			
DELIBERATE SELF HARM			MENTAL HEALTH CONCERNS (PLEASE RISK SPECIFY BELOW)			
ACCIDENTAL OVERDOSE RISK			PHYSICAL HEALTH CONCERNS			
RISK OF EXPLOITATION BY OTHERS			BLOOD BORNE VIRUS RISK			
UNSAFE INJECTING PRACTICES			UNSAFE ACCOMMODATION			
UNSAFE SEXUAL PRACTICES			HISTORY OF DISENGAGEMENT			
UNSAFE SEX WORKER PRACTICES			RISK OF RELAPSE			
UNSAFE DRUG AND ALCOHOL MISUSE			RISK FROM SOCIAL ENVIRONMENT			
OTHER RISKS PLEASE SPECIFY (INCLUDING ARSON AND DRIVING WHILST INTOXICATED)						

DETAILS OF **HIGH** RISKS

DETAILS OF **MEDIUM** RISKS

MENTAL HEALTH CONCERNS (INCLUDING)

DATE COMPLETED or REVIEWED	DATE TO BE NEXT REVIEWED

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Appendix 12
Sample Consent Form for Pharmacies

Patient Consent Form for Pharmacies

The pharmacist will:

- Share information with, the prescriber and key drug worker on a need to know basis only - for your improved your health
- Dispense your medication in accordance with the written instructions on the prescription
- Provide a discreet area for supervision
- Keep records of your attendance
- Supervise your consumption of medication, if requested by the prescriber
- Have a shared responsibility for your care
- Refer you back to the prescriber if you miss three or more consecutive daily doses
- Withhold your prescription if you attend intoxicated
- Provide a dispensing service until your treatment is complete
- Reserve the right to withdraw a dispensing service if there is a breach of the agreement
- Provide health promotion information and advice on drug related issues
- Provide advice on general health care

The patient will:

- Attend the pharmacy at a time agreed with the pharmacist
- Attend alone and leave pets outside
- Consume the supervised medication in front of the pharmacist if requested
- Treat pharmacy staff and property with respect
- See the prescriber or drugs worker if three or more consecutive daily doses are missed
- Forfeit all the days of a missed pick up if s/he does not turn up on the date of pick-up: unless the following text has been added:
  "Instalment prescriptions covering more than one day should be collected on the specified day; if this collection is missed the remainder of the instalment (i.e., the instalment less the amount prescribed for the day(s) missed) may be supplied."
- Consent to necessary information being shared with the prescriber and or drugs worker
- Attend the named pharmacy until treatment is complete (unless exceptional circumstances require a change in pharmacy).

....

I have read and understand the above information I agree to the terms set out.

Signature (Patient): .... Date:...........................

Name:..

Signature (Pharmacist): .... Date:...........................

Name:..

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Appendices

Appendix 13

Sample TOP Form

The TOP is a national outcomes monitoring tool for drug treatment in England, to be used by all keyworkers with clients who are both entering and currently in structured treatment programmes. The TOP is a series of simple questions, asked by the keyworker and answered by the client, in order to measure outcomes in a meaningful way that is sensitive to change over time[24].

Treatment Outcomes Profile

Name of client ______ D.O.B. (dd/mm/yyyy) __/__/____ Name of keyworker ______

TOP interview date (dd/mm/yyyy) __/__/____ Gender: M ☐ F ☐ Treatment stage: Modality start ☐ Care plan review ☐ Discharge ☐ Post-discharge ☐

Section 1: Substance use

Record the average amount on a using day and number of days substances used in each of past four weeks

	Average		Week 4		Week 3		Week 2		Week 1		Total	
a Alcohol		units/day		0–7		0–7		0–7		0–7		0–28
b Opiates		g/day		0–7		0–7		0–7		0–7		0–28
c Crack		g/day		0–7		0–7		0–7		0–7		0–28
d Cocaine		g/day		0–7		0–7		0–7		0–7		0–28
e Amphetamines		g/day		0–7		0–7		0–7		0–7		0–28
f Cannabis		spliff/day		0–7		0–7		0–7		0–7		0–28
g Other problem substance?		g/day		0–7		0–7		0–7		0–7		0–28

Name......................................

Section 2: Injecting risk behaviour

Record number of days client injected non-prescribed drugs in past four weeks (if no, enter zero and go to section 3)

	Week 4		Week 3		Week 2		Week 1		Total	
a Injected		0–7		0–7		0–7		0–7		0–28

b Inject with needle or syringe used by someone else? Yes ☐ No ☐
c Inject using a spoon, water or filter used by someone else? Yes ☐ No ☐
Enter 'Y' if any yes, otherwise 'N'

Section 3: Crime

Record days of shoplifting, drug selling and other categories committed in past four weeks

	Week 4		Week 3		Week 2		Week 1		Total	
a Shoplifting		0–7		0–7		0–7		0–7		0–28
b Drug selling		0–7		0–7		0–7		0–7		0–28

c Theft from or of a vehicle Yes ☐ No ☐
d Other property theft or burglary Yes ☐ No ☐
e Fraud, forgery and handling stolen goods Yes ☐ No ☐
Enter 'Y' if any yes, otherwise 'N'
f Committing assault or violence Yes ☐ No ☐ Enter 'Y' or 'N'

Section 4: Health and social functioning

a Client's rating of psychological health status (anxiety, depression and problem emotions and feelings)

Poor 0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 **Good** 0–20

Record days worked and at college or school for the past four weeks

	Week 4		Week 3		Week 2		Week 1		Total	
b Days paid work		0–7		0–7		0–7		0–7		0–28
c Days attended college or school		0–7		0–7		0–7		0–7		0–28

d Client's rating of physical health status (extent of physical symptoms and bothered by illness)

Poor 0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 **Good** 0–20

Record accommodation items for the past four weeks

e Acute housing problem Yes ☐ No ☐ Enter 'Y' or 'N'
f At risk of eviction Yes ☐ No ☐ Enter 'Y' or 'N'

g Client's rating of overall quality of life (e.g. able to enjoy life, gets on well with family and partner)

Poor 0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 **Good** 0–20

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[24] Marsden J, Farrell M, Bradbury C, Dale-Perera A, Eastwood B, Roxburgh M & Taylor S. The Treatment Outcomes Profile (TOP): A structured interview for the evaluation of substance misuse treatment. London: National Treatment Agency for Substance Misuse. © NTA 2007.

Appendix 14
Sample Operating Procedures for Supervision

Pharmacy Supervision of Methadone Consumption

- The daily dose should be measured into an individual dispensing container, capped and labelled appropriately before the patient arrives (when a prescription is current)
- The patient's identity should be checked before the dose is supplied
- The patient will be required to consume their dose of methadone in a discreet area in the pharmacy, which is mindful of the patient's dignity (Supervision should not take place in the dispensary)
- The patient should check the name, quantity and dose on the label before swallowing. (The dose may then be poured into a plastic cup; patients should be discouraged from drinking the dose of methadone from the dispensing bottle, however this may not always be acceptable)
- The patient should be offered a drink of water or engaged in conversation to satisfy the pharmacist that the dose has been swallowed
- The pharmacist should remove the labels from the patient's bottle after the patient has finished, and ensure appropriate disposal
- Stock and patient bottles should be rinsed out to remove any remaining methadone
- A record of missed doses should be kept
- Patients should be advised on safe storage for any take homes and containers should be fitted with child-resistant closures
- A safety-storage methadone box should be offered to a patient where children may be present (request through SCAS addictions nurse)
- All daily dispensing should be entered in the CD register on the day of supply
- Records of dispensing should be made on the patient's PMR
- Pharmacists should make adequate provision for the storage of methadone
- Supervision should be withheld if the pharmacist believes the patient is intoxicated or the patient's behaviour is unacceptable; the prescriber should then be contacted
- Steps should be taken to minimise risks of infection through meticulous hygiene.

Supervision of Buprenorphine (Subutex) Consumption

- Check the patient's identity
- Check the patient understands the treatment and whether they have any questions.
- Advise the patient:
  - ✓ To place the tablet/s under the tongue and allow to dissolve
  - ✓ **DO NOT SWALLOW OR CHEW the TABLET**
  - ✓ They may feel unwell for the first day or two, but by day 3-4 will start to feel better.
  - ✓ They may experience nausea and occasionally vomiting, with initial doses. If the tablet has dissolved in the mouth, re-dosing is not required
  - ✓ **NOT to** take any other drugs, particularly alcohol and benzodiazepines
- The daily dose should be dispensed and labelled appropriately before the patient arrives (when a prescription is current)
- The patient will be required to consume their dose of buprenorphine in a discreet area in the pharmacy, which is mindful of the patient's dignity. (Supervision should not take place in the dispensary)
- Offer the patient a drink of water **before** dispensing, to moisten the mouth to speed up dissolution
- The pharmacist should allow the patient to check the name, quantity and dose on the label before placing the tablet into a small disposable pot and handing it to the client, alternatively you can ask the patient to pop the tablet/s into the plastic cup
- Remind the patient to tip the tablet/s under the tongue without handling
- Ask the patient to avoid swallowing whilst the tablets are under the tongue
- The pharmacist is responsible for ensuring the tablet goes into the mouth, under the tongue and confirming that the dose has been absorbed. (It may not be necessary to watch the patient continuously)
- The patient should be engaged in conversation and offered another drink of water to ensure the tablets have been taken-the tablets can leave an unpleasant taste in the mouth
- If the pharmacist believes the dose is being diverted he should contact the prescriber/addictions nurse
- A record of missed doses should be kept
- Patients should be advised on safe storage for take homes
- Staff should be made aware of the procedure for operating this service
- Records of dispensing should be made on the patient's PMR.

Notes

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