Livewell Southwest

Substance Misuse (including Alcohol Misuse) Prescribing Policy

Version No. 5.2
Expiry Date: January 2025

Notice to staff using a paper copy of this guidance

The policies and procedures page of Intranet holds the most recent version of this guidance. Staff must ensure they are using the most recent guidance.

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Asset Number: 614

Reader Information

Title	Substance misuse (including alcohol misuse): prescribing policy v.5.2
Asset number	614
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Category	Clinical
Document purpose/summary	To provide guidance on prescribing interventions for clients with substance misuse / alcohol issues.
Author	Clinical Lead / Acting Substance Misuse Governance Pharmacist
Ratification date and group	MGG Jan 2022 **If the above 'Ratify by' date is exceeded, then the policy is still valid until it is replaced**
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Review date and frequency	Expires January 2025 (initial 3 year expiry agreed at MGG). Or earlier if there is a change in evidence
Disposal date	The PRG will retain an e-signed copy for the archive in accordance with the Retention and Disposal Schedule. All copies must be destroyed when replaced by a new version or withdrawn from circulation.
Target audience	Livewell SW prescribers working within specialist drug and alcohol services All staff (including Livewell SW) working with clients within specialist substance / alcohol misuse services Staff (including Livewell SW) working outside of specialist substance / alcohol services who encounter clients with substance / alcohol misuse problems
Circulation List	Electronic: Livewell Southwest (LSW) intranet and website (if applicable) Written: Upon request to the Policy Coordinator at **livewell.livewellpolicies@nhs.net** Please contact the author if you require this document in an alternative format.

Stakeholders	Livewell-PTH prescribers, administrators and clinical staff Harbour managers and Specialist Workers Staff (including Livewell SW) working outside of specialist substance / alcohol services who encounter clients with substance / alcohol misuse problems (including LES GPs; community pharmacists; mental health services; Derriford hospital staff)
Consultation process	Acting Substance Misuse Governance Pharmacist started the consultation process with Clinical Manager and Medical Lead who in turn have consulted the team (including all prescribers) and answered all the questions raised by the pharmacist. The Pharmacist collated the information into the document.

References/sources of information	**Advice for prescribers** on the risk of the misuse of pregabalin and gabapentin. Public Health England 2014 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/385791/PHE-NHS_England_pregabalin_and_gabapentin_advice_Dec_2014.pdf **At a glance guide** to the current medical standards of fitness to drive (DVLA 2014) https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/435071/aagv1.pdf **BAP updated guidelines**: evidence-based guidelines for the pharmacological management of substance abuse, harmful use, addiction and comorbidity: recommendations from BAP (British Associate for Psychopharmacology 2012) http://www.bap.org.uk/pdfs/BAP_Guidelines-Addiction.pdf **Breastfeeding Network** https://www.breastfeedingnetwork.org.uk/detailed-information/drugs-in-breastmilk/ **British National Formulary** via BNF British National Formulary – NICE **Confidentiality:** reporting concerns about patients to the DVLA or DVA (GMC 2017) https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/confidentiality---patients-fitness-to-drive-and-reporting-concerns-to-the-dvla-or-dva [Accessed 26.02.20] **Drug and Driving**: the Law (DVLA 2015) https://www.gov.uk/drug-driving-law https://www.gov.uk/driving-medical-conditions [Accessed 26.02.20] **Drug Misuse and Dependence:** UK Guidelines on Clinical Management (NTA 2017) "The Orange Book" https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/628634/clinical_guidelines_2017.pdf **LactMed**: monographs for use in breastfeeding (http://toxnet.nlm.nih.gov/newtoxnet/lactmed.htm) **LSW Substance Misuse Service Prescription and Controlled Drugs Standard Operating Procedures for Livewell SW Prescribing Team within Harbour (Livewell-PTH)** **Maudsley** Prescribing Guidelines 12th Edition 2015

	Medications in recovery: Reorienting Drug Dependence Treatment (NTA 2012) [ARCHIVED CONTENT] (nationalarchives.gov.uk) **NICE Antenatal Care** https://www.nice.org.uk/Guidance/CG62 **Pain and substance misuse**: improving the patient experience. The British Pain Society 2007 https://www.britishpainsociety.org/static/uploads/resources/misuse_0307_v13_FINAL.pdf **Renal Drug Handbook** **Safer use of controlled drugs**: preventing harms from the use of methadone (CQC 2014) http://www.cqc.org.uk/sites/default/files/20141107_safer_use_of_controlled_drugs_preventing_harms_from_the_use_of_methadone_v2.pdf **Summaries of product characteristics** www.medicines.org.uk **Toxbase** monographs for exposure in pregnancy (www.toxbase.org/Exposure-in-pregnancy)
Equality analysis checklist completed	Yes
Is the Equality and Diversity Policy referenced	No
Is the Equality Act 2010 referenced	No
Associated documentation	LSW Substance Misuse Service Controlled Drugs SOP's Livewell SW Prescribing Team in Harbour Livewell – PTH Detoxification of Alcohol in Community Policy LSW Medicines Policy **Drug Misuse and Dependence:** UK Guidelines on Clinical Management (NTA 2017) "The Orange Book" https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/628634/clinical_guidelines_2017.pdf
Supersedes Document	LSW Substance Misuse (including alcohol misuse) Prescribing Policy v5.1
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Document Review History

Version no.	Type of change	Date	Originator of change	Description of change
Contact PRG Secretary for Older Versions				
4	Reviewed	Jan 2018 Ratified MGG 30th Jan 2018	Clinical Lead and Specialist Pharmacist	Major Review: re-arrangement of some sections; some sections split into drugs and alcohol; addition of details in 'Transfer of Prescribing'; addition of 'collection of medication by others; addition of Harbour Prenoxad Supply (Appendix L); updates in line with 2017 NTA Guidelines
4.1	Updated	January 2020	Advanced Clinical Pharmacist	Minor update to driving section 18
4.2 4.3	Minor Minor	Feb 2021 March 21	MGG MGG	Extended Extended
5.0	Full Review	January 2022	Medical Lead, Clinical Manager and Acting Substance Misuse Pharmacist	**Full Review** **Added**: Strong statement regarding not starting any patients on Diamorphine injection; More cautions to the use of Methadone and buprenorphine (convulsion disorders added);Clonidine added instead of Lofexidine **Updated**: Vocabulary changed to be more trauma informed; Section 13: the review expectations for OST has been updated (as per orange guidelines to reflect flexibility); Approach in prescribing Diazepam for Benzodiazepine dependence adjusted for more clinical oversight and to be more practical in delivering treatment; Take Home Naloxone SOP updated to match the most up to date SOP **Removed**: Lofexidine removed as discontinued; Take Home Naloxone SOP separated
5.1	Minor	Feb 2022		Dates and versions corrected

5.2	Minor	Apr 2022	Acting Substance Misuse Pharmacist	Link to the Detoxification of alcohol Misuse policy updated in Section 27

Contents

Substance Misuse (including Alcohol Misuse): Prescribing policy v.5.0

1. Introduction

1.1. The aim of prescribing is to promote a client's recovery from addiction to, or reduction of harm from, drugs and alcohol. At times, different approaches are required for alcohol clients as opposed to drug clients which have been highlighted in this edition.

1.2. Treating substance misuse brings unique challenges to safe prescribing particularly for those unfamiliar with addiction work. This policy is designed to offer guidance on how best to navigate the challenges such as risk of overdose, diversion or use on top, while still keeping 'recovery' central to our thinking of how we can best support an individual client in treatment.

1.3. Prescribing is only one component within a client's treatment package for substance misuse.

1.4. Important psychosocial interventions, with prescribing in the background, form the mainstay of broad treatment packages that help clients to advance their journey of recovery. Research indicates that prescribing alone without such interventions is less effective. Psychosocial interventions are comprehensive including health (physical and mental), legal issues, risk management, personal development and skills, productive activities at home, in the local community and workplace.

1.5. This policy applies to professionals working within Livewell SW in partnership with other agencies of the drug and alcohol treatment system and provides guidance that can be applied in the wider Plymouth healthcare setting on the use of medications in the management of drug and alcohol misuse.

1.6. The term client will be used throughout rather than patient or service user.

2. Purpose

2.1. The objective of this policy is to facilitate the safe and effective prescribing and use of medication for clients with drug or alcohol misuse problems within Plymouth receiving treatment from Livewell SW clinicians. Other providers such as Harbour, Primary Care, hospital and prison services may choose to adopt this policy.

2.2. This policy aims to provide a prescribing framework for the following scenarios:

- Opiate substitution
- Benzodiazepine substitution
- Opiate and alcohol relapse prevention (there is a separate policy for Home Opiate & Alcohol Detox)
- Guidance on prescribing for these scenarios for particular medical groups

3. Definitions

Care co-ordinator	Person working within substance / alcohol misuse with oversight of client's care
CDAO	Controlled Drug Accountable Officer
Client	Person in receipt of substance / alcohol misuse intervention
CNT	Complex needs team. Livewell SW Mental health team within substance misuse services for clients with comorbid complex drug misuse and mental health problems
Detoxification	Planned reduction in substance / alcohol use to ZERO
Halo	Computer system used for recording of client information in substance / alcohol misuse services
Harbour Specialist Worker	Harbour staff with oversight of client's care
OFT	Oral fluid test (used in drug testing)
On-hold	When medication is not issued to the client from the pharmacy until substance misuse services have stated that it can be released
OST	Opioid Substitution Treatment
OTC	Medication brought over the counter
PToC	Prison Transfer of Care: the temporary process to allow prescribing prior to a Comprehensive Assessment
Substitution	Replacement of illicit substance with a prescribed medication
Supervised consumption	When the client's doses are observed within the community Pharmacy
TOP	Treatment Outcomes Profile
Withdrawal symptoms	Symptoms experienced by a client when they stop taking a substance / alcohol

4. Duties & Responsibilities

4.1. The **Chief Executive** is ultimately responsible for the content of all policies, implementation and review.

4.2. Responsibility of **Director(s)**

Directors are responsible for identifying if this policy is relevant in their area and its subsequent implementation.

4.3. Responsibility of **line managers**

- Embed this policy within the practice of relevant staff
- Keep a signature list of staff who have read this policy, declaring that they are familiar with its contents and will work within its boundaries
- Include this policy in induction of new **staff**
- Follow-up prescribing / medication errors / incidents
- Make staff aware of prescribing / medication errors / incidents

4.4. Responsibility of all **staff**

- Follow the content of this policy and associated SOPs
- Act within their confidence and competence
- Inform the prescriber of any circumstances in which safe prescribing may be compromised
- Keep Halo updated of all actions concerning prescribing
- Inform prescribers and managers if, for whatever reason, prescribing falls short of this policy
- Report medication / prescribing incidents / errors

4.5. Responsibility of **prescribers**

- **Responsibility for any prescription rests ultimately with its prescriber.** This role is conducted in collaboration with others particularly the pharmacy, the Harbour Specialist Worker or other agency care co-ordinator.
- Write letters to every client's GP, detailing the outcome of prescribing meetings.
- Write to other Livewell SW services, and / or Derriford Hospital departments, that clients are under the care of, detailing the outcome of prescribing meetings.
- Liaise directly with GPs and other healthcare professionals where necessary and appropriate.
- Recognise "red flag symptoms" and refer appropriately.
- Refer to other healthcare providers if needed.
- Ensure that client has a signed copy of the The Plymouth Medication for Recovery Agreement when initiating ALL new prescriptions (see Appendix G).
- Prescribe responsibly, within their field of competence.
- Prescribe generically, except for special circumstances, in which case the reason for not prescribing generically must be recorded on Halo. Whole team prescribing decisions (e.g. to prescribe a particular brand of drug) do not need to be documented.
- Ensure that the prescription is safe and appropriate based on the client's physical health and other prescribed and non-prescribed medications.
- Specify monitoring required for medications prescribed and review prescriptions based on the results of this monitoring.
- Advise clients of their responsibilities around prescribed medication– including not to give their medication to anyone else (adults or children).
- Discuss risk and consequences of misuse of prescription.
- Discuss the safe storage of prescribed medications with clients.
- Advise clients of their responsibility to inform the DVLA of their condition.
- Discuss and record the risk of overdose with clients and safe injecting advice.

- Provide appropriate verbal and written information about medications prescribed.
- Prescribe within the framework of the South and West Devon Formulary and keep up to date with its content in relevant areas of practice.
- Complete MHRA 'Yellow Card' reports for relevant suspected adverse effects of medication, including where medications are suspected of causing dependency https://yellowcard.mhra.gov.uk/

4.6. Responsibility of **Harbour Specialist Workers** (within the substance misuse treatment system)

- Ensuring the client understands the Plymouth Medication for Recovery Agreement and has a signed copy that is reviewed annually or sooner as required.
- Ensuring that prescribers and their administrators are made aware of any significant changes to the client's circumstances especially if safe prescribing is compromised.
- Maintain contact with clients and liaise with others involved in the Care Plan including relevant outside agencies.
- Liaising with other workers from the Mental Health services where the client has a dual diagnosis.
- Liaising with local pharmacies and other health and social care professionals (see also section 9).
- Writing to or emailing the client's GP and other healthcare professionals closely involved with their care (e.g. mental health care co-ordinators) ideally every 3 months, and at least every 6 months, detailing current situation. More frequent correspondence will be required for complex cases or when significant issues occur.
- Inputting and updating Halo system with recovery plans including interventions. The Recovery Plan will be reviewed within appropriate timeframes or at a minimum on a 3 monthly basis.
- Recording relapse prevention/overdose awareness.
- Providing one to one sessions for drug clients, tailored to the needs of the client; initially weekly during the stabilisation period followed by regular appointments thereafter according to Standard Operating Procedure.
- Anything else relevant within Harbour operational policies.

4.7. Responsibility of **prescribing administrators (medical secretaries)**

- Ordering and security of FP10 stationery as per Controlled Drug Standard Operating Procedures.
- Produce computer generated prescriptions for substance misuse clients.
- Keep a log of all prescriptions issued.
- Liaising with local pharmacies (see section 9).
- Additional secretarial duties – letter writing, minute taking, audits, appointments and organisational duties.

4.8. Responsibility of **substance misuse pharmacist**

- Advise prescribers and other professionals on medicines related issues.
- Lead on medication related audits.
- Provide training about this policy as necessary.
- Liaise with the Livewell SW CD accountable officer.

- Liaise and advise on reported incidents.

4.9. Expectations of **clients**

- Take medication as prescribed.
- Report any changes in physical or mental health.
- Report use of illicit substances and alcohol.
- Agree to drug screening as requested.
- Attend appointments.
- Behave appropriately during appointments and when collecting medication from pharmacy (see also Appendix G prescribing agreement).
- Commitment to changing substance misusing behaviour

4.10. Expectations of **community pharmacies**

- Work within the SLA agreement.
- Dispense prescribed medication.
- Not to supply medication if client unreasonably intoxicated.
- Contact Harbour Specialist Worker and / or prescriber if client fails to collect medication or if concerned about the client in any other way.
- Contact prescribing administrators if expected prescriptions are not received.

NOTE: Harbour Specialist Workers (and any other professionals involved) are responsible for sharing with the prescriber all information relevant to the safe provision of the prescribing intervention. This includes any change in the client's physical or mental health, illicit drug or alcohol use, and newly prescribed or OTC medication or significant changes to their social situation.

5. Principles of Good Prescribing

5.1. The client's recovery from their addictive behaviour(s) is the central focus of the treatment episode with consideration for harm reduction and eventual abstinence within each Care Plan.

5.2. Prescribing should take place within a framework where co-existing physical, psychological, emotional, social and legal problems are addressed at the same time.

5.3. To ensure client safety whilst receiving a prescribing intervention, regular monitoring and the demonstration of at least harm reduction and hopefully progressive recovery from the addictive behaviour is required.

5.4. The client should make an informed choice about taking medication, having been made aware of the relevant risks and benefits.

5.5. Prescribing should be generic except in exceptional circumstances, including whole team decisions to prescribe a particular brand of drug (e.g. Physeptone for all methadone prescriptions).

5.6. Decisions to work outside of this prescribing policy should be made with multi-

disciplinary input and must ultimately be supported by the prescriber concerned, be within their clinical competency and have organisational approval from the relevant Clinical Lead or team manager. All such discussions, rationale and decisions must be clearly documented in the electronic Halo record.

6. Aims of Prescribing

6.1. The fundamental aim of prescribing is to engage and retain clients in their treatment programme with established harm reduction goals within a dynamic recovery plan that supports the client towards abstaining from harmful substance use or complete abstinence from substances and successful exit from treatment.

6.2. Specific aims will be agreed with the client within the general themes that:

- stabilise the client on substitute medication to alleviate withdrawal symptoms.
- reduce or eliminate the misuse of illicit, OTC or prescribed drugs.
- reduce the dangers associated with drug misuse particularly spread of blood borne viruses e.g. reducing injecting and sharing of injecting paraphernalia.
- reduce the risk of prescribed drugs being diverted.
- improve the client's overall functioning from a personal, social, family and community perspective.
- reduce criminal activity associated with drug misuse.
- achieve a safe detoxification programme.

7. Starting a prescription and Prescription Changes

7.1 Prerequisites to commencing any prescribed intervention for drug or alcohol misuse are

- **Commitment** from the client to changing substance misusing behaviour. Note: a prescription is not an automatic right. It comes with conditions and expectations to change addictive behaviours.

- **Comprehensive assessment** and risk assessment by the Harbour Specialist Worker inputted on Halo to include:
  - Physical dependency
  - Substance/ alcohol use (e.g. pattern and extent of use)
  - Dual Diagnosis
  - Contact with other services
  - Physical/Psychological health problems
  - Blood Borne Virus (BBV) status
  - Pharmacological needs
  - Social circumstances including family, children and housing
  - Safeguarding vulnerable adults
  - Legal circumstances
  - Child protection
  - Areas of Risk
  - Treatment History/Goals

- Contact with the GP for Patient Profile including current prescribing, allergies and sensitivities, relevant medical history and any on-going investigations. If the client consents, current medication can also be confirmed using the Summary Care Record accessible via SystmOne.

- Client allocated Tier 3 worker.

- The Harbour Specialist Worker should only refer for a prescriber assessment if the initial assessment indicates that a prescribing intervention is appropriate.

IN ADDITION, FOR DRUG CLIENTS:

- Confirm history of problematic drug, and if relevant alcohol use.
- **Drug (and alcohol) screen** (urine or OFT): at least two within the past 2 weeks and one week apart. All results must be documented on Halo before a prescribing assessment is booked.
- Assess risk of heroin or opiate overdose and arrange supply of Take Home Naloxone (THN) as appropriate.

7.2 Prescriber assessment should cover:

- current/past medical history, including hospital admissions and recent surgery
- current/past psychiatric/forensic history
- current medical problems including investigations
- Blood Borne Virus status, any treatment and HBV vaccination
- all current prescribed medication by GP or hospital department
- use of all purchased medicines including over the counter medicines, complementary and alternative medicines and supplements, and medicines bought via the internet
- recording of all allergies / sensitivities
- substance and alcohol misuse history and current usage (amounts, frequency, route) including illicit, OTC and prescribed sources
- current/past treatment history – prescribing and psychosocial
- details of other clinicians involved with client for later liaison
- thorough assessment of risk / benefit of prescribing intervention, including of medicines' safety for the client
- rationale and indication for prescribing
- review and monitoring processes

7.3 Establish an initial prescribing care/recovery plan that includes:

- goals of prescribing
- contact with a community pharmacy

IN ADDITION, FOR DRUG CLIENTS:

- frequency of prescription pickup and supervised consumption
- circumstances which would result in the discontinuation of a prescription including failure to collect, non-attendance at reviews and unsafe drug or alcohol

use
- frequency of monitoring and reviews
- attendance policy expectations and non-attendance consequences
- requirement to undertake drug/alcohol screening on request
- any client specific requirements

Appendix B- Treatment Goals and Example Treatment Outcome MeasuresAppendix B- Treatment Goals and Example Treatment Outcome Measures has some examples of treatment and prescribing goals

7.4 Liaison with other agencies

- Clients must be registered with a general practitioner, within the commissioned Plymouth boundary.
- **Contact GP Surgery to clarify any pre-existing prescribing before commencement of new prescribing**
- The GP must be informed of the prescription and its arrangements (if they are not the prescriber). The GP must be updated with any changes as they occur, including treatment discontinuation.
- Before prescribing, every client must sign the Plymouth Medication for Recovery Agreement (Appendix G), and copies are to be distributed to client, pharmacy, prescriber and Harbour Specialist Worker.

7.5 Client information

Discussions will cover the following areas with written material(s) provided when appropriate:

- the effects and side effects of prescribed drugs (including written information from approved internet sources)
- the need to take identification to the pharmacy for each collection
- the need to update all services of changes to contact details particularly mobile phone numbers
- safe storage of medications
- warnings about overdose and how to manage others who have overdosed
- advice that replacement of lost or stolen medications or prescriptions will only occur in exceptional circumstances subject to:
  - the client reporting the incident to the Police on Online lost property reporting - Report My Loss UK and obtaining a verified Log Number
  - a Harbour worker and a prescriber supporting this action on clinical grounds following a risk assessment fully documented on the Halo client record
  - Accidental spillages in sight of a health or social care professional (e.g. broken methadone bottle in the pharmacy) may be replaced
- advice on blood borne viruses screening & vaccination, safer injecting and sexual practices
- advice on driving – see section Driving

7.6 FOR CONTROLLED DRUGS (methadone, buprenorphine or diazepam): To start the prescription

- Prescriptions should be initiated at the start of the week (Monday or Tuesday) to allow regular contact and monitoring during induction.
- Supervised consumption is the norm until stability is established and clean screens demonstrate congruence with Opioid Substitution Treatment
- Harbour Specialist Workers, or in their absence a duty colleague, need to arrange post-dose contact either face to face or by telephone with each client to evaluate for toxicity. This should occur regularly in the first week for Methadone and Buprenorphine.
- Particular care should be taken with clients that are new to treatment, polydrug users and alcohol drinkers.
- Ensure new prescriptions include information asking the community pharmacy to inform the prescriber or Harbour Specialist Worker of **any missed doses** within the **first 2 weeks**
  There is a separate process for **prison releases – see section 8.2**

7.7 FOR OTHER MEDICATION:
To start the prescription

- Prescriptions should be initiated at the start of the week (Monday or Tuesday) to allow regular contact and monitoring during induction.
- It is possible to arrange daily pickup at the pharmacy via the specialist service if overdose risk merits this or more regular pharmacy monitoring is warranted. Generally weekly pickup is appropriate for non-controlled drugs where there is low risk of dependency or misuse potential.

7.8 Prescribing for parents / carers of children

- The client will be told not to give their medication to children in any circumstances and counselled on **safe storage** arrangements of their prescription and associated risks of overdose to children.
- Lockable containers will be available to all clients who are a parent or carer for a child under 5 years.
- Discussions should be documented in the Halo record.

7.9 Restarting a prescription after a period of disengagement

In order to establish that a client is committed and ready to engage in a new prescribing intervention, clients must have attended **two appointments** with their Harbour Specialist Worker **before** being rebooked for a prescribing assessment. This will include engagement in a broader care plan and treatment package to avoid a singular focus on receiving a prescription.

7.10 PRESCRIPTION CHANGES

- 5 WORKING DAYS' NOTICE IS REQUIRED FOR ROUTINE CHANGES.

- **All routine prescription changes** should wait until the next batch as generated on a 14-day cycle unless an exceptional circumstance applies such as:

- there is believed to be a significant risk to the physical health or safety of the client as supported by multi-disciplinary input and no alternative approaches are possible and rationale is recorded on Halo
- a prescription change adds significant client stability that is crucial to treatment gains
- clinical reasons to suspend or stop a prescription due to client's non-engagement in treatment care plans, theft of medicines, diversion, refusal to comply with supervised consumption or breakdown in working relationship at the pharmacy.
- All changes to prescriptions must be discussed with the regular prescriber or the duty prescriber if they are unavailable.

- **All requests for a prescription change from a Harbour Specialist Worker** (such as change in dose or pickup) must be made in writing by email to the relevant prescriber and copied to their administrator.

- Information provided by the Harbour Specialist Worker must include **the following information:**
  - reason for change; whether the worker supports the request; start date; drug; preparation; form; dose; pickup frequency and whether supervised consumption; return to Plymouth collection date (if applicable)

Every effort will be made to accommodate a request in urgent circumstances but this cannot be guaranteed and is at the discretion of the prescriber.

- The pharmacy should be pre-warned, via telephone or secure email, of any impending prescription changes.

- The pharmacy should be contacted by telephone if a prescription needs to be put on hold

- Prescribing Administrators will request that pharmacies void any incorrect prescriptions and note this in the prescribing records.

- All staff are responsible for making appropriate records of the decisions and actions around FP10 changes and recording in the client's Halo record.

- NOTE: change of pharmacy does NOT require prescriber consent and requests can be made to the administrator directly.

7.11 Data collection

- All clients in receipt of a prescribed intervention for drug or alcohol dependency or problematic use must be registered with the National Drug Treatment Monitoring System (NDTMS). This is the responsibility of the care co-ordinator or the prescriber if under GP managed care. Regional funding is dependent upon accurate returns to the NDTMS (NDTMS - National Drug Treatment Monitoring System)

8. Transfer of Controlled Drug Prescribing: Prison, Court, Hospital or Inward/Outward transfer

- There are particular circumstances for substance misuse clients when close co-operation is required between services to ensure that a safe and efficient transfer of prescribing occurs from one practitioner or team to another, avoiding both double dosing and gaps in prescribing that may lead to relapse due to withdrawals.

- There is an increased risk of miscommunication since the services involved may be geographically separate and operate within different employment cultures, such as staff availability rotas, and with different aims and objectives. At times one prescribing system transfers to two or more other systems e.g. transfer from prison to the community where GPs, mental health services, drug & alcohol agencies and community pharmacies are involved.

- Agencies that have regular transfer interfaces often develop protocols to diminish the risk of errors or incidents occurring. Whenever interagency work is uncommon, then extra care must be taken by all parties to ensure that the process is client focused with high standards of verbal and written communication to ensure safe and continuous provision of medication in a timely fashion with clear and pre-agreed actions taken that close prescribing in one system and open it up in another, followed by confirmatory checks between systems. This is rather like a relay race when the baton needs to be precisely transferred and not dropped.

8.1 Prison remand

- As soon as an alert has been received by the Harbour Criminal Justice administrator that an existing client has been held on remand they will close the current prescribing episode and inform the Harbour worker, prescriber and medical secretary.

- Preparation for the client's return to community treatment is established by creating a Tier 1 fast track episode (PToC – Prison Transfer of Care) that is only activated on release – see 8.3 below.

- A PToC is a temporary device (up to 6 weeks maximum) to allow prescribing prior to a Comprehensive Assessment when a Tier 3 episode is started and the PToC will be closed.

8.2 Prison release

- An alert is received by the Harbour Criminal Justice administrator giving the release date of a client (new or old) in receipt of a methadone, buprenorphine or naltrexone prescription. The Criminal Justice prescriber and medical secretary then activate a PToC to generate continuity of prescribing with a community prescription.

- The client has to attend Harbour on the day of release to meet their Harbour worker and to collect the prescription which they take to the nominated pharmacy.

- The prison will dispense a dose on the day of release so the community

prescription will commence on the following day. At this time they also receive an appointment for a prescribing review at Harbour within 4 weeks of release when the usual Non-Attendance Policy applies. Any prescriptions that are not collected or required will be cancelled after 3 days and prescribing review is cancelled.

8.3 Court release

- An alert is received by the Harbour Criminal Justice administrator giving the court attendance date of a client (new or old) in receipt of a methadone, buprenorphine or naltrexone prescription.

- The outcome may be that the client is remanded, released or put on a community drug or alcohol treatment order. The Criminal Justice prescriber and medical secretary then activate a PToC to generate continuity of prescribing with a community prescription.

- If released the client has to attend Harbour on that day to meet their Harbour worker and to collect the prescription which they take to the nominated pharmacy.

- The prison will dispense a dose on the day of release so the community prescription will commence on the following day. At this time, they also receive an appointment for a prescribing review at Harbour within 4 weeks of release when the usual Non-Attendance Policy applies. Any prescriptions that are not collected or required will be cancelled after 3 days and the prescribing review is cancelled.

8.4 Hospital admission

Compared to Prison and Court releases, this process is less well organised. Hospital staff do not always inform prescribers, pharmacies or GPs of acute admissions, leaving community staff to learn about it through a variety of routes such as non-collection at pharmacy, family and friends or professional liaison. **Community prescribing must be stopped as soon as news of an admission is received in order to avoid double prescribing.** All staff must inform the Harbour Specialist Worker, prescriber and medical secretary if they discover such information.

8.5 Hospital discharge

8.5.1 **Pre-existing clients**

Hospital staff will often discharge a client quickly once they are fit for discharge or the client may take their own discharge against advice. Notice may be brief so community staff wishing to continue prescribing have to ascertain the following key information with written confirmation:

- the exact details of substance misuse treatment medication to be transferred
- any changes to dose since admission
- the date the hospital last dispensed the medication to the client
- details of any ‘to take away’ (TTA) medication issued
- clarifying with the GP about any other medication that the GP will prescribe
- establish the commencement date of the community prescription

Only then can the prescribing transfer take place.

8.5.2 **New clients commenced on OST whilst an in-patient**

- Heroin dependent clients requiring emergency hospital treatment may need OST induction to avoid withdrawals in order to receive acute care. On discharge, such clients require the usual assessment process (Comprehensive and Risk) in order to be absorbed into the usual drug and alcohol treatment processes even though they are already in receipt of OST.

- If there is sufficient notice, then a Harbour worker will conduct this assessment on the ward, or if not, then as soon as possible after discharge. The same process as in 8.5.1 needs to be followed and an obligatory prescriber assessment booked within 2 weeks.

- Experience shows that many such clients do not wish to continue OST and soon stop collecting their community prescription and disengage from services - nevertheless the offer of treatment must be made.

- A PToC can be used to generate a prescription quickly if client is not already open as a Tier 3.

8.6 **Client transfer in/out of area from/to another substance misuse service**

- Generally a client transfer relates to a change in accommodation, so can be pre-planned, but on other occasions, a client moves urgently such as into a Women's Refuge or a safe house.

- Communication must occur between Harbour Specialist Workers to transfer all levels of information including Comprehensive and Risk Assessment, Care Plans and the key information listed in 8.5.1 that will then result in the prescribing transfer actions.

- In unusual circumstances, a prescriber will continue to prescribe by sending prescriptions to a nominated pharmacy in the new area to allow a vulnerable client to make contact with local services but **only to a maximum of 4 weeks**.

9. Pharmacy liaison including collection of medication by a nominated third party

High standards of communication between drug services and community pharmacies are crucial to enable safe prescribing that then benefits client welfare. Although Harbour Specialist Workers and medical secretaries will both make calls to and receive calls from pharmacies, it is important to clarify who has responsibility for particular types of calls in order to reduce the risk of a prescribing error.

9.1 Harbour Specialist Workers specific tasks:

- Assisting client to select a suitable pharmacy (client to have identification) and introduce the client if necessary

- Sharing risk factors with the pharmacy as needed e.g. previous ban for shoplifting, client on a restricted access order or previous aggression/violence to pharmacy or

other social or healthcare staff.

- Responding to information about client non-collection

- Contacting the pharmacy to advise about prescriptions on hold/released at Harbour Specialist Worker reviews or prescriptions stopped due to client disengagement

- Contacting the pharmacy to advise about dose changes or other prescription changes
  NOTE: Due to pharmacy practices of stock ordering and advanced preparation of medication, there is a risk that a client will receive the wrong dose unless the pharmacy receives prior notice of changes

- Sharing information on changes of pharmacy whether short or long term
  NOTE: The current pharmacy must know when to stop dispensing and the new pharmacy when to start.

9.2 Medical secretary specific tasks:

- Contacting pharmacies to advise about prescriptions on hold/released following prescriber reviews

- Liaising with pharmacies over prescription issues e.g. errors, ambiguities

- For missing/mislaid prescriptions in the pharmacy, recording the loss and replaced prescription and completing a LSW incident report (refer to Substance Misuse Service CD SOPs for further details).

- For prescriptions not arriving at the pharmacy, making necessary checks that the prescription was sent and for recording replaced prescriptions and completing a LSW incident report (refer to Substance Misuse Service CD SOPs for further details).

If a Harbour Specialist Worker is unexpectedly absent then the medical secretaries will assist in keeping the pharmacy informed.

Due to the differing skill sets between Harbour Specialist Workers and medical secretaries, all client welfare information needs to be dealt with by the Harbour Specialist Worker. All staff need to work within their own competencies.

9.3 Pharmacy specific tasks:

- It is crucial that pharmacy staff share any concerns about safe prescribing and client stability with the Harbour Specialist Worker and prescriber. This may include non-collection, erratic pickup, disinhibited behaviours or a decline in physical or mental health.

- The pharmacy must not dispense the prescription and must contact the Harbour Specialist Worker or prescriber if a service user has missed collections of 3 days or more in a row or, in the case of dose titration, if any escalating dose is missed.

- If a client misses 3 or more times from a 14-day prescription then the pharmacist will inform the client's Harbour Specialist Worker, prescriber or Harbour manager who will investigate the reasons why this is happening.

- Prescribers or Harbour Specialist Workers should also be alerted if a pharmacy has concerns over an unexpected non-collection.

- The pharmacist can make a decision not to dispense a prescription if the client presents as intoxicated or significantly unwell. They should liaise with the Harbour Specialist Worker / prescriber in these circumstances.

- Clients should be made aware that shoplifting, aggression or violence to pharmacy staff or customers may result in termination of their contract with that pharmacy. The client will then be responsible for securing another pharmacy in order to continue their prescription.

9.4 Collection of medication by a nominated third party

9.4.1 If a client is unable to collect their own CD prescription, for an appropriate/reasonable reason, then an assessment must be made to ensure that an adequate and safe alternative arrangement is established that promotes the continuation of safe prescribing, reduces the risk of CD diversion and protects vulnerable clients from exploitation.

9.4.2 At times there will be a longstanding arrangement (e.g. due to work commitments), whilst at other times there can be acute situations relating to illness or injury, and occasionally there are requests that relate to manipulative behaviour.

9.4.3 There may be other exceptional circumstances (either due to detox or risk) when staff need to collect on the client's behalf.

9.4.5 Clients must be informed that they need permission from their prescriber or Harbour Specialist Worker to allow another person to collect their prescribed CD or other medication on their behalf on a regular basis

9.4.6 Clients must sign and receive a copy of The Plymouth Medication for Recovery agreement (Appendix G) at the start of prescribing interventions and at reviews if issues have arisen that require clarification.

9.4.7 The Harbour Specialist Worker is responsible for investigating, reviewing and recording the client's inability to collect for themselves. If there is any doubt as to the validity of any health issues leading to the third party request this should be verified by the client's GP (or recent hospital discharge letter if appropriate).

9.4.8 If a third party is regularly collecting on behalf of a client, the prescriber and Harbour Specialist Worker should ensure that they are happy that the client is taking the medication as intended and that there is no risk of diversion.

9.4.9 Where a client is ill or there are other unforeseen circumstances, short term collection by a friend or relative may be necessary; this may be outside of Harbour hours when the pharmacist will need to exercise their professional judgement.

9.4.10 The client is free to nominate whoever they wish to collect the medication but the prescriber, Harbour Specialist Worker, MDT or pharmacy may take the view that a particular person is unsuitable.

9.4.11 The client will need to provide a letter of authorisation to the pharmacy detailing the arrangements. The Harbour Specialist Worker can assist with this if necessary.

9.5 Collection of medication by Harbour/Livewell-PTH staff

9.5.1 In all cases the decision for a staff member to collect the medication on the client's behalf must be peer reviewed, the Clinical Manager informed and fully documented on Halo with the rationale recorded as to why other transport possibilities could not be utilised.

9.5.2 In the event of collection by Harbour/ Livewell-PTH staff, an Audit Trail Form for Medication Delivery (See CD SOPs Appendix C) must be used and the community pharmacist should be asked to sign this paperwork to confirm that the controlled drug has been handed to the appropriate Harbour/ Livewell-PTH staff. Clients must then countersign this form once they have received the medication

9.5.3 Harbour/ Livewell-PTH staff must carry proof of their identity when collecting controlled drugs from any community pharmacy. The pharmacy should ask for proof of identity and may record the staff member's personal home address in the CD register.

9.5.4 Livewell-PTH staff must use a lockable case or box; hold the medicines for the minimum time period possible; access and manage any safety concerns relating to the journey and document the process.

9.5.5 If Livewell-PTH staff are using their own transport, their insurance must include Business Use and staff must carry identification with them.

9.5.6 If the Harbour/ Livewell-PTH staff fail to deliver the controlled drug, it must be immediately returned to the pharmacy from which it was collected.

9.5.7 If the pharmacy is closed, the staff must return the medication to another pharmacy. To avoid this scenario, the collection arrangement should be done in the morning whenever possible.

10. Holiday Requests

Definition of holiday prescription – an actual holiday or an event that leads to a request for doses to be dispensed outside of regular regime

10.1 Provision of holiday prescriptions is dependent upon the client's engagement in treatment and stability, and remains at the prescriber's discretion. Prescriptions should be restricted to the minimum time period possible and mirror existing dispensing arrangements.

10.2 Five working days' notice is required for holiday prescriptions in the UK or 10 working days if abroad to generate a prescription.

10.3 The Holiday Request Form (that includes a Risk Assessment) from the latest Substance Misuse Prescribing Policy should be completed by the Harbour Specialist Worker and submitted to the Prescriber and Prescribing Administrator with a statement of their agreement towards its appropriateness.

10.4 Evidence of the holiday and/or travel will be required.

10.5 Requests of over 14 days require recorded MDT agreement and rationale.

10.6 In general the following rules apply to the use of CD prescriptions for holidays:

- Use FP10 (green) prescriptions for single supplies of medication i.e. no instalments with buprenorphine or methadone mixture or tablets
- Use FP10MDA (blue) prescriptions in UK where instalment prescribing is still required. Note this includes methadone mixture 1mg/1ml prescriptions supplied in ONE dispensing episode BUT where the prescriber wants individual daily containers supplied.

10.7 There is a good practice requirement that the quantity of Schedule 2, 3 and 4 CDs be limited to a quantity for up to 30 days treatment. In cases where the prescriber believes that a prescription should be issued for a longer period they may do so but will need to be able to justify that there is a clinical need and that it would not cause an unacceptable risk to patient safety. Pharmacists are able to dispense Schedule 2, 3 and 4 CD prescriptions ordering a supply of more than 30 days' supply (from PSNC website http://psnc.org.uk/dispensing-supply/dispensing-controlled-drugs/controlled-drug-prescription-forms-validity/) but this will need to be agreed with the dispensing pharmacy and following an assessment of the risks involved and safe storage requirements.

Holidays within the UK

10.8 The Harbour Specialist Worker must contact the holiday pharmacy to secure their involvement, establish the same dispensing/supervised consumption, avoid double prescribing and confirm the details of the holiday prescription with relevant stop and start dates to both the existing and the holiday pharmacy.

10.9 If the prescriber requests a different schedule of dispensing whilst the client is on holiday the client must be informed of this decision and clinical rationale and this information documented in their Halo record.

10.10 The Harbour Specialist Worker will ensure that clients are aware that any lost or stolen prescriptions will not be replaced.

10.11 Consideration must be given to safe storage, with particular attention if camping, in shared accommodation or travelling with children. Safe storage boxes can be obtained.

Flying or travelling abroad

10.12 When travelling abroad for any length of time, controlled drugs are carried at the risk of the individual, who is subject to legal requirements and restrictions of the country or countries of transit and destination. These can be checked with the relevant embassies and consulates to enquire about any restrictions in the country to be visited (contact details can be found at www.gov.uk/travelling-controlled-drugs).

10.13 It is the client's responsibility to check that controlled drugs can be taken into the country they are visiting and for the purpose for which they are prescribed.

10.14 In general medicines should:

- be carried in original packaging
- meet carriers' requirements for hand and hold luggage (for example, restrictions on volumes of liquids in hand luggage on aeroplanes*)

* Although the Gov.uk website states You're allowed to carry the following in your hand luggage: essential medicines of more than 100ml, including liquid dietary foodstuffs and inhalers, it is still advisable for the client to check with the airline before travelling https://www.gov.uk/hand-luggage-restrictions/essential-medicines-and-medical-equipment

10.15 If flights are involved and airlines apply restrictions, then methadone tablets can be used to replace liquid formulations but these will revert to liquid once usual arrangements restart.

10.16 For controlled drugs in schedule 2,3 or 4 the client will need a proof of ownership letter (see Appendix K). The letter must include:

- the client's name
- which countries they are visiting and when
- a list of medications, quantity and dosages
- the signature of the prescriber.

10.17 The client will need to apply for a personal export licence if they are **travelling for 3 months or more or carrying medication that will last 3 months or more**. See Gov.uk website for up to date information. https://www.gov.uk/travelling-controlled-drugs

10.18 The export licence is to allow the carriage of the medicine out of the UK and any surplus back in. It does not mean that the holder of the licence has the right to take the medicine into the country to be visited. Therefore, it is important that the patient checks with the embassy or consulate before departure, to establish that the country or countries to be visited will accept the Home Office licence.

10.19 Anyone applying for a licence should allow at least 10 working days, assuming all the information needed is contained in the letter from the prescriber, for the processing of the application. https://www.gov.uk/government/publications/personal-import-export-licence-application-form

11. Missed doses

11.1 Loss of tolerance occurs if a client misses doses for either opiate substitution or benzodiazepine prescribing as they are dependency forming. This section describes the management of missed doses for controlled drugs and non-controlled medication, to which the client is not dependent but takes a regular prescription for relapse prevention, adjuvant treatment for alcohol disorders or for their mental health needs.

The key decision is whether it is safe to release the prescription at the usual dose or to reduce the dose or start again. If the client has not been engaging in treatment then this may trigger a review prior to restarting some or all of the prescribing.

11.2 CONTROLLED DRUGS – methadone, buprenorphine and diazepam

11.2.1 For clients on daily dispensing of opiates or benzodiazepines the rules in the table at 11.2.3 should be applied (this prevents an inadvertent overdose)

11.2.2 **Irregular pickup by client at the pharmacy**
If a client misses 3 or more times from a 14 day prescription then the pharmacist will inform the client's Harbour Specialist Worker, prescriber or Harbour manager who will investigate the reasons why this is happening.

Clients who miss collection whilst on three times a week, twice a week or weekly pickup should be considered for an increased frequency of medication collection, which may be upto daily supervised, depending on the medication risks (for opiates or benzodiazepines)

If a client repeatedly misses their pickup then a prescribing review must be arranged and procedures outlined in section 13 (Review of Clients) followed to re- engage the client in their recovery journey.

11.2.3 Table for missed doses of controlled drugs

Dose(s) missed	Action to be taken
1 day or 2 consecutive days	Allow pick up next day as usual

3 to 5 consecutive days **Assessment recorded on Halo:** Why did they miss their pickup? What illicit opiate or benzodiazepine has the client consumed while not taking their prescription? What alcohol or other drugs have been taken? How reliable is this history? Has the client supplied negative screens in past 2 months? How well is the client engaged in treatment? Is there a history of overdosing?	Pharmacy to suspend prescription. Pharmacist to contact Harbour Specialist Worker or prescriber or refer client to make contact themselves. 1. If the client is known to the service, has been engaging well with treatment, is knowledgeable about loss of tolerance, is a reliable historian who has continued using a similar amount of opiates or benzodiazepines over the missed doses, then the prescriber, or the Harbour Specialist worker at the direction of a prescriber, can choose to release the existing prescription. 2. If a partial loss of tolerance for opiate or benzodiazepine has occurred then a new prescription at a lower dose can be generated following liaison with the prescriber. 3. If loss of tolerance is likely and/or safe prescribing is in doubt then proceed to actions as for clients that have missed 6
6 consecutive days or more	Prescription is stopped. Client must be seen by Harbour Specialist Worker for re-assessment and drug & alcohol screening. Harbour Specialist Worker to liaise with prescriber before any new prescribing begins when daily supervised consumption will typically be stopped. Exceptionally the prescriber may decide the patient can continue on the same prescription , if it is a safe titration dose, such as Methadone 20mgs per day.

11.3 NON-CONTROLLED MEDICATION – naltrexone, acamprosate, disulfiram, baclofen, antidepressants, antipsychotics, mood stabilisers

11.3.1 Continuity of taking medication at the prescribed doses and frequency is important for clients to benefit from these medications in their treatment. The majority of non-controlled medications are not dependency forming and therefore can be stopped and restarted without harm to the client. However there are discontinuation syndromes described when certain medications are stopped suddenly such as certain antidepressants and baclofen. Clients should be alerted to these problems before prescribing begins.

11.3.2 Clients are less likely to miss collecting non-controlled medications that are prescribed with weekly, 2 weekly or monthly collections rather than daily. As a

result, awareness that a client has stopped these medications is often more gradual and, being outside of Controlled Drug Regulations, the pharmacy are not required to contact the prescriber for missed doses. Pharmacies may inform the prescriber when they notice this behaviour and a decision can then be made about whether to contact the client to discuss the matter - immediately if the medication is important - or to arrange a prescribing review.

11.3.3 A client may choose to close a prescribing intervention particularly with relapse prevention and adjuvant prescribing for alcohol disorders and continue only with their psychosocial interventions with their Harbour keyworker. The prescriber and medical secretary must be informed to stop further automated prescription generation and the client's reasoning recorded on Halo.

11.3.4 Beware the risk of clients hoarding unused medication which represents an overdose risk by the client or others who access the household. The specialist prescribing service within Harbour can prescribe any medication for daily collection if risks indicate such a need (also refer to sections 12.3 and 14).

12. Lost or stolen prescriptions, fraud, hoarding and CD diversion

12.1 Lost or stolen prescription form (a single green or blue FP10)

- FP10 prescription forms are controlled stationery. In the event of a loss or suspected theft of a prescription form, the person discovering the incident should initiate a search and try to establish the circumstances under which the form has gone missing.

- A prescriber whose prescription pad has gone missing may be instructed to write and sign all newly issued prescription forms in a particular colour for a period of two months.

- If the missing form included a controlled drug and the form cannot be accounted for, the matter must be reported to the CDAO for further action.

- In the event of such an incident, the CDAO will conduct an investigation and/or request advice from the Local Counter Fraud Service and/or notify the police, as appropriate.
- The member of staff reporting the incident should complete a Livewell Southwest incident report form. Any theft or loss report must include the following details:

  - Date and timeframe of loss/theft
  - Date and time of reporting loss/theft
  - Place where loss/theft occurred
  - Type of prescription stationery
  - Serial numbers if known
  - Quantity

- In the event of prescription loss or theft, NHS England and/or NHS Protect may cascade alerts to local community pharmacies, local CCGs and other relevant parties.

- Record keeping for any FP10 prescription pads must follow the LSW Prescription Security guidelines. For details on records for printed FP10 prescriptions refer to the LSW Substance Misuse Service CD SOPs.

12.2 Fraud

- Clients must be made aware that any alterations made to a prescription will be reported to the police and may result in prescription suspension or client discharge from treatment.

- Staff must complete a Livewell Southwest incident form.

- Staff may also report any concerns about fraud to the confidential NHS Fraud and Corruption Reporting Line on 0800 028 4060.

- Prescriptions presented to community pharmacies for unusual/unexpected items or expensive items and large doses or quantities may be checked by the community pharmacy with the prescriber to ensure the prescription is genuine.

- If corrections on a prescription form have not been initialed and dated, community pharmacists may try to contact the prescriber to verify the changes.

- Community pharmacies should follow the advice in the latest edition of Medicines, Ethics and Practice relating to possible fraudulent prescriptions.

12.3 Hoarding

- If Harbour or Livewell staff discover that a client is hoarding their own prescribed medication, they should inform their manager and the prescriber and arrange for an urgent review. This includes medication for physical or mental health problems as well as for substance misuse.

- Clients who are found to be hoarding CD medication prescribed for substance misuse should be seen by a prescriber by the next working day. Typically this results from police information and an urgent re-evaluation is required to ascertain whether to continue, reduce or stop the existing prescription and consider the possible reintroduction of supervised consumption to avoid overdose risk.

- The client should be advised to return the medication to a community pharmacy for destruction (ideally the pharmacy that originally dispensed it).

- If the client refuses to return the medication and staff are concerned that there is a risk to the client or others in leaving the medication with the client, they can remove the medication and record their reasons in the client's Halo record under a duty of care action. In the case of Controlled Drugs follow the procedure in the Livewell-PTH CD SOP 13.

12.4 CD Diversion

- If Harbour or Livewell staff discover that a client is or might be diverting their prescribed medication, they should inform their manager and the prescriber and arrange for an urgent review with screening by the next working day.

- Where a client has been anonymously accused of diversion by another client, it is prudent to initiate a phased re-introduction of supervised consumption for a minimum of 2 weeks with close monitoring, in order to resolve the suspicions about diversion (see section 14.1 for guidelines on phased re-introduction).

13. Review of Clients

13.1 Clients have to be seen regularly as a condition of receiving their prescribed intervention to ensure safe and effective prescribing.

13.2 Review should be a rigorous process of 'stepping-back' to review the care plan previously agreed with the client by way of gains (or losses) in recovery capital and addressing identified problems.

13.3 Objective measures should be used including TOP (Treatment Outcome Profile), drug/alcohol screening results, compliance at the pharmacy and independent measures such as updates from day services, groups, training, friends and family, housing, volunteering , or employment sources.

13.4 **Drug clients**: After initiation of prescribing, the client should be assessed by phone/video/face to face contact, at least weekly, for the first two weeks, by their alcohol / drug Harbour Specialist Worker. Subsequently the client should be contacted in the same manner at least one further time in the following 2 weeks. This could be decreased or increased following discussion between the Harbour Specialist Worker and the Prescriber. Any discussion should be recorded in the patient clinical record.

Regularly assess risk of heroin or opiate overdose and arrange supply of THN as appropriate.

13.6 Early on, the focus will be on reducing and stopping hazardous illicit drug or alcohol use, co-morbid problems (e.g. mental health, HCV, DVT) and support for accommodation.

13.7 Later on, the focus will be skill development, accessing a diverse menu of services and interventions; family work; relapse prevention and social networks with the client becoming increasingly self-managing.

13.8 Clients that have been agreed as on OST Maintenance and are stable should be reviewed no less than yearly by their prescriber. Other OST prescribed clients should be reviewed depending on their risk and treatment plan. For more stable clients this will usually be between 9-3 monthly. For those clients on OST that present with more risk they should be reviewed 3-1 monthly and may at times be seen by their prescriber more often than this e.g. during pregnancy or following

overdoses.
Clients that are prescribed Benzodiazepines should be reviewed no less than 3 monthly by their prescriber.
Drug and alcohol workers should input into the decision into how often the client will see their prescriber as part of the assessment of progress against their treatment plan

13.9 Clients with more complex needs and risks will require more frequent prescriber reviews.

14. Non-attendance

14.1 **CD medication**: refer to Appendix H (Harbour and LSW Joint Non-attendance Policy) for the processes to be followed. Following a non-attendance, a client's prescription is put 'on hold' at the pharmacy for the next appointment and only released after attendance.

14.1.1 Based on the risks and benefits for each client and discussion between the prescriber, Harbour Specialist Worker and other professionals, a persistent non-attender will receive further conditions to their prescription which may include:

- prescription 'on hold' at the pharmacy for EVERY appointment
- revert to daily pickup
- reintroduce daily supervised consumption at the pharmacy
- weekly reduction in dose until they do attend e.g. methadone 10ml, buprenorphine 2mg and diazepam 5mg
- release prescription at appointment to be taken to the pharmacy
- ultimately the prescription may be stopped – see section 16.

14.1.2 There is a risk that a non-attending client is selling or diverting their prescribed medication and <u>not</u> actually taking it, so supervised consumption must be introduced in safe increments (**not immediately**) to avoid accidental overdose. Part of the dose is transferred from takeaway to supervised consumption; takeaway doses are reduced and this continues until the whole dose becomes daily supervised.

14.1.3 **Methadone example** with a dose of 70ml/day:
Days 1-3: 20ml supervised + 50ml takeaway;
Days 4-7: 30ml supervised + 40ml takeaway;
Day 8: 40ml supervised + 30ml takeaway;
Day 9: 50ml supervised + 20ml takeaway;
Day 10: 60ml supervised + 10ml takeaway;
Day 11 onwards: 70ml supervised
(The maximum weekly supervised dose increase is 30ml).

14.1.4 **Buprenorphine** can be converted back to supervised consumption over 3 days but may result in precipitated withdrawals if heroin or other opiates have been taken within the previous12-48 hours. More careful client preparation is required to make sure precipitated withdrawal is avoided, by the client being in mild-moderate withdrawals before taking their first supervised dose of buprenorphine.

14.1.5 All changes must be documented on Halo with written confirmation sent to the client both at their postal address and via their pharmacy. The pharmacy must be contacted directly so they can comply with the latest arrangements.

14.2 Non-CD Medication – naltrexone, acamprosate, disulfiram, baclofen, antidepressants, antipsychotics, mood stabilisers

14.2.1 The condition of regular attendance at all appointments, whether prescriber or Harbour Specialist Worker, also applies to clients in receipt of non-controlled drug medication as part of their treatment. However the response process is different and not so acute since the risk of misuse of or dependency to these medications is substantially less.

14.2.2. These prescriptions are not usually collected from the pharmacy on a daily basis but a response to non-attendance still has to be made to ensure that it is safe to continue to prescribe and that re-engagement of the client occurs.

14.2.3 At the time of non-attendance, the client should be contacted to ascertain the reason for non-attendance. If the client cannot be contacted then the Harbour Specialist Worker will contact the pharmacy to enquire if medication is being regularly collected, if the client was aware of the appointment and if there are any welfare concerns.

14.2.4 A new appointment should be made with a letter sent to the client and a copy sent to their pharmacy, at which point the prescription can be put 'on hold' to encourage client attendance **provided** that delayed dose taking will not have a significantly detrimental effect on client well-being. This will need prior discussion with the prescriber.

14.2.5 If despite these measures the client continues not to attend, then the Harbour Specialist Worker will make assertive efforts to have contact with the client and re-engage them into their treatment. They will liaise with all other professionals or family involved in the client's care and may convene a professionals or risk meeting. Reduced pickup may help re-engage the client who can be supported more regularly by pharmacy staff.

14.2.6 If all reasonable efforts fail to re-engage a client then see section 17 (discontinuation of an ineffective and/or unsafe prescribing intervention) which describes the process for removing a prescribed intervention. The prescriber will advise on whether a tapered dose reduction is required (certain antidepressants and baclofen) rather than abrupt discontinuation.

14.2.7 Note that a client may choose to close a prescribing intervention - particularly with relapse prevention and adjuvant prescribing for alcohol disorders - yet continue with their psychosocial interventions with their Harbour Specialist Worker. If this is the case then the prescriber and medical secretary must be informed to stop further automated prescription generation and the client's reasoning recorded on Halo.

15. Screening for drugs and alcohol

15.1 Purposes of screening:

General:

- To promote safe prescribing by monitoring for illicit drug or alcohol use
- Support of Child Protection plan or Court ordered treatments only provided that testing is consistent with routine clinical practice.
- NOTE: Any drug or alcohol screening for court orders or Child Protection plans must be proportionate to the usual testing provided to clients in treatment.
- Test results from Derriford Hospital may be dismissed during legal proceedings due to the lack of a chain of custody.
- Staff undertaking the tests must be competent in performing the test and interpreting the results.
- Testers and prescribers should be satisfied that the test is accurate and fit for purpose before they undertake it and interpret the results.
- The choice of screen depends on the situation, the drugs being tested for and the cost.
- There is wide variation in the cost of drug screening and tests must be justified in terms of their clinical benefits.

FOR DRUG CLIENTS:

- Initial assessment to confirm use of illicit drugs/alcohol (at least 2 positive screens required before substitute prescribing).
- **Polydrug use is common but may not be shared hence the need to be professionally curious and substantiate the substance using history with evidence.**
- Initial and periodic breathalyser tests for alcohol should be considered with drug clients.
- To ensure that the client is taking their prescribed treatment by random urinalysis / OFT which must occur **at least every three months** or more frequently if clinically indicated.
- To manage the ending of supervised consumption.
- Part of assessment for Drug Rehabilitation placement.
- Drug testing to confirm on-top drug use when a patient has admitted it AND is already in treatment is generally not cost effective.

NOTE: “Opiate” screening - **which is clinically sufficient for the majority of screenings** - will detect a broad range of opiates including codeine, pholcodine, dihydrocodeine, hydrocodeine, morphine, 6-mono acetyl morphine (6- MAM), hydromorphone, morphine-3-glucuronide, oxycodone, nalorphine, acetylcodeine and dextromethorphan **BUT NOT THE SYNTHETIC OPIOIDS** (buprenorphine, methadone) used in substitution treatment – these must be specifically requested. If clinically indicated then the more specific screening for heroin using the OFT 6-MAM test can be used whilst avoiding the more expensive hospital laboratory Opiate Identification test.

FOR ALCOHOL CLIENTS:

- Clients attending exclusively for alcohol misuse treatment often do not undergo routine screening tests as part of their assessment and continuing care.
- Clients are using a single substance and their histories of drinking generally provide a reliable means on which to build an active care plan. Random screening results have much less value in marked comparison to work with drug clients.
- Alcohol screening will occur as part of treatment during the monitoring of a detox, as part of the assessment for adjuvant prescribing for alcohol use, or when there is concern for prescribing safety or for client well-being, when screening for drugs can also be added. In the latter situation blood tests are often useful.
- There is a value for some clients to use an alcohol breathalyser to gain a better understanding of the speed of effect or the exact levels of alcohol in the body so enhancing awareness of harmful effects. Negative breathalyser results can also be used as a contingency management approach to reward clients who achieve a period of abstinence.

15.2 Negative drug screening for prescribed medication

- If a “negative” result is obtained for a prescribed intervention then this must be discussed with a prescriber IMMEDIATELY.

- An urgent re-evaluation is required to rule out diversion, or whether a vulnerable client is being exploited, and whether to stop the prescription.

- If the client contests the result then this can be repeated with the best quality assurance coming from a urine sample tested in the Hospital Lab.

- Potential interactions with other medications need to be considered also that might give a false negative result. Consult the hospital biochemist for advice.

- A period of supervised consumption may be required if treatment is continued. If this was from an OFT then a urine screen can be undertaken, as the concentration may be higher. If this was from an instant test, then a lab test can be requested.

15.3 Types of screening

Oral fluid test (OFT) – Drug clients only

- An OFT sample is easier to collect and harder to adulterate than urine.
- However, drugs are present in lower concentrations than urine samples.
- Detection windows tend to be shorter.
- Should be used when sample adulteration is an issue.
- More cost-effective as a multiple rather than a single item screening

Urinalysis

- Ethanol (alcohol) levels may also be assessed using urinalysis but are expensive.

- The client cannot (usually) be observed while the sample is being collected which allows easier adulteration. Derriford labs routinely check urine samples for adulteration by measuring pH and the creatinine concentration.
- Methods to reduce the risk of adulteration include:
  - Giving the patient a pre-labelled sample pot before they give the sample and confirm it is the same pot on return of the sample.
  - Check the temperature (32.2°C-34.4°C) by hand touch.
  - Check urine creatinine level on sample - results below 1.8 mmol/L or 0.2 g/L suggest that the sample has been diluted.

Alcohol Breathalyser

- May be useful when staff need to have an instant result for monitoring and safety purposes.
- In general there is no "safe" alcohol reading and the management of clients with ongoing "problematic" alcohol use should involve regular liaison with the prescriber.
- A reading above 35 micrograms per 100mls or 0.35 g/l (current English legal alcohol limit for driving), regular positive breath tests or evidence of morning drinking episodes should be regarded as indicators for further discussions and re- evaluation of the safety of any existing prescribing.

16. Managing Drug Use or Alcohol Misuse 'On Top' of Opiate Substitution Treatment

16.1 DRUG CLIENTS USING DRUGS 'ON TOP' OF OPIATE SUBSTITUTION

'On top' use refers to a client's illicit consumption of either the same class of drugs or other classes of misused drugs, over and above their prescription.
This section should be read in conjunction with section 14 (Non-attendance)

- Try to ascertain whether use is in addition to the prescription or whether the client is trading their prescription for other illicit drugs or with vulnerable clients they are being coerced or taxed to hand over their prescription to others.

- Assess risk of heroin or opiate overdose and arrange supply of THN as appropriate.

- Clients starting a prescription for an opiate substitute (methadone or buprenorphine) aim to replace the heroin or other opiate use with their new (prescribed) substitute. Drug screening will detect whether this has been achieved. Buprenorphine doses of 12mg daily or more block on top opioid use due to its mixed antagonist/agonist drug effects.

- In the case of a diazepam prescribing it is not possible to differentiate illicit from prescribed treatment hence the great reservations in initiating such treatment.

The following actions or conditions may be incorporated into a structured plan:

1. Collaborative work with the client to eliminate the problem.

2. Reconsider the frequency of interval dispensing i.e. three times a week dispensing reduced to daily dispensing. Ask the pharmacy to inform the service of any missed doses.

3. Consider phased re-introduction of supervised consumption – see section 13 (Review of clients) and 14 (Non-attendance).

4. With methadone clients: If actions 1-3 above have not been successful consider increasing the dose **provided the client is motivated to cease on top use** and/or they report heroin use only to manage withdrawal symptoms. Clients who continue to use to experience the 'hit' or the drug effects are less likely to benefit from a dose increase.

5. Consider a transfer from methadone to buprenorphine. NOTE: This is not always a practical choice as clients in the community need to have reduced to methadone 30ml daily to transfer to buprenorphine 8mg daily to avoid excessive withdrawal symptoms. Supportive medication can be arranged for the transition if the client is not too chaotic.

6. Consider a brief admission to a residential or in-patient unit for stabilisation.

7. Consider prescription reduction: weekly reductions will usually be Methadone by 10ml, Buprenorphine by 2mg and Diazepam by 5mg.

8. Consider cessation - possibly as a therapeutic break for client to reassess their motivation to use a prescribed intervention with its conditions and expectations. See section 17.

9. In situations of significant risk then a **professionals or risk management meeting** (or sometimes a series of these) will need to be held and minuted in order to reach an appropriate decision regarding how to proceed. All relevant professionals, or their deputy, need to attend and the use of GP surgeries as a venue is to be encouraged to enhance primary care involvement. Referral to the multi-agency Creative Solutions Panel may also be considered to expand available options.

16.2 DRUG CLIENTS WITH PERSISTENT ALCOHOL MISUSE

- Heavy and often dependent drinking is a regular feature encountered by drug treatment services and constant vigilance is needed to detect the problem.

- Many clients are in denial about the dangers that alcohol poses to their health.

- Those with Hepatitis C infection are at higher risks of alcohol related complications.

Regular enquires should be made of alcohol intake at review appointments supplemented by alcohol testing by breathalyser.

- A detailed drinking history helps in assessing the scale of the problem and clients will be asked to keep drink diaries.

- Following assessment the client will be offered education on the dangers of drinking, advice on reducing their consumption and on-going support to maintain these changes. DoH recommendations are:

  Men and women are advised not to drink more than 14 units a week on a regular basis. Spread your drinking over three or more days if you regularly drink as much as 14 units a week. If you want to cut down, try to have several drink-free days each week.

- Concerns will be shared with the GP and all medication reviewed with regard to interactions, cautions and contraindications. Blood tests may add useful information.

- Adjuvant prescribing may be indicated (see section 27)

- If appropriate alcohol detox can be arranged either in the community or in a residential setting (as indicated by risk assessment). See Detoxification of Alcohol in community Policy. The Harbour Specialist Worker will discuss the case with the Detox team, arrange an MDT review and make the necessary referrals.

- Collaborative work with the client will aim to eliminate the problem of excessive alcohol use. Time conditions will be introduced by which the client will make changes, otherwise, in order to establish safe prescribing, their prescribed intervention maybe reduced or stopped. See section 17

- In situations of significant risk, then a professionals or risk management meeting (or sometimes a series of these) will need to be held and minuted in order to reach an appropriate decision regarding how to proceed. All relevant professionals, or their deputy, need to be in attendance, and the use of GP surgeries as a venue, is to be encouraged to enhance primary care involvement. Assess risk of heroin or opiate overdose and arrange supply of THN as appropriate. Referral to the multi-agency Creative Solutions Panel may also be considered to expand available options.

17. Discontinuation of ineffective and / or unsafe prescribing interventions

Prescribing may come to an end for a number of reasons such as:

- continued and problematic illicit drug misuse or alcohol consumption despite multiple attempts to reduce these risks
- risks and safety concerns for the client or others (including staff)
- insufficient commitment towards care planned recovery goals rendering a

place in treatment unjustifiable
- unacceptable breach of prescribing contract
- prescription fraud
- persistent non-attendance at review appointments

- A therapeutic discharge – a time limited, organised disengagement from treatment – may assist a client to find motivation to seek treatment afresh in the future.

- At the onset of treatment the client should be made aware of the circumstances in which the prescription could be discontinued (Plymouth Medication for Recovery Agreement)

- When prescription discontinuation is considered, the situation should be discussed between the client, the prescriber and the Harbour Specialist Worker.

- Unless there is a clear safety risk to the client or others, a reformulation of treatment goals should be considered.

- The client should be kept informed of all concerns and professional discussions, so that they are fully aware of the process and possible consequences.

- The decision to discontinue a prescription requires that a balanced and measured approach is taken weighing up the benefits and risks to the individual and their family.

- If the prescription is stopped then, except in extreme circumstances (e.g. violent behaviour towards staff), the Harbour Specialist Worker will continue to try to engage the client in a meaningful way.

- The client must still be encouraged to access harm reduction services such as the needle exchange.

- All decisions to end prescribing should be communicated to the client's GP (if not already involved as a prescriber) and their dispensing pharmacy.

- When there is a disagreement between a client and the team over prescribing, then all efforts to negotiate a new treatment agreement will be made including assistance from other professionals. If agreement cannot be reached to continue a prescribed intervention then a unilateral decision to reduce or stop a prescription may result. The client retains their right to follow the organisation's Complaints Policy when a further review will occur.

18. Driving

18.1 General

It is the duty of the licence holder to notify the DVLA of any condition which may affect safe driving. This includes any use of illicit drugs or misuse of prescription drugs.

The DVLA is then legally responsible to decide if a person is medically fit to drive or not and determine any restrictions.

- Advice regarding drinking alcohol and drugs, together with the responsibility to inform DVLA, will be provided to all clients and recorded in the Halo record.

- Clients should be advised:

    - Not to drive if they develop any signs or symptoms suggesting that their driving may be impaired, such as experiencing sleepiness, poor coordination, impaired or slowed thinking, dizziness, or visual problems.
    - Not to drive at certain times when the risk may be temporarily increased, for example, when first starting, or when first increasing or reducing the dose of, a medicine that may potentially impairi their driving.
    - To take particular care in circumstances that may increase the risk of their driving being impaired whilst taking their medicine, and to avoid driving if this occurs.

- In addition to DVLA notification, clients are also required to inform their insurance company of their condition.

18.2 Driving under the influence of alcohol or drugs

- It is illegal to drive while ability to do so is impaired by drugs (whether illicit or prescribed).
- The police have powers to stop and test any driver who they suspect to be driving under the influence of certain drugs.
- For certain prescribed medications (including methadone and diazepam) there is now a threshold level which it is acceptable for drivers to have in their blood ONLY if:
    - Driving is not impaired

      AND
    - These medications are taken in accordance with instructions from a healthcare professional.
- Clients may therefore wish to carry evidence that they are prescribed the drugs in question.

18.3 Informing the DVLA

- All drivers are legally required to notify the DVLA of any disability likely to affect safe driving. This includes all clients with:
    - Persistent alcohol misuse
    - Alcohol dependence
    - Alcohol related disorders (e.g. hepatic cirrhosis with chronic encephalopathy, alcohol induced psychosis, cognitive impairment)
    - Drug misuse or dependence (including prescribed use of benzodiazepines above BNF limits)
    - Seizures associated with alcohol or substance use

- The prescriber and/or key worker must inform all clients currently holding a driving license that their condition may affect their ability to drive and that they (the client)

are legally required to inform the DVLA about their condition. The client should be issued with a DVLA notification leaflet (See Appendix M) and the conversation must be clearly documented in the Halo record.

- Notification questionnaires can be found on the DVLA website at https://www.gov.uk/health-conditions-and-driving . It is the client's responsibility to complete the questionnaire and to post it to the DVLA.

- Further details on what level of dependency/abuse constitutes a requirement to notify the DVLA can be found in the DVLA guidance for medical professionals. Under GMC guidance, if a client refuses to accept that their condition requires DVLA notification, clinicians can suggest they seek a second opinion (and should help them to do so). Clients should be advised not to drive until the second opinion has been obtained.

- If the client does not inform the DVLA and continues to drive, every reasonable effort should be made to persuade them to stop. As long as the client agrees, concerns may be discussed with family, friends or carers.

- If it becomes clear that the client is continuing to drive contrary to advice, relevant clinical information should be passed immediately, in confidence, to the DVLA. Whenever possible the client should be informed of this decision before giving information to the DVLA. Once the DVLA has been informed the client should have confirmation, in writing that a disclosure has been made.

- Once the client has submitted the notification questionnaire, the DVLA will undertake an assessment of the client's medical condition. In some cases the DVLA will need to contact Harbour services (usually the prescriber) for further information or conduct their own independent medical assessment but this does not occur in every case.

- During the assessment period the DVLA states that clients may continue to drive provided the medical condition they have declared on their application doesn't stop them from driving. If in doubt, clients are advised to discuss their fitness to drive with their prescriber who should follow advice in the DVLA guidance for medical professionals. In the majority of scenarios, this guide will indicate that the client should not drive. Further information can be found at https://www.gov.uk/government/publications/inf1886-can-i-drive-while-my-application-is-with-dvla.

- Following assessment, the DVLA will decide one of the following:
    - The client needs to get a new driving license
    - The client can have a shorter licence – for 1, 2, 3 or 5 years
    - The client must stop driving and give up their licence immediately

- Where the DVLA has revoked the driving license, clients will be able to re-apply following a designated time period. Reinstatement of their driving license will be dependent on the client meeting a number of criteria. Details of standard requirements can be found in the DVLA guidance for medical professionals however the DVLA will issue specific advice for each client.

- For clients with opiate dependency, the DVLA will only approve driving licenses for clients under oral treatment (including oral substitution therapy with methadone or buprenorphine). Licenses will not be granted for those under parenteral treatment such as diamorphine. Further details are listed in the DVLA guidance for medical professionals.

- Should a client disagree with a DVLA decision to revoke their driving license, they can contact the DVLA directly. Full details are available at https://www.gov.uk/driving-medical-conditions/what-dvla-will-decide however, the client will need to provide proof that they meet the required standards for driving. Decisions can also be appealed via the local magistrate's court, however this must be raised within 6 months and the DVLA must be informed of this decision.

- In addition to DVLA notification, clients are also required to inform their insurance company of their condition.

19. Medication/Prescribing Incidents and Errors

- All staff should ensure that incidents and errors (including near misses) are reported as per the LSW Medicines Policy and the LSW Incident Reporting and Investigation Policy and Procedure.

- Incidents involving controlled drugs should be reported to the LSW CD Accountable Officer for Controlled Drugs (currently the Clinical Director of Pharmacy).

20. OPIOID SUBSTITUTION TREATMENT (OST)

- Aim: to establish the patient on a dose that prevents withdrawal, reduces craving and supports the total cessation of illicit opiate use.
- Starting opioid substitution is never an emergency.
- Confirm drug screen results are appropriate and within 2 weeks of planned initiation, or that the prescriber is clear that the patient is opiate dependent.
- Assess risk of heroin or opiate overdose and arrange supply of THN as appropriate.
- The care plan for opioid substitution should be formulated with the client before the prescription is started.
- Ensure client is aware of risk of overdose, especially if used in combination with other opioids, or sedative drugs.
- The treatment options include methadone, buprenorphine and naltrexone.
- There is a historical cohort of patients who is under review in Plymouth currently prescribed diamorphine. These prescriptions are under review and no new prescriptions of injectable opioid treatments for substance misuse will be started for Plymouth patients. Patients on injectable opioid treatments moving to Plymouth will have their treatment needs assessed on a case by case basis. There is no expectation that their injectable opioid treatments will continue, if this is not in the patients best treatment interests, as assessed by senior clinicians. Any decision to take over prescribed opioid injectables will be agreed by clinicians and commissioners,

prior to treatment commencing

The use of opioids can be fatal.
Opioid withdrawal however is not fatal.

In a **non-medical setting**, opioid overdose can be reversed by:

NALOXONE intramuscular *injection* (into deltoid region or anterolateral thigh) Adult dose: 400 micrograms repeated at intervals of 2–3 minutes (in subsequent resuscitation cycles if patient not breathing normally) until consciousness regained, breathing normally, medical assistance available, or contents of syringe used up.

20.1 Choice between methadone and buprenorphine

Factors to consider:

- an estimate of the risks and benefits of each treatment, made by the prescriber in conjunction with the client
- client's commitment to a particular long-term management strategy
- client's preference
- previous treatment history
- whether a sedating (methadone) or less sedating (buprenorphine) opioid would be advantageous
- Clients with a history of major trauma or severe and enduring mental illness often prefer methadone
- Buprenorphine is safer in overdose
- The opioid receptor blockade effects of buprenorphine may be beneficial in some clients

Methadone is cheaper than the equivalent dose of buprenorphine so should be considered as first line if the two drugs are otherwise equally suitable.

20.2 Pain relief for clients on substitute opioids

- Clients should not be denied adequate analgesia because they are on an opioid substitution prescription.
- Always consider non-pharmacological interventions for pain, especially chronic pain.
- For mild to moderate pain use non-opioid analgesics.
- For severe acute pain for clients on methadone an opioid analgesic can be used IN ADDITION to the regular methadone dose. Titrate the dose of the analgesic to the client's pain. Monitor respiratory function. Do not use sub-therapeutic doses of analgesia.
- For severe acute pain for clients on buprenorphine, particularly high doses of

opioid analgesia may be required to overcome the antagonist effects. This requires close monitoring of respiratory function and other CNS depression. Titrate the dose of the analgesic to the client's pain. The opioid analgesia should be discontinued over 36-72 hours.

- It may be necessary to convert a client on buprenorphine to an equivalent dose of methadone so that appropriate opioid analgesia can be administered.
- Further advice can be sought from the Pain Clinic at Derriford Hospital.

21. Methadone (including QTc Monitoring)

- Clients can be given a copy of the "Methadone handbook" (available from Exchange Supplies).

21.1 Methadone Use

- As an adjunct to a package of psychosocial intervention in the management of opioid dependency.

21.2 Methadone Formulations

In Plymouth methadone hydrochloride **sugar-free** oral solution 1mg/1ml is the formulation of choice. Methadone 10mg/ml should NOT be used

- Methadone hydrochloride oral solution 1mg/ml (sugared) may be used in exceptional circumstances.

- Methadone tablets are not licensed for the treatment of opioid dependence and should not normally be prescribed for this indication. They can be used following an appropriate risk assessment in special circumstances e.g. holiday prescription where flying is involved and liquid preparations are not acceptable.

- Methadone injection may be prescribed by specialist services only (note that not all strengths are licensed for opioid dependence).

21.3 Methadone Contra-indications and Cautions

- Refer to current BNF or manufacturer's SPC (www.medicines.org.uk) for full details of contra-indications and cautions.

21.4 Methadone Absolute contra-indications

- client with **no** established opioid dependence
- allergy or proven intolerance to methadone or any of the excipients
- Phaeochromocytoma (adrenal gland tumour)
- risk of paralytic ileus (obstruction of the intestine due to paralysis of the intestinal muscles)
- head injury / raised intracranial pressure
- do not use concurrently or within 2 weeks of stopping MAOI (monoamine oxidase inhibitor) - risk of CNS hyper- excitation

21.5 Methadone Relative contra-indications and cautions

- Under 18 years old – specialist use only (see section 38)
- Pregnancy and breastfeeding – see section 33 and 34.
- Respiratory disease – use with caution.
- Avoid in acute respiratory depression
- Hepatic disease (see section 36)
- Convulsive disorders as all opiods lower the seizure threshold
- Renal disease (see section 35)
- History of cardiac arrhythmia or abnormal ECG, family history of sudden death
- Risk of QT prolongation and torsade de pointes. ECG monitoring required (see section 19.7 below)
- Alcohol dependence
- Hypotension
- Urethral stenosis
- Shock
- Myasthenia gravis (a rare condition causing muscle weakness)
- Prostatic hypertrophy
- Obstructive or inflammatory bowel disorders
- Diseases of the biliary tract and convulsive disorders
- Elderly or debilitated patients (see section 37)
- Hypothyroidism – reduced dose recommended
- Adrenocortical insufficiency – reduced dose recommended

21.6 Methadone Adverse effects

- Side effects are generally the same as for other opioids
- Refer to current BNF (http://www.evidence.nhs.uk/formulary/bnf/current) or manufacturer's SPC (www.medicines.org.uk) for full list
- Before starting treatment inform patients about relevant side-effects
- Advise patients to seek advice for any side-effects that are troubling them
- Ask about side-effects at each prescription review (as a minimum)

21.7 Methadone Risk of QT_c prolongation

- The QT interval is a measure of the time between the start of the Q wave and the end of the T wave in the heart's electrical cycle. The QT interval represents electrical depolarization and repolarization of the ventricles
- Prolongation of the QT interval can lead to ventricular arrhythmias, including a life threatening ventricular arrhythmia known as torsades de pointes which can result in sudden cardiac death.
- Risk assessment for QT_c prolongation should be carried out prior to initiation
- Factors increasing the risk of QT_c prolongation include:
    - cardiac disease
    - liver disease
    - electrolyte disturbances
    - concomitant treatment with CYP3A4 inhibitors (see table below)
    - taking combinations of drugs that can prolong the QT_c interval (including, but not limited to: citalopram, escitalopram, most

antipsychotics, lithium, erythromycin, clarithromycin, methadone, cocaine)
    - doses of methadone greater than 100mg/day (include those for whom you expect to require this)
- Obtain a baseline ECG for any client with any of these risk factors before treatment with methadone
- Obtain an ECG for any client who develops any of these risk factors during methadone treatment.
- Explain the risk to the client and the reasons for the risk assessment / ECG.
- Repeat ECG annually unless there are new risk factors or the client develops cardiac symptoms (in which case repeat as clinically indicated).
- In all circumstances discuss with the client
- Consider buprenorphine if there are cardiac concerns
- **NOTE:** transfer to buprenorphine is probably of little value as requires methadone dose to be reduced to 30ml daily.

QT_c	**Action**	**Refer to cardiologist**
<440ms (male) <470ms (female)	Upper range of normal QT No action necessary [c] unless abnormal T-wave morphology	Consider if doubt
440-500ms (male) 470 - 500ms (female)	Consider reducing dose or switching to drug of lower effect; repeat ECG	Consider
≥500ms	Repeat ECG. Stop suspected causative drug(s) and switch to drug of lower effect	Immediately
Abnormal T-wave morphology	Review treatment. Consider reducing dose or switching to drug of lower effect	Immediately

(From the Maudsley Prescribing Guidelines in Psychiatry 13th edition)

21.8 Methadone Drug interactions

- All patients including patients receiving a prescription for **benzodiazepines** should be advised of the risks of concomitant use of other CNS depressants (see below) including “on-top” use of illicit opiates and benzodiazepines and alcohol.
- Methadone is metabolised primarily through the CYP3A4 enzyme so drugs that inhibit or induce this can be expected to affect levels.
- Buprenorphine is less affected.
- Interactions with anti-retrovirals (for HIV infection) are complex. The substance misuse prescriber should liaise with the specialist clinician in HIV medicine for any client prescribed these medications.

Drugs that may **increase plasma level of methadone**	**Hepatic enzyme (CYP3A4) inhibitors:** some anti-retrovirals, macrolide antibiotics (e.g. erythromycin),

↑ dose effect and overdose risk Consider reducing methadone dose	cimetidine, ciprofloxacin, fluconazole, ketoconazole, fluvoxamine, possibly fluoxetine
	Drugs that displace methadone from plasma proteins: cimetidine, phenytoin
	Urinary alkalinisers: e.g. sodium bicarbonate, sodium citrate
Drugs that may **decrease plasma level** of methadone	**Hepatic enzyme (CYP3A4) inducers:** some antiretrovirals, rifampicin, phenytoin, phenobarbital, carbamazepine
↓ dose effect and risk of withdrawals **Consider increasing methadone dose**	**Urinary acidifiers:** e.g. ascorbic acid
Drugs that have **additive effects** with methadone	Benzodiazepines, alcohol and other CNS depressants
	MAOIs – concurrent use is contra-Indicated, or within 14 days of stopping MAOI
	Drugs that increase the **risk of QT prolongation** (see above)
Methadone's effects on **other drugs**	**May increase plasma level of:** Zidovudine
	May reduce GI motility

This table is not exhaustive. Refer to current BNF or manufacturer's SPC (www.medicines.org.uk) for full details of all drug interactions.

21.9 Methadone Dosing

- The rate of initiation will be a balance: too quickly and there is a risk of overdose, too slowly there will be excessive withdrawal symptoms and risk of on-top use or drop- out from treatment.
- From an initial low dose the optimal dose should be reached safely and as quickly as possible
- Starting dose: 10-40mg daily **based on amount of opiates being used**, if tolerance is low or uncertain start with 10-20mg daily.
- Increases of 5-10mg per day, with a maximum of 30mg a week for the first two weeks.
- It takes 4-5 days for the plasma level to reach steady state after each dose increase
- Maintenance dose in the range of 60-120mg daily (the best evidence of

positive outcomes).

- Some examples of initiation regimes:

    - **Methadone 1mg/ml Mixture from 20 to 40ml daily.**
      Day 1: 20ml; Day 2: 30ml; Day 3 onwards: 40ml daily.

    - **Methadone 1mg/ml Mixture from 40 to 80ml daily.**
      Day 1: 40ml; Day 2: 50ml; Day 3: 60ml daily; Days 4-7: 70ml;
      Day 8 onwards: 80ml daily.

- **The ideal dose is achieved when the client reports feeling comfortable (no withdrawal symptoms) and is no longer using illicit opiates**
- Opiate withdrawal symptoms include feeling sick, muscle cramps, feeling cold, pounding heart, muscular twitching/spasms/tension, aches and pains, yawning, runny eyes, sleep problems.
- Refer to appendices D and E for opioid withdrawal scales that can be used to assess whether dose is adequate.
- Stay on optimal (maintenance) dose until completely stopped using illicit opioids, then consider planned withdrawal.

21.10 Methadone Supervised consumption / Frequency of dispensing

- Administration should be administered as supervised doses (in the client's chosen pharmacy) at commencement of prescribing until stability is evidenced by screening results and client engagement in their care plan.
- Supervised consumption should be extended if stability is not achieved to ensure safe prescribing.
- Subsequently clients can move to 3 times weekly, then 2 times weekly, then once weekly pick-up in a progression based on their recovery. This should be reflected in the client's care plan.
- If there are signs of relapse the frequency of pick-up should be increased.
- See also section 16 (Managing use 'on top' of a prescribed intervention)

21.11 Methadone Split doses

- Split doses (i.e. two doses in one day) can be helpful for certain clients who may experience withdrawal symptoms before the next dose is due. This may include (but is not necessarily limited to):

    - taking enzyme inducing medications (see table above)
    - suffer with a chronic pain condition
    - pregnancy (especially third trimester)

- If split doses are suitable, review whether supervised consumption needs to continue.
    - If so the main part of the dose should be supervised and a smaller dose given to take home
    - the prescription instructions must be clear (i.e. what is to be supervised and what is to take home). Note that this will incur two dispensing charges.

21.12 Methadone Detoxification or Therapeutic discontinuation

- Provide the client with information about full detoxification options
- It is possible to reduce the daily methadone dose to 30mg and then transfer to buprenorphine 8mg daily, from which it may be easier to complete detoxification
- Consider clonidine detoxification (see section 25)
- A typical reduction could be 5mg every 1-4 weeks to 30mg daily, then reducing 2mg increments every 1-4 weeks.
- Faster initial reduction possible
- Slower reduction if preferred by the client
- Slow down or suspend reduction if client experiencing difficulties
- Commonly about 12 weeks to reduce to zero

21.13 Methadone Relevant clinical pharmacology and pharmacokinetics

Receptor effects	Full agonist at μ (mu) receptors
Time to peak plasma level	1-5 hours after oral dose
Time to steady state	5 days
Elimination half life	25 hours

22. Buprenorphine (including Suboxone and Espranor)

22.1 Buprenorphine Use

- As an adjunct to a package of psychosocial intervention in the management of opioid dependency.

- Suboxone® is a compound preparation of buprenorphine plus naloxone. It can be considered (by specialist services) in preference to buprenorphine alone if there is a risk of the client snorting or injecting buprenorphine and doses cannot be supervised at the pharmacy. As it is significantly more expensive, rationale for use must be clearly justified.

- Buprenorphine is now available as a lyophilisate which has a different absorption to sublingual tablets. Lyophilisates must be placed on the tongue and allowed to dissolve. This has advantages where clients have issues with using sublingual tablets or there are concerns about clients under supervised consumption diverting sublingual tablets (they dissolve very quickly). They are often used for buprenorphine clients in prison.

- Buprenorphine lyophilisates are only available as the Espranor brand. Espranor is more expensive than sublingual buprenorphine. However, there may be periods where Espranor can be prescribed under a rebate scheme with the manufacturer. Standard prescribing of Espranor in place of sublingual buprenorphine should only occur when

approved as routine practice by the Clinical Lead. Outside of this, Espranor can be prescribed in exceptional cases but rationale must be justified and clearly documented.

- Sublingual buprenorphine and Espranor lyophilisates have different bioavailability. As such, they may not be used interchangeably and dose adjustments may be required following intentional switches between them. See below for more information.

22.2 Buprenorphine Formulations

- Buprenorphine 8mg, 2mg, 400microgram and 200microgram SUBLINGUAL tablets
- Suboxone 2mg/500microgram and 8mg/2mg SUBLINGUAL tablets
- Espranor 2mg and 8mg LYOPHYILISATE tablets

22.3 Buprenorphine Contra-indications and Cautions

Refer to current BNF or manufacturer's SPC (www.medicines.org.uk) for full details of contra-indications and cautions.

Absolute contra-indications

- client with **no** established opioid dependence
- allergy or proven intolerance to the active ingredient or any of the excipients
- severe hepatic insufficiency

Relative contra-indications and cautions

- Under 18 years old – specialist use only (see section 38)
- Pregnancy and breastfeeding see sections 33 and 34
- Respiratory disease – use with caution.
- Avoid in acute respiratory depression
- Hepatic disease – (see section 36)
- Renal disease (see section 35)
- Alcohol dependence
- Hypotension
- Urethral stenosis
- Shock
- Myasthenia gravis
- Prostatic hypertrophy
- Obstructive or inflammatory bowel disorders
- Diseases of the biliary tract and convulsive disorders
- Elderly or debilitated patients – reduced dose recommended
- Hypothyroidism – reduced dose recommended
- Adrenocortical insufficiency – reduced dose recommended
- Convulsive disorder as it reduces the seizure threshold

22.4 Buprenorphine Adverse effects

- Side effects are generally the same as for other opioids
- Refer to current BNF or manufacturer's SPC (www.medicines.org.uk) for full list.

- Before starting treatment inform patients about relevant side-effects
- Advise patients to seek advice for any side-effects that are troubling them
- Ask about side-effects at each prescription review (as a minimum)
- Allergic reactions may occur due to the presence of sunset yellow (E110) in some generic tablets. These clients may be prescribed branded as Subutex, or GabUp (whichever has the lowest cost).

22.5 Buprenorphine Drug interactions

- All patients including patients receiving a prescription for **benzodiazepines** should be advised of the risks of concomitant use of other CNS depressants including "on-top" use of illicit opiates and benzodiazepines and alcohol.

Interaction	Interacting Drugs
Drugs that may **increase plasma level** of buprenorphine **↑ dose effect and overdose risk. Consider reducing buprenorphine dose.**	**CYP3A4 hepatic enzyme inhibitors:** • Interactions with strong inhibitors (clarithromycin, azole antifungals plus others)
Drugs that may **decrease plasma level** of buprenorphine **↓ dose effect and risk of withdrawals Consider increasing buprenorphine dose**	**CYP3A4 hepatic enzyme inducers** • e.g. some antiretrovirals, rifampicin, phenytoin, phenobarbital, carbamazepine. • This is theoretical and may have less clinical significance than for enzyme inhibitors.
Drugs that have **additive effects** with substitute opioid	Benzodiazepines, alcohol and other CNS Depressants

This table is not exhaustive. Refer to current BNF or manufacturer's SPC (www.medicines.org.uk) for full details of all drug interactions

22.6 Buprenorphine Dosing

- Delay first dose until client is experiencing symptoms of opioid withdrawal (preferably 12 hours after last heroin use or 24 - 48 hours after last methadone dose). This is to reduce the risk of causing precipitated withdrawal.
  (Note for Suboxone, the following refer to the buprenorphine content).
- Espranor lyophilisates have a different bioavailability to sublingual buprenorphine. When switching from one to the other the manufacturer recommends dose adjustments. Local experience is that straight dose swaps are usually tolerated but close monitoring is advised.

Sublingual buprenorphine (including Suboxone):

- Typically start with 4mg daily (can use up to 8mg daily as initiation dose for high use opioid misusers).
- Dose increases of 2-4mg daily
- Examples of initiation regimes:

Buprenorphine from 2 to 8mg daily.
Day 1: 2mg supervised; Day 2: 4mg supervised; Day 3 onwards: 8mg supervised daily

Buprenorphine from 8mg to 16mg daily.
Day 1: 4mg supervised + 4mg takeaway; Day 2: 12mg supervised; Day 3 onwards: 16mg supervised daily.

For "low level" opiate (including codeine or dihydrocodeine) dependency
Day 1: 2mg supervised; Day 2 onwards: 4mg supervised daily

- Maintenance dose of 8-32mg daily (For Suboxone, maximum of 24mg daily (of buprenorphine)).

Espranor Lyophilisates:

Initiation therapy (induction):
2mg Espranor Lyophilsate. An additional one to two Espranor 2mg oral lyophilisates may be administered on day one depending on the individual client's requirement.

Dosage adjustment and maintenance:
Can be titrated up or down in steps of 2-6mg until the minimum effective maintenance dose is achieved.
The maximum single daily dose of Espranor is 18 mg

Less than daily dosing:
Stabilised patients can be decreased to dosing on every other day. The daily dose should be doubled with no doses given on the day in-between. E.g. currently on 8mg daily could receive 16mg on alternate days.
Treatment can be further decreased to 3 times a week. This should be a Monday, Wednesday and Friday – Monday and Wednesday dose should be twice the previous daily dose and Friday dose should be three times the previous daily dose (each dose must not however be higher than 18mg). E.g. currently on 6mg daily could receive 12mg on Monday and Wednesday and 18mg on Friday.
N.B. Clients Patients requiring > 8 mg/day may not find this regimen adequate.

- Due to its partial agonist effect 12-16mg daily blocks the effect of heroin & other opiates if used "on-top".
- Opiate withdrawal symptoms include feeling sick, muscle cramps, feeling cold, pounding heart, muscular twitching/spasms/tension, aches and pains, yawning, runny eyes, sleep problems, so when these are absent it is indicative of an adequate dose being achieved.

- Refer to appendices D and E for opioid withdrawal scales that can be used to assess whether dose is adequate.
- Stay on optimal (maintenance) dose until completely stopped using illicit opioids.
- Following dose stabilisation reduce dose at a rate to suit the client.
- When switching clients to Espranor, ensure they are aware of how to take it (place on the tongue and allow to dissolve).

22.7 Buprenorphine Supervised consumption / Frequency of dispensing

- Buprenorphine administration could be administered as supervised doses (in the client's chosen pharmacy) until stability is evidenced by screening results and client engagement in their care plan.
- Supervised consumption could be extended if stability is not achieved to ensure safe prescribing.
- Subsequently clients can move to 3 times weekly, then 2 times weekly, then once weekly pick-up in a progression based on their recovery. This should be reflected in the client's care plan.
- If there are signs of relapse the frequency of pick-up could be increased.
- See also Section 16 (Managing use 'on top' of a prescribed intervention)

22.8 Buprenorphine Discontinuation

- Generally 2-4mg every 2 weeks
- Work collaboratively with the client to reduce the dose and pace of reduction as clinically indicated
- Slower reduction if preferred by the client
- Slow down or suspend reduction if client experiencing difficulties
- May need to change to 400 microgram tablets once reduced to 2mg (for clients on Espranor, treatment will need to be changed to sublingual buprenorphine).

22.9 Buprenorphine disengagement from minimum acceptable prescribing reviews

- Consider a reduction rate of by 2mg weekly
- Can be stopped abruptly if clinical risk demands. Consider the high risk of opiate relapse and other potential consequences when making this decision.

22.10 Buprenorphine Relevant clinical pharmacology and pharmacokinetics

Receptor effects	Partial agonist at μ (mu) receptors Weak antagonist at κ (kappa)
Time to peak plasma level	90-150 minutes after sublingual dose
Time to steady state	5-8 days
Elimination half life	20-37 hours

23. Naltrexone for opiate abstinence

23.1 Naltrexone Use

- Aid to abstinence in former opioid dependent clients
- Aid to abstinence in former alcohol dependent clients (unlicensed use but approved by NICE – see section 29)
- Potential groups for naltrexone treatment include:
  - Clients who want to achieve abstinence as a treatment goal
  - Clients currently abstinent but who are afraid of relapse. Need to have been opiate-free for the preceding 7-10 days

23.2 Naltrexone Formulations

- Naltrexone Hydrochloride 50 mg Film-coated Tablets

23.3 Naltrexone Contra-indications and Cautions

- Refer to current BNF or manufacturer's SPC (www.medicines.org.uk) for full details of contra-indications and cautions.

23.4 Naltrexone Contra-indications

- Any current use of opioids (prescribed or illicit) - it is essential that the client is counselled on the risk of using opioids along with naltrexone
- Hypersensitivity to naltrexone hydrochloride or to any of the excipients in the tablets
- Severe renal impairment
- Severe hepatic impairment
- Acute hepatitis
- Positive screening result for opioids or after failure of the naloxone provocation test

23.5 Naltrexone Cautions

- Impaired (not severe) renal impairment (see section 35)
- Impaired (not severe) hepatic impairment (see section 36)

23.6 Naltrexone Adverse effects

- Refer to current BNF or manufacturer's SPC (www.medicines.org.uk) for full list
- Before starting treatment inform patients about relevant side-effects
- Advise patients to seek advice for any side-effects that are troubling them
- Ask about side-effects at each prescription review (as a minimum)

23.7 Naltrexone Drug interactions

- Opioids: including (but not limited to) methadone, buprenorphine, diamorphine, morphine, codeine, tramadol
- Concomitant use will result in opioid withdrawal symptoms
- High doses of opioids in combination with naltrexone can lead to life-

threatening opioid overdose from respiratory and circulatory impairment.

- Acamprosate: naltrexone significantly increases plasma level of acamprosate
- Data on interactions with other medicinal products is lacking (no interaction studies)
- No known interaction with alcohol
- This list is not exhaustive. Refer to current BNF or manufacturer's SPC (www.medicines.org.uk) for full details of all drug interactions

23.8 Naltrexone Monitoring

- Monitor liver function tests before and 3 monthly during treatment

23.9 Naltrexone Dosing

- Should be initiated by a specialist in the field of substance misuse, but on-going treatment may be managed by a general practitioner.
- For previously opioid dependent patients, naltrexone must only be started when at least 7- 10 days opiate free (as demonstrated by negative urine sample for opioids)

Typical wash out periods

Opioid	Wash out period
Methadone	Up to 10 days
Heroin	Up to 7 days
Buprenorphine	Up to 7 days (only 2-3 days if dose < 2mg for 2 weeks or less)

- 25mg on Day One and Day Two (half a 50mg tablet)
- Advise the client to remain on the premises following the first dose for 30-60minutes in case of withdrawal problems
- Then 50mg daily (if no withdrawal symptoms with first dose)
- The total weekly dose (350 mg) may be divided and given on 3 days of the week for improved compliance (e.g. 100 mg on Monday and Wednesday, and 150 mg on Friday)

23.10 Naltrexone Discontinuation

- Consider an initial treatment period of 3 months before planned stopping, however longer may be required.
- Consider discontinuing treatment if there is evidence of opioid (ab)use.

23.11 Pain relief for clients taking naltrexone

- Opioid based analgesia should not routinely be prescribed. There are no anticipated problems with paracetamol or non-steroidal anti-inflammatory drugs.

- Before minor or intermediate elective surgery:
  - Discuss with client, community drugs team and surgical team
  - Discontinue Naltrexone 48-72 hours before the procedure if opiate pain relief is considered to be necessary.

- Before major surgery: As above but discontinue oral Naltrexone 72 hours beforehand.

- For unexpected severe pain (e.g. trauma or emergency surgery): Use non-opioids such as intravenous paracetamol.

23.12 Naltrexone Relevant clinical pharmacology and pharmacokinetics

Receptor effects	Competitive opioid antagonist, mainly at μ (mu) receptors in the brain
Time to peak plasma Level	1 hour
Metabolism	Extensive first-pass metabolism to the active metabolite beta-naltrexol
Elimination half life	Naltrexone: 4 hours Beta-naltrexol: 13 hours (major metabolite)
Long duration of action	

24. Take Home Naloxone (THN) Procedure

Injected Naloxone from a pre-filled syringe has the potential to save life in the case of opiate overdose so needs to be readily available. Commonly, this is used for IV heroin overdose but can be used for all opiate overdoses. Schemes have been developed in Scotland and Wales to increase availability for friends and family of all opiate injectors to receive training and easy access to naloxone. For the local provision refer to Appendix L for the Standard Operating Procedure for supply of naloxone to clients for use in overdose.

25. Clonidine

25.1 Clonidine Use

- Used for symptomatic relief of symptoms of opioid withdrawal. It is used after buprenorphine to complete an opiate detox.
- This is an off-license use of clonidine. Practice had been locally agreed following the discontinuation of lofexidine. Prescribers should follow

guidance for using unlicensed medicines (Refer to LSW Medicines Policy). In particular the client and any staff involved in administration of clonidine must be informed that this is an off-license use.
- Clients require close monitoring due to risks of hypotension and bradycardia.
- Additional supportive medications should be used (see appendix J and LSW Detox Policy).

25.2 Clonidine Contra-indications and Cautions

- Refer to current BNF or manufacturer's SPC (www.medicines.org.uk) for full details of contra-indications and cautions.

25.3 Clonidine Contra-indications

- Known allergy to clonidine or any of its excipients (see SPC for complete list).
- Clients under 16 years old.
- Severe bradyarrhythmia resulting from either sick-sinus syndrome or AV block of 2nd or 3rd degree

25.4 Clonidine Cautions

- **Caution in use with 16-18yrs old.**
- Pregnancy and breast-feeding (see section 33 and 34)
- Severe heart disease (including heart failure), recent myocardial infarction, cerebrovascular disease
- Mild to moderate bradyarrhythmia
- Renal impairment (see section 35)
- Hepatic impairment (see section 36)
- Clients who use CNS depressants excessively, chaotically, in binges or in other dangerous ways
- History of depression (only likely to be a problem if lofexidine is used long term) – monitor for worsening or recurrence of symptoms
- Constipation
- Polyneuropathy
- Raynaud's syndrome or other occlusive peripheral vascular disease

25.5 Clonidine Adverse Effects

- Refer to current BNF or manufacturer's SPC (www.medicines.org.uk) for full list of adverse effects
- Before starting treatment inform patients about relevant side-effects
- Advise patients to seek advice for any side-effects that are troubling them
- Ask about side-effects at each prescription review (as a minimum)
- The adverse effects of clonidine are primarily related to its central alpha- adrenergic agonist effects and comprise drowsiness and related symptoms and dryness of mucous membranes especially mouth, throat and nose. Patients should be advised not to drive or operate machinery if drowsiness occurs.
- Common or very common adverse effects reported in the BNF include constipation, depression, dizziness, dry mouth, fatigue, headache, nausea, postural hypotension, salivary gland pain, sedation, sexual dysfunction, sleep disorders, vomiting.
- Adverse effects including rapid rise in blood pressure can occur if abruptly

discontinued (see below).

25.6 Clonidine Bradycardia and hypotension

- There is a risk of hypotension and bradycardia with clonidine treatment, tolerance to this effect usually develops rapidly.
- Blood pressure and pulse should be measured:
  - If there are concerns regarding past hypotension.
  - Twice on the first day.
  - At least daily while clonidine dose is being titrated up
  - In the presence of clinical signs of hypotension (dizziness and light-headedness)
- If blood pressure falls below 90/60mmHg, omit or delay increasing clonidine dose until blood pressure returns to above this level.
- If pulse falls below 60bpm, omit or delay increasing clonidine dose until pulse increases to above 60bpm.
- Seek medical advice if hypotension or bradycardia is persistent relevant to clinical context.
- Clonidine should be gradually withdrawn over 2-4 days. Agitation, restlessness, palpitations, rapid rise in blood pressure, nervousness, tremor, headache and/or nausea has been reported following abrupt discontinuation.

25.7 Clonidine Drug interactions

- No significant interactions are listed in the BNF. Interactions are listed with drugs that also cause hypotension, bradycardia and/or sedation so may cause increased side effects.
- Drugs with alpha-blocking properties including mirtazapine and tricyclic antidepressants (TCAs) may block the effects of clonidine decreasing the ability of clonidine to lower blood pressure. The manufacturer advises considering an increase in clonidine dose however as the use in detox is already off-license, the maximum dose listed in the policy should not be exceeded. Other dose adjustments should be guided by response and BP/pulse.
- This list is not exhaustive. Refer to current BNF or manufacturer's SPC (www.medicines.org.uk) for full details of all drug interactions

25.8 Clonidine Dosing

- Consider clonidine as a community detoxification agent for clients on 30mg or less of methadone per day or 6mg or less of Buprenorphine.
- Community clonidine detoxification should start on a Monday
- Clonidine administration should start 24 hours after the last dose of methadone
- Clonidine should be given four times a day (including a dose at bedtime)
- The minimum effective dose to manage symptoms should be used.
- Starting dose: 0.025mg four times a day
- Increase by 0.025mg to 0.2mg each day (divided across the doses), based on COWS score
- Dose adjusted daily and increased in correlation with COWS starting at doses of 0.025mg with mild opiate withdrawal, increasing to 0.050mg in moderate opiate withdrawal, up to 0.1mg in moderate to severe opiate withdrawal.
- Maximum single dose of 0.1mg
- Maximum daily dose of 0.4mg

- The duration of the clonidine detoxification will usually be for 7-10 days (longer may be warranted based on individual assessment)
- Clonidine should be withdrawn over 2-4 days to avoid rebound hypertension.

26. Benzodiazepine Prescribing for Dependence

26.1 Introduction

- Contrary to clinical recommendations, the prolonged prescribing of benzodiazepines is a common problem, as is use of benzodiazepines obtained illicitly.
- Anxiety and fear are typically associated with benzodiazepine reduction and clients require specific support to manage these psychological challenges.
- Prescribing requires careful assessment, with multiple screening, and should always be conducted somewhat reluctantly within a boundaried framework.

26.2 Benzodiazepine Use

- Benzodiazepines and related drugs are licensed only for short-term use for the management of insomnia and anxiety.
- Not licensed for the management of benzodiazepine dependence. Prescribers should follow guidance for using unlicensed medicines (Refer to LSW Medicines Policy). In particular the client and any staff involved in administration must be informed that this is an off-license use.
- All benzodiazepine prescriptions for dependency treatment should be on a reducing schedule rather than a maintenance schedule.
- A pattern of binge use (large doses, irregularly) of this class of drugs is common and a benzodiazepine prescription is not clinically appropriate in such circumstances; usually individuals must be using them on a daily basis to warrant prescribing.
- At least two benzodiazepines positive urine screens before commencing prescribing.
- The prescription should generally not be for more than six months, although many clients will be on the benzodiazepine prescription for a longer period.
- When initiating a benzodiazepine substitution prescription, the client should be informed that a reducing schedule will be prescribed with the aim to come off benzodiazepines.
- Decision to prescribe for the management of benzodiazepine dependence to involve prescriber and Harbour Specialist Worker plus another clinician for more complex presentations.
- It is essential to understand the history of dependence and past benzodiazepine treatment so that this can be addressed as part of a wider package of psycho-social treatment and support (e.g. childhood trauma or insomnia to “come down” from stimulants).
- Except in the case of liver disease (see below) all benzodiazepines should be converted to an equivalent dose of diazepam at Equivalent doses of oral benzodiazepines – SPS - Specialist Pharmacy Service – The first stop for professional medicines advice
- In the event of co-morbid opiate and benzodiazepine dependency:
    - commence and stabilise treatment for the opiate dependency before considering starting a reducing prescription for the benzodiazepine dependency
    - prescribe for benzodiazepine dependency only when other interventions to reduce use have been unsuccessful

    - reductions in the substitute opioid and benzodiazepine should generally **not** be made concurrently
- Where benzodiazepines are used on-top of a client's other primary drug of misuse, there is no evidence that benzodiazepine substitute prescribing reduces its misuse so be more reluctant to prescribe.
- Psychiatric co-morbidity should be assessed and managed appropriately.
- The prescription should be reviewed at least every 3 months.

26.3 Benzodiazepine Formulations

- Diazepam 2mg,5mg and 10mg tablets

26.4 Benzodiazepine Contra-indications and Cautions

- Refer to current BNF (http://www.evidence.nhs.uk/formulary/bnf/current) or manufacturer's SPC (www.medicines.org.uk) for full details of contra-indications and cautions

26.5 Benzodiazepine Absolute contra-indications

- Marked neuromuscular respiratory weakness including unstable myasthenia gravis (a neuromuscular disorder affecting eyes, face and throat)
- Acute pulmonary insufficiency
- Sleep apnoea syndrome
- Allergy to the active benzodiazepine drug or any of the excipients (refer to SPC for complete list).

26.6 Benzodiazepine Cautions and relative contra-indications

- Liver disease (see section 36)
- Pregnancy and breastfeeding (see section 33 and 34)
- Elderly (see section 37)
- respiratory disease
- muscle weakness and myasthenia gravis
- organic brain changes
- history of drug or alcohol dependence
- personality disorder
- Challenging behaviours that prevent cooperation with reduction plan
- Cognitive/memory impairment
- Learning Disability
- Concurrent, severe mental illness including suicidality and self-harm.
- Obsessional states and phobic states

26.7 Benzodiazepine Adverse effects

- Most commonly drowsiness and light-headedness, confusion, ataxia (especially in the elderly), amnesia.
- Refer to current BNF (or manufacturer's SPC (www.medicines.org.uk) for full list of adverse effects.
- Before starting treatment, inform patients about relevant side-effects.
- Advise patients to seek advice for any side-effects that are troubling them
- Ask about side-effects at each prescription review (as a minimum).

26.8 Benzodiazepine Drug interactions

Ritonavir (ingredient in a number of compound anti-retroviral medicines)	risk of severe sedation and respiratory depression – **do not co-prescribe**
Fluconazole or Voriconazole	can increase diazepam levels and cause prolonged sedation – caution, consider dose adjustments (single doses of fluconazole are unlikely to be a problem)
Rifampicin (plus other less frequently used drugs, see SPC/BNF)	Can decrease diazepam levels – avoid where possible or monitor response.
Phenytoin or Fosphenytoin	Diazepam affects the concentration of phenytoin and fosphenytoin – monitor and consider dose adjustments (refer to manufacturer information).
Alcohol	Additive effects of sedation and respiratory depression – caution
Opioids	Additive effects of sedation and respiratory depression – caution
Other drugs that can cause drowsiness	Additive effect of sedation – caution
Other drugs that can cause hypotension	Additive effect of hypotension – caution, especially note risk of falls

- This table is not exhaustive. Refer to current BNF or manufacturer's SPC (www.medicines.org.uk) for full details of all drug interactions

26.9 Benzodiazepine Dosing

- For prescribed benzodiazepines: transfer to an equivalent daily dose of diazepam, one dose at a time over about a week.
- For illicit benzodiazepine use: aim to commence diazepam at the lowest dose needed to prevent withdrawal symptoms, ideally the client should be observed for sedation.
- Daily doses of diazepam should generally not exceed 30mg (this is sufficient to prevent withdrawal seizures even in very high dose benzodiazepine users).
- If doses higher than 30mg Diazepam required this needs to be discussed with the medical lead/clinical lead.

- There is increasing evidence that doses of above 30mg daily are harmful.
- Dose can be taken as once daily dose (usually at night), or in divided doses – whichever regimen will best help manage withdrawal symptoms for the particular client's pattern of benzodiazepine use.
- Once dose established set plan to reduce diazepam dose over an agreed time period (see discontinuation section below).

26.10 Benzodiazepine Discontinuation

26.10.1 Planned reduction

- Clients may be resistive to dose reductions in their benzodiazepine prescription so this needs to be done in the context of firm boundaries, yet empathic support.
- The rate of reduction is often determined by the individual's capacity to tolerate withdrawal symptoms.
- Doses above 30mg can be reduced to this dose fairly rapidly, in the absence of withdrawal symptoms.
- For doses greater than 20mg / day aim for a reduction of 5mg a fortnight.
- For doses lower than 20mg / day aim for a reduction of 2mg a fortnight.
- Review the patient after each dose reduction.
- If uncomfortable withdrawal symptoms occur, maintain this dose until symptoms lessen
- If the patient is not coping and is experiencing severe withdrawal symptoms, it may be necessary to increase the dose to alleviate the symptoms.
- For a "short-term" dependence of 6 months or less, reduction to zero should be achievable within 1-2 months.
- For "long-term" dependence, the period needed for complete withdrawal may vary from several months to a year or more.

26.10.2 Non-compliance with care plan/failure to benefit

- In situations where there is non-compliance with the care plan the decision may be made to stop treatment.
- Do NOT immediately stop the prescription due to the risk of severe withdrawal symptoms and seizures (Note that if the client is using illicit benzodiazepines or drinking significant amounts of alcohol this risk will be mitigated).
- If the patient has been reasonably stable on the prescription:
    i. > 30mg reduce by 5mg daily to 30mg.
    ii. 10 - 30mg reduce by 5mg every 3 days to 10mg
    iii. < 10mg reduce by 2mg every two days to zero.
- In extreme circumstances with evidence of a client not collecting regularly and significant illicit drug use, the prescription can be stopped immediately.
- In certain situations (e.g. co-morbidity with severe mental health problems) either the prescriber or the Harbour Specialist Worker may wish to consider an alternative regime in order to minimise risk. It is essential that this is discussed with Medical lead/clinical lead.
- For clients with severe mental health problems then a psychiatrist may need to be involved in the prescribing / care plan interventions.

26.11 Benzodiazepine Prescribing / dispensing arrangements

- Diazepam can be prescribed on a FP10(MDA) (blue) prescription, allowing the prescribing of 14 days' supply to be dispensed in instalments

- Initiate prescriptions for benzodiazepines on daily collection
- Frequency of collection can be reduced if the client:
  - is well engaged in treatment
  - is following their care plan, including attending appointments regularly
  - shows no evidence of drug or alcohol misuse
- If there are signs of relapse, the frequency of pick-up should be increased.
- Pickup should be at least weekly except in exceptional circumstances (e.g. holidays; refer to SOP for holiday prescriptions)

26.12 Benzodiazepine Relevant clinical pharmacology and pharmacokinetics

Receptor effects	GABA agonist
Time to peak plasma level	30-90 minutes
Metabolised	By the liver, active metabolites include desmethyldiazepam, oxazepam, temazepam
Elimination half life	Diazepam: 1-2 days Desmethyldiazepam: 2-5 days

27. Prescribing to support reduction and abstinence in alcohol misuse

This section should be read in conjunction with the Detoxification of Alcohol in the Community Policy Detoxification of Alcohol in Community Policy LSW v 2_0 Intranet.pdf (swest.nhs.uk)

- Men and women are advised not to drink more than 14 units a week on a regular basis and to spread their drinking over three or more days if they regularly drink as much as 14 units a week. If they want to cut down they should try to have several drink-free days each week.
- All pharmacotherapy should be used as an adjunct to psychosocial interventions.
- Acamprosate and naltrexone are supported by NICE for mild alcohol dependence in combination with a psychological therapy, if the client has not responded to psychological therapy alone or has specifically requested a pharmacological intervention.
- Acamprosate, naltrexone and disulfiram are supported by NICE for moderate to severe alcohol dependence after successful withdrawal (see specific drug sections).
- Nalmefene is supported by NICE in certain conditions where drinking continues (see below).
- Prescribing should take place for up to 6 months, or longer for those benefiting from the drug, who want to continue it.
- As with other forms of drug treatment it is important to establish clear goals.

28. Acamprosate

28.1 Use

- Mild alcohol dependence in combination with a psychological therapy, if the client has not responded to psychological therapy alone or has specifically requested a pharmacological intervention.
- Moderate to severe alcohol dependence after successful withdrawal (as an adjunct to psychological therapy).
- Best suited to supporting abstinence among those who fear craving will lead to relapse.
- Start as soon as possible after withdrawal.

28.2 Acamprosate Formulations

- Acamprosate calcium tablets 333mg

28.3 Acamprosate Contra-indications and Cautions

- Refer to current BNF or manufacturer's SPC (www.medicines.org.uk) for full details of contra-indications and cautions

28.4 Acamprosate Absolute contra-indications

- Hypersensitivity to acamprosate or any of the excipients (see SPC for excipient list).

28.5 Acamprosate Relative contra-indications and cautions

- Pregnancy and breastfeeding (see sections 33 and 34)
- Renal impairment (see section 35)
- Under 18 years old (safety and efficacy has not been established)
    - May be considered for 16 or 17 year olds who have not engaged with or benefited from a multicomponent treatment programme (see section 38)
- Over 65 years old (see section 37)
- Severe liver insufficiency (see section 36)

28.6 Acamprosate Adverse effects

- Refer to current BNF or manufacturer's SPC (www.medicines.org.uk) for full list
- Before starting treatment inform patients about relevant side-effects
- Advise patients to seek advice for any side-effects that are troubling them
- Ask about side-effects at each prescription review (as a minimum)

Very common (≥1/10)

Diarrhoea.

Common (≥1/100 to <1/10):

Abdominal pain, nausea, vomiting, flatulence, pruritus, maculo-papular rash, frigidity or impotence, decreased libido.

28.7 Acamprosate Drug interactions

- Acamprosate levels increased by naltrexone.
- Refer to current BNF (http://www.evidence.nhs.uk/formulary/bnf/current) or manufacturer's SPC (www.medicines.org.uk) for full details of all drug interactions

28.8 Acamprosate Dosing

- In clients weighing over 60kg: 666mg three times a day
- In clients weighing less than 60kg: 666mg in the morning, 333mg at midday and 333mg at night

28.9 Acamprosate Discontinuation

- Stop if drinking persists after 4-6 weeks of treatment.

28.10 Acamprosate Relevant clinical pharmacology and pharmacokinetics

Receptor effects	May act by stimulating GABAergic inhibitory neurotransmission and antagonising excitatory amino- acids, particularly glutamate.
Time to steady state plasma level	Around 7 days
Metabolism	None significant
Elimination	Excreted unchanged in the urine

29. Naltrexone for alcohol abstinence

29.1 Use

NOTE: Naltrexone is used more commonly for treatment of alcohol use disorders than as an opiate blocker (see section 23).

- For harmful drinkers and people with mild alcohol dependence who have not responded to psychological interventions alone or who have specifically requested a pharmacological intervention
- Adjunct to prevent relapse in former alcohol dependent clients
- unlicensed use but approved by NICE (prescribers should follow process for unlicensed medicines in the LSW Medicines Policy in particular ensuring the client is aware it's an off-license use).
- In preparation for an alcohol detox to reduce consumption
- For moderate to severe alcohol dependence where benefits outweigh risks and with regular liver function testing (supported by BAP Guidelines)

29.2 Naltrexone Formulations

Naltrexone Hydrochloride 50 mg Film-coated Tablets

29.3 Naltrexone Contra-indications and Cautions

Refer to current BNF or manufacturer's SPC (www.medicines.org.uk) for full details of contra-indications and cautions.

29.4 Naltrexone Contra-indications

- Any current use of opioids (prescribed or illicit) - it is essential that the client is counselled on the risk of using opioids along with naltrexone
- Hypersensitivity to naltrexone hydrochloride or to any of the excipients in the

tablets (refer to SPC for complete list)
- Severe renal impairment
- Severe hepatic impairment
- Acute hepatitis
- Positive screening result for opioids or after failure of the naloxone provocation test

29.5 Naltrexone Cautions

- Impaired (not severe) renal impairment (see section 35)
- Impaired (not severe) hepatic impairment (see section 36)

29.6 Naltrexone Adverse effects

- Refer to current BNF or manufacturer's SPC (www.medicines.org.uk) for full list
- Before starting treatment inform patients about relevant side-effects
- Advise patients to seek advice for any side-effects that are troubling them
- Ask about side-effects at each prescription review (as a minimum)

Very common (≥1/10)
Headache, restlessness, nervousness, abdominal pain, nausea, vomiting, joint and muscle pain, anxiety, insomnia, asthenia.

Common (≥1/100 to <1/10):

Thirst, dizziness, chills, increased sweating, increased lacrimation, chest pain, diarrhoea, constipation, rash, lack of appetite, delayed ejaculation, erectile dysfunction, libido disorders, increased energy, irritability, affective disorder, tachycardia, heart palpitation, ECG abnormalities.

29.7 Naltrexone Drug interactions

- Opioids: methadone, buprenorphine, diamorphine, morphine, codeine
  - Concomitant use will result in opioid withdrawal symptoms
  - High doses of opioids in combination with naltrexone can lead to life-threatening
  - opioid overdose from respiratory and circulatory impairment.
- Acamprosate: naltrexone significantly increases plasma level of acamprosate
- No known interaction with alcohol
- This list is not exhaustive. Refer to current BNF or manufacturer's SPC (www.medicines.org.uk) for full details of all drug interactions

29.8 Naltrexone Monitoring

- Monitor liver function tests and renal function before and 3 monthly during treatment.

29.9 Naltrexone Dosing

Should be initiated by a clinician with specialist experience in the field of substance misuse, but on-going treatment may be managed by a general practitioner.

- 25mg on day one (half a 50mg tablet) and 50mg daily thereafter.
- The total weekly dose (350 mg) may be divided and given on 3 days of the week for improved compliance (e.g. 100 mg on Monday and Wednesday, and 150 mg on Friday)

29.10 Naltrexone Discontinuation

- Stop if no change in drinking pattern within 4-6 weeks
- Consider an initial treatment period of 3 months before planned stopping, however longer may be required.

29.11 Pain relief for clients taking naltrexone

- Opioid based analgesia should not routinely be prescribed. There are no anticipated problems with paracetamol or non-steroidal anti-inflammatory drugs.
- Before minor or intermediate elective surgery: discuss with client, community drugs and alcohol team and surgical team to arrange to discontinue Naltrexone 48-72 hours before the procedure if opiate pain relief is considered to be necessary.
- Before major surgery: As above but discontinue oral Naltrexone 72 hours beforehand.
- For unexpected severe pain (e.g. trauma or emergency surgery): Use non-opioids such as intravenous paracetamol.

29.12 Naltrexone Relevant clinical pharmacology and pharmacokinetics

Receptor effects	Competitive opioid antagonist, mainly at μ (mu) receptors in the brain
Time to peak plasma level	1 hour
Metabolism	Extensive first-pass metabolism to the active metabolite beta-naltrexol
Elimination half life	Naltrexone: 4 hours Beta-naltrexol: 13 hours
Long duration of action	

30. Disulfiram

30.1 Use

- Disulfiram has a weaker evidence base than acamprosate but its use is supported by NICE for maintenance of abstinence in moderate to severe dependency (in combination with psychological intervention) if:
  - acamprosate or naltrexone are not suitable **OR**
  - the client prefers disulfiram and is aware of the relative risks
- Supervision of administration should ideally take place by a family member or carer
- Should only be initiated by a specialist in the field of substance misuse
- Disulfiram works by causing an intensely unpleasant experience (“disulfiram reaction”) if alcohol is ingested while taking it
- Intense vasodilation of the face and neck causing flushing, increased body temperature, sweating, nausea, vomiting, pruritis, urticaria, anxiety, dizziness, headache, blurred vision, dyspnoea, palpitations and hyperventilation.

- In severe cases tachycardia, hypotension, respiratory depression, chest pain, QT prolongation, ST depression, arrhythmias, coma and convulsions may occur.
- Rare complications include hypertension, bronchospasm and methaemoglobinaemia.

30.2 Disulfiram Formulations

- Disulfiram tablets 200mg

30.3 Disulfiram Contra-indications and Cautions

- Refer to current BNF or manufacturer's SPC (www.medicines.org.uk) for full details of contra-indications and cautions

30.4 Disulfiram Absolute contra-indications

- Cardiac failure
- Coronary artery disease
- History of cerebrovascular accident
- Hypertension
- Severe personality disorder
- Suicidal risk or psychosis
- Consumption of alcohol
- Hypersensitivity to disulfiram or to any of the excipients (refer to SPC for complete list)
- Pregnancy and breast-feeding (see section 33 and 34)

30.5 Disulfiram Relative contra-indications and cautions

- Renal failure (see section 35)
- Hepatic disease (see section 36)
- Respiratory disease
- Diabetes mellitus
- Hypothyroidism
- Cerebral damage
- Epilepsy
- Avoid in acute porphyrias

30.6 Disulfiram Adverse effects

- Frequency not known: Psychotic reactions; depression, paranoia, schizophrenia, mania, reduction in libido, drowsiness (during initial treatment), peripheral neuritis, optic neuritis, encephalopathy, nausea, vomiting, hepatic cell damage, drug induced liver injury (fatal cases have been reported), allergic dermatitis, rash, halitosis.
- Refer to current BNF or manufacturer's SPC (www.medicines.org.uk) for full list
- Before starting treatment inform patients about relevant side-effects
- Advise patients to seek advice for any side-effects that are troubling them
- Ask about side-effects at each prescription review (as a minimum)

30.7 Disulfiram Drug interactions

Alcohol	Flushing, nausea, palpitations and, more seriously, arrhythmias, hypotension and collapse ("Disulfiram reaction")
Amitriptyline	May increase intensity of disulfiram reaction
Chlorpromazine	May decrease some components of disulfiram reaction but may increase overall intensity
Aminophylline / theophylline Tricyclic antidepressants, coumarins (including warfarin) Phenytoin / fosphenytoin Other medication which are converted in the liver.	Disulfiram inhibits the metabolism of these medications – increase risk of adverse effects
Isoniazid	Disulfiram may increase CNS side-effects
Metronidazole	Psychotic reaction reported
Rifampicin	Disulfiram inhibits oxidation and renal excretion
Benzodiazepines	Inhibits the metabolism of some benzodiazepines (including diazepam and chlordiazepoxide) causing increased sedation. Benzodiazepines can reduce the disulfiram-like reaction.

This table is not exhaustive. Refer to current BNF or manufacturer's SPC (www.medicines.org.uk) for full details of all drug interactions

30.8 Disulfiram Information for clients

- The interaction between disulfiram and alcohol (which may also be found in food, perfume, aerosol sprays and so on), the symptoms of which may include flushing, nausea, palpitations and, more seriously, arrhythmias, hypotension and collapse – this is unpredictable and can be severe. Care should also be taken with low-alcohol or "no alcohol" beverages.
- The rapid and unpredictable onset of the rare complication of hepatotoxicity; advise service users that if they feel unwell or develop a fever or jaundice that they should stop taking disulfiram and seek urgent medical attention

30.9 Disulfiram Dosing

- Start at least 24 hours after last alcoholic drink
- Initial dose of 200mg daily
- If 200mg daily is insufficient to deter drinking, and drinking continues after taking for at least one week consider increasing the dose (e.g. 200mg twice a day) in consultation with the client

30.10 Disulfiram Discontinuation

- Do not drink alcohol for 14 days following cessation of treatment

31. Nalmefene

31.1 Use

- To reduce alcohol consumption in clients with alcohol dependence who are:
  - Drinking more than 7.5 units (men) or 5 units (women) per day and
  - Do not have physical withdrawal symptom and
  - Do not need to stop drinking immediately or completely

- Only prescribe to clients who persistently drink 7.5 units (men) or 5 units (women) per day at least two weeks after initial assessment.

31.2 Nalmefene Formulations

Nalmefene hydrochloride 18mg film coated tablets

31.3 Nalmefene Contra-indications and Cautions

- Refer to current BNF or manufacturer's SPC (www.medicines.org.uk) for full details of contra-indications and cautions

31.4 Nalmefene Absolute contra-indications

- Any current use of opioids (prescribed or illicit or current acute withdrawal symptoms)
- Severe hepatic impairment (see section 36)
- Severe renal impairment (eGFR <30 ml/min) (see section 35)
- Recent history of acute alcohol withdrawal syndrome
- Hypersensitivity to nalmefene or any of the excipients in the tablets (refer to SPC for complete list)

31.5 Nalmefene Relative contra-indications and cautions

- Current or history of psychiatric illness
- Current or history of seizure disorder (including alcohol withdrawal seizures)
- Mild to moderate hepatic impairment (see section 36)
- Mild to moderate renal impairment (see section 35)

31.6 Nalmefene Adverse effects

- Refer to current BNF or manufacturer's SPC (www.medicines.org.uk) for full list
- Before starting treatment inform patients about relevant side-effects
- Advise patients to seek advice for any side-effects that are troubling them
- Ask about side-effects at each prescription review (as a minimum)

Very common (≥1/10)
Insomnia, dizziness, headache, nausea
Common (≥1/100 to <1/10):
Decreased appetite, sleep disorder, confusional state, restlessness, libido decreased, somnolence, tremor, disturbance in attention, paraesthesia, hypoaesthesia, tachycardia, palpitations, vomiting, dry mouth, diarrhoea, hyperhidrosis, muscle spasm, fatigue, asthenia, malaise, feeling abnormal, weight decreased.

31.7 Nalmefene Drug interactions

Opioids	Nalmefene blocks the effects of opioids (see below for advice on administering opioid analgesia)
Potent inhibitors of the UGT2B7 enzyme (e.g. diclofenac, fluconazole, medroxyprogesterone acetate)	• may significantly increase the exposure to nalmefene. • unlikely to present a problem with occasional use, but if long-term concurrent treatment with a potent UGT2B7 inhibitor is initiated, a potential for an increase in nalmefene exposure cannot be excluded
UGT inducers (e.g. dexamethasone, phenobarbital, rifampicin, omeprazole)	may potentially lead to sub-therapeutic nalmefene plasma concentrations

This list is not exhaustive. Refer to current BNF or manufacturer's SPC (www.medicines.org.uk) for full details of all drug interactions

- No pharmacokinetic interaction with alcohol (but note that nalmefene also impairs cognitive and psychomotor function)

31.8 Nalmefene Dosing

- One tablet (18mg) to be taken on each day the client perceives themselves to be at risk of drinking.
- Ideally taken 1-2 hours before anticipated time of drinking.
- If alcohol has already been consumed take as soon as possible

31.9 Nalmefene Discontinuation

- No special instructions
- There is no clinical data for use beyond one year

31.10 Nalmefene Pain relief for clients taking nalmefene

- There are no anticipated problems with paracetamol or non-steroidal anti-inflammatory drugs.
- Discontinue nalmefene for one week prior to the use of anticipated opioid analgesics (e.g. for elective surgery)
- If opioids are required in an emergency, the dose of the opioid should be titrated individually, based on response

31.11 Nalmefene Relevant clinical pharmacology and pharmacokinetics

Receptor effects	Opioid antagonist at μ (mu) and δ (delta) receptors and partial agonist at κ (kappa) receptor.
Time to peak plasma level	1.5 hours
Metabolism	Mainly to nalmefene-3-O-glucuronide (not pharmacologically active)
Elimination half life	12.5 hours

32. Gabapentinoids (gabapentin and pregabalin)

- Practitioners need to be alert to the increasing trend in misuse of these drugs either directly prescribed to clients or acquired by them from the illicit market in both the community and secure environment (prison) settings, due to their significant euphoric effects. Diversion of prescribed gabapentinoids is common.

- Licensing in the UK is for the following indications:
  Gabapentin: epilepsy; peripheral neuropathic pain
  Pregabalin: epilepsy; neuropathic pain; generalised anxiety disorder

- Note that morphine can increase the bioavailability of gabapentin.

- Management of the misuse is an emerging field with little specific guidance available. There are parallels with benzodiazepine misuse treatment although prescribing by drug & alcohol services is unlikely due to cost considerations. PHE issued advice in 2014 recommending **tapering schemes**:

  Gabapentin: reduce the daily dose at a maximum of 300mg every 4 days
  Pregabalin: reduce the daily dose at a maximum of 50/100mg/week
  For further information refer to the Orange Guidelines 2017 p208.

33. Pregnancy

- Early engagement and retention of pregnant substance misusers is important for the outcome of both mother and baby. This should include the engagement of drug-misusing partners in treatment.

- Heroin use during pregnancy, particularly dependent heroin use, is associated with a wide range of problems, affecting both mother and unborn baby, including growth & development (often associated with malnutrition), increased risk of premature birth. If the mother is using intravenous drugs, this will also present risk of blood borne virus to both mother and unborn baby. If the mother has withdrawal symptoms from substances she is dependent on, the unborn baby will also suffer withdrawal symptoms.

- Use of other substances including cocaine, crack cocaine, amphetamine, etc. can be damaging to the unborn baby. The vaso-constrictive action of these substances can damage the fragile blood vessels in the placental system which can lead to reduced blood flow to the unborn baby. The unborn baby is also at risk of cerebral damage due to the vasoconstrictor action. If a mother has used cocaine/crack cocaine during her pregnancy, a cranial ultrasound is recommended for baby after its birth to assess if this has occurred

- If the mother is groin injecting drugs this leads to an increased risk of deep vein thrombosis / pulmonary embolus.

- Clients should be advised to avoid alcohol throughout the pregnancy as this is potentially damaging to an unborn baby during all stages of the pregnancy. Structural defects are more likely to occur with heavy alcohol use in the first/second trimester (0-12 weeks & 12-28 weeks) and risk of miscarriage is increased. In the third trimester (28-40 weeks) of the pregnancy, foetal brain development can be affected leading to neurological problems including behavioural issues/difficulty concentrating/mental health problems, etc.

- Research indicates that alcohol can be implicated in a range of effects known as the Foetal Alcohol Spectrum Disorders including Foetal Alcohol Syndrome (FAS) where birth defects are very obvious, Alcohol-Related Neurodevelopmental Disorders (ARND) and Foetal Alcohol Effects (FAE) which are more subtle disabilities.

- Clients should be advised that binge drinking is more harmful to the unborn baby than drinking smaller regular amounts. When the unborn baby is exposed to large amounts of alcohol at once, this is highly toxic and more likely to cause structural damage to what (at that stage in the pregnancy) is being developed. In the latter stages of pregnancy, the central nervous system 'fine tuning' is occurring.

- The drug / alcohol treatment programme for pregnant substance misusers should be co- ordinated or have input from a GPwSI or specialist working in the field of substance misuse.

- Clients should be referred to the Drug Liaison Midwife (DLMW) who will monitor her pregnancy more closely and offer support clinically but also assist with addressing any social issues.

- The DLMW liaises with obstetricians, anaesthetists, hepatologists, neonatologists and other medical staff as required.

- Serial growth scans are usually carried out to monitor the unborn baby's development.

- Blood borne virus screening is carried out - more than once if continuing to use IV drugs. Risk of vertical transmission (mother to unborn baby) of Hepatitis C is very low however use of instrumentation is avoided e.g. avoid foetal scalp electrodes, amniohooks, foetal blood sampling blades. The baby's thigh is thoroughly cleaned prior to administering the routine post-birth vitamin K injection.

- The DLMW will advise the mother of risks associated with her substance use and reiterate this if necessary.

- The most up to date information about medication use in pregnancy can be accessed from the UK Teratology Information Service (0844 892 0909) or via Toxbase (https://www.toxbase.org/) – login required – contact LSW pharmacy services for log-in details.

- Refer also to the manufacturer's SPC (Home - electronic medicines compendium (emc))

- In general concerns about drug / medication use in pregnancy are:-
  - Risk of teratogenicity – mainly (although not limited to) use in the first trimester
  - Effects on foetal growth (e.g. intrauterine growth retardation)
  - Effects in the neonate
  - Withdrawal in the neonate
  - Long term effects of exposure whilst *in utero* – there is very little information about this for most drugs
- Much of the data about the use of medications in alcohol / substance misuse in pregnancy is difficult to interpret due to being limited in number and the presence of multiple confounders.

- All prescribing decisions in pregnancy must be based on an individual assessment of the relative risks and benefits, bearing in mind the known risks of alcohol and / or illicit drug use in pregnancy.

- In all cases the client must give informed consent to a prescribing intervention in pregnancy, after a full discussion with the prescriber about potential risks and benefits.

- Delivery should generally take place in Derriford Maternity Unit, where there are adequate facilities to care for both the mother and the neonate.

33.1 Methadone

- Methadone is the pharmacological treatment of choice for managing opioid dependency in pregnancy.
- The amount of methadone they need is likely to increase as the pregnancy progresses due to the increased metabolic rate and the haemodilution effect. The woman is more likely to need an increase after 28 weeks gestation but this will vary between women.
- There is much experience with the use of methadone in pregnancy, which has evidence for improving maternal and foetal health outcomes.
- Clients already on methadone should be maintained on the same dose if they become pregnant.
- Clients wishing to detoxify should be discouraged from doing so in the first trimester due to the risk of miscarriage.

- Detoxification from methadone is safest to take place in the second trimester at a rate of 2- 3mg every 3-5 days, as long as there is no illicit drug use.
- Detoxification should be avoided in the third trimester due to the risk of premature labour occurring if the mother has severe withdrawal symptoms (including abdominal cramps).
- Split dosing may be required, particularly if the woman suffers from pregnancy nausea/vomiting.
- The mother will discuss analgesia for labour with the DLMW antenatally. The usual dose of diamorphine given to women in labour may be totally ineffective. Entonox is recommended. If opioids are needed, the anaesthetist will need to review the labouring mother so her pain can be managed appropriately.
- The methadone dose should be taken at the usual time during labour.
- The neonate will experience withdrawal symptoms which can range from mild and subtle symptoms such as yawning, mild tremors to severe symptoms including high pitched crying, inability to feed, severe diarrhoea, weight loss etc.
- Safe storage of methadone should be discussed with the mother and her partner.
- Even if their baby is too young to access their own methadone, they have to be mindful of the possibility of visitors' children accessing it.

33.2 Buprenorphine

- In comparison to methadone, there is less information about buprenorphine use in pregnancy.
- Although opiates as a group have not been associated with an increased risk of teratogenicity, the data on buprenorphine specifically is insufficient to quantify the risk.
- Buprenorphine has been associated with reduced birth weight.
- Buprenorphine would not usually be a first line treatment to start in pregnancy.
- If a client already stabilised on buprenorphine becomes pregnant they may choose to continue with this treatment, rather than transferring to methadone. The client must give informed consent.
- The dose may need to be increased in the second or third trimester.
- The neonate may experience withdrawal symptoms.
- Due to its partial agonist action, buprenorphine may interfere with opioid analgesia in labour, although epidurals are usually effective. Analgesic choices should ideally be discussed prior to going into labour with a specialist midwife or anaesthetist. The usual buprenorphine dose should continue during labour.

33.3 ClonidineLofexidine

- There is a lack of data about the use of clonidine for opiate detox in pregnancy, therefore it is not recommended for use.

33.4 Naltrexone

- There is a lack of data about the use of naltrexone in pregnancy, therefore it is not routinely recommended.
- However, in the knowledge of the known risks of alcohol and / or opiates in pregnancy, prescribing may occur.
- Administration of systemic doses of opioids (e.g. IM diamorphine in labour) may

result in acute opioid intoxication which may be life threatening. In an emergency requiring opioid analgesia, an increased dose of opioid may be required to control pain. The patient should be closely monitored for evidence of respiratory depression or other adverse symptoms and signs.

33.5 Diazepam

- Data about the potential for diazepam to cause congenital malformations is conflicting.
- Prolonged use, especially near term and at high doses, is likely to result in respiratory depression in the neonate, and neonatal withdrawal / floppy infant syndrome.
- Where possible diazepam (and other benzodiazepines) should be avoided in pregnancy, although they should not be stopped abruptly.
- The second trimester is preferred for benzodiazepine detoxification.

33.6 Acamprosate

- There are no human or animal trials to indicate the safety of acamprosate in human pregnancy.
- Acamprosate is not routinely recommended for use in pregnancy. However, alcohol is a confirmed human teratogen, therefore any potential risk to the foetus from acamprosate exposure may be outweighed by the known risk of high alcohol exposure.

33.7 Disulfiram

- There is a lack of data on the safety of disulfiram in human pregnancy.
- There are case reports of congenital malformations – especially when taken along with alcohol.
- Disulfiram is not routinely recommended in pregnancy.

33.8 Nalmefene

- There is limited data on the safety of nalmefene in human pregnancy.
- Nalmefene should be avoided in pregnancy.

34. Breastfeeding

- Breastfeeding is generally listed by manufacturers as a contra-indication to their medications. Often this reflects a lack of data, rather than data that the drug is harmful to the baby.
- Mothers should generally be encouraged to breastfeed unless there is a contra-indication. Assessment of the risks and benefits should be made on a case by case basis.
- The person recommending the medication for an individual takes ultimate responsibility if there are any adverse effects in the baby / child.
- Particular care should be taken if the baby is premature as there is a higher risk of drug accumulation due to immature kidney and liver function.
- The mother should be fully informed of any potential adverse effects in the baby /

child, along with the risks of not breastfeeding, in order that they can make a fully informed choice about taking medication.

Further information may be obtained from the LactMed website (an American database so does not include all UK drugs) https://www.toxnet.nlm.nih.gov/newtoxnet/lactmed.htm

or UK Drugs in Lactation Advisory Service on 0116 258 6491 or 0121 424 7298. https://www.sps.nhs.uk/articles/ukdilas/

34.1 Methadone

- Babies exposed to methadone during the pregnancy should breastfeed normally if the mother is stable.
- Breastfeeding can mitigate neonatal withdrawal effects, although the baby may still need treatment for this as the amount of methadone that passes into the milk is small.
- Exclusively breast fed babies should be closely monitored for drowsiness, adequate weight gain, respiratory problems and developmental milestones.
- Babies may experience withdrawal if breastfeeding is stopped abruptly.

34.2 Buprenorphine

- There is less experience than with methadone.
- Babies who have been exposed to buprenorphine in utero should breastfeed normally as long as the mother is stable.
- Breastfeeding can mitigate neonatal withdrawal effects, although the baby may still need treatment for this as the amount of buprenorphine that passes into the milk is small.
- Exclusively breast fed babies should be closely monitored for the first month for drowsiness, adequate weight gain, respiratory problems and developmental milestones.
- Babies may experience withdrawal if breastfeeding is stopped abruptly.

34.3 Clonidine

- There is a lack of data on the use of clonidine for detox in breastfeeding and it is not known if it passes into the milk.
- It should therefore be avoided in breastfeeding.

34.4 Naltrexone

- The limited data on naltrexone indicate that only negligible amounts of naltrexone pass into breast milk.
- Naltrexone can be considered as an option for breastfeeding mothers to prevent relapse to alcohol or opiates.
- The benefits to the baby of the mother refraining from alcohol appear to outweigh any unknown risks.

34.5 Diazepam

- Due to the long half-life of diazepam and its active metabolite there is the potential for accumulation in the breastfed baby (especially in new-borns and preterm babies).
- Avoid benzodiazepines if possible.
- If a benzodiazepine is absolutely necessary, consider using an agent with a shorter half-life such as lorazepam or oxazepam.
- Intermittent, rather than regular use is preferred.
- Babies exposed to benzodiazepines through breast milk should be monitored for sedation.
- Poor feeding, adequate weight gain, and developmental milestones should be monitored if therapy is prolonged.

34.6 Acamprosate

- There is a lack of evidence of safety in breastfeeding, although low levels are expected in breast milk.
- The benefits to the baby / child of the mother refraining from alcohol appear to outweigh any unknown risks.
- There is a risk of accumulation in the baby / child due to the long half-life.

34.7 Disulfiram

- Contra-indicated in breastfeeding as the baby may develop adverse effects if exposed to alcohol (either if ingested by the mother or through some paediatric pharmaceuticals).

34.8 Nalmefene

- It is not known if nalmefene passes into human milk and a risk to new-born babies cannot be excluded.
- Avoid if breastfeeding unless benefits clearly outweigh risks.

35. Renal impairment

This information is for guidance. Refer to current BNF or manufacturer's SPC (www.medicines.org.uk) for full and current information

- The risks of using certain medications in renal impairment are:
  - drug accumulation
  - further kidney injury
- The client's renal function should be assessed before initiation of prescribing.
- The substance misuse pharmacist can be consulted about drug choice / dosing in renal impairment.
- Further advice may be obtained from the renal specialist physicians at Derriford Hospital, always if the client is subject to dialysis.

35.1 Methadone

- Glomerular filtration rate (GFR) 10-50 ml/min: dose as in normal renal function
- GFR < 10 ml/min: reduce starting dose to 50-75 % of normal dose, increase according to response. Seek further information from the renal drug handbook/Substane Misuse pharmacist

35.2 Buprenorphine

- GFR 20-50 ml/min: dose as in normal renal function
- GFR 10-20 ml/min: dose as in normal renal function, but avoid very large doses
- GFR < 10 ml/min: reduce dose by 25-50%, increase as tolerated, avoid very large single doses. Seek further information from the renal drug handbook/Substane Misuse pharmacist

35.3 Clonidine

- Use with caution in severe renal impairment, reduce initial dose and make further dose changes gradually.
- GFR (mL/min) 20–50: Dose as in normal renal function.
- GFR (mL/min) 10–20: Dose as in normal renal function.
- GFR (mL/min): <10 Dose as in normal renal function.

35.4 Naltrexone

- Use with caution, avoid in severe renal impairment.
- Excretion is primarily renal
- GFR (mL/min): 20–50:Dose as in normal renal function.
- GFR (mL/min): 10–20: Use with caution.
- GFR (mL/min): <10: Use with caution

35.5 Diazepam

- GFR 20-50 ml/min: dose as in normal renal function
- GFR < 20 ml/min: use small doses and titrate to response
- The active metabolites are renally excreted so accumulate in renal impairment
- Clients should be warned of the increased risk of adverse effects and overdose

35.6 Acamprosate

- Avoid if serum creatinine greater than 120micromol/litre
- GFR 30-50 ml/min: 333mg three times a day
- GFR 10-30 ml/min: 333mg twice a day
- GFR < 10 ml/min: 333mg once daily
- Seek further information from the renal drug handbook/Substance misuse pharmacist

35.7 Disulfiram

- GFR 20-50 ml/min: dose as in normal renal function
- GFR 10-20 ml/min: use with caution
- GFR < 10 ml/min: avoid

35.8 Nalmefene

- Use with caution but no dose adjustment required in mild-moderate impairment
- GFR < 30 ml/min: contra-indicated

36. Hepatic impairment

This information is for guidance. Refer to current BNF or manufacturer's SPC (www.medicines.org.uk) for full and current information

- The substance misuse pharmacist can be consulted about drug choice / dosing in hepatic impairment. Further advice may be obtained from the hepatology department at Derriford Hospital.
- The risks of using certain medications in hepatic impairment are:
  - drug accumulation
  - further liver injury
  - The use of sedative drugs in hepatic impairment is associated with an increased risk of hepatic encephalopathy
- The client's liver function should be assessed before initiation of prescribing.

36.1 Methadone

- Use with caution with careful monitoring of liver function.
- Liaise with hepatology department as needed (especially severe impairment).
- Benefits of prescribing may outweigh risks.
- Take care to avoid constipation which may precipitate hepatic encephalopathy.
- Reducing the dose is advised by manufacturers.

36.2 Buprenorphine

- Use with caution with careful monitoring of liver function.
- Contra-indicated in severe liver dysfunction.
- Cases of acute hepatic injury have been reported, ranging from asymptomatic elevations in hepatic transaminases to case reports of liver failure.
- The risk seems to be higher in those with pre-existing liver enzyme abnormalities, hepatitis B or C infection, taking other potentially hepatotoxic medications or who continue to inject illicit drugs.
- Discontinue if buprenorphine is suspected to be the cause of hepatic dysfunction
- Liaise with hepatology department as needed.
- Benefits of prescribing may outweigh risks.
- Take care to avoid constipation which may precipitate hepatic encephalopathy.
- For lyophilsates (Espranor) – the manufacturer advises using lower initial doses in mild to moderate impairment.

36.3 Clonidine

- No cautions for patients with hepatic impairment or liver disorders are listed in the BNF or by the manufacturers.
- As clonidine for detox is an off-license indication, caution should still be used in patients with hepatic impairment but as the drug is mainly renally excreted as unchanged drug (70%) minimal impact is expected.

36.4 Naltrexone

- Contra-indicated in acute hepatitis or severe hepatic impairment
- Use with caution in other forms of hepatic impairment (consider dose reduction)
- Has been associated with alterations in liver function tests
- Monitor liver function before and during treatment (at least every 3 months)

36.5 Diazepam

- Diazepam is hepatically metabolised and may accumulate
- Consider using lower doses
- Consider using a benzodiazepine that is not metabolised by the liver e.g. lorazepam or oxazepam.
- Decision to treat should be made in conjunction with a specialist prescriber in the field of substance misuse and the hepatology department.

36.6 Acamprosate

- Safety has not been established in severe hepatic impairment (caution advised).

36.7 Disulfiram

- Use with caution.

36.8 Nalmefene

- Use with caution but no dose adjustment required in mild-moderate impairment
- Contra-indicated in severe hepatic impairment

37. Prescribing for older adults

- Many of the medications used in alcohol / substance misuse have not been specifically tested in clients over 65 years old. Therefore the manufacturers may advise that their medication should not be used, or used with caution in this client group.
- Clients presenting for treatment should not be excluded from a pharmacological intervention that would otherwise be considered appropriate, based solely on their age.
- Dose reductions may be required with advancing age and should be considered at reviews.
- In general consideration should be made to the client's:
  - co-morbidities

    - other medications
    - hepatic function
    - renal function (which generally declines with increasing age).
- Older adults with a history of drug misuse may be at risk of hepatic damage from hepatitis B or C infection.
- Older adults with a history of alcohol misuse are at risk of alcoholic liver disease, as well as other impairments in physical health, cognitive function and social and psychological functioning.
- The falls risk and cognitive decline should be considered.
- Older adults are generally more susceptible to the adverse effects of medications.
- Doses should be increased carefully.
- **Benzodiazepines in particular** should be used with care in the elderly due a known increased risk of falls and cognitive impairment. Anecdotal evidence suggests this is also a route for diversion to the illegal market.
- Refer to manufacturers' SPCs (www.medicines.org.uk) for full details for individual drugs.
- Further advice / liaison can be sought from the care of the elderly physicians at Derriford or Mount Gould hospital, or relevant specialist physician(s) where appropriate.

38. Young People (under 18 years)

- Many of the medicines used in alcohol / substance misuse have not been specifically tested in young people.
- Psychosocial interventions will form the mainstay of treatment, with additional prescribing interventions indicated for a smaller number.
- Considerations when prescribing to young people:
    - Type and extent of misuse (which may more often follow a binge pattern in which prescribing interventions are unlikely to be appropriate)
    - Differences in drug metabolism
    - Their ability to give informed consent
    - Information sharing / confidentiality and involvement with those with parental responsibility
    - The product licence of the proposed medication (i.e. off-label use)
    - Provision of appropriate information about the medication, including about off-label use

38.1 Methadone

- Not advised for use in children
- Licensed in over 16s
- Commence at 10mg if tolerance is unclear
- Titrate doses carefully
- All doses should be supervised

38.2 Buprenorphine

- Licensed for use in over 16s
- Usually commence at 4mg daily

- Titrate doses carefully
- All doses should be supervised

38.3 Clonidine

- NOT to be used in children as a DETOX option

38.4 Naltrexone

- Not licensed in under 18s
- Can consider (off-license) for motivated young people, with the support of family

38.5 Diazepam

- Can be used with the same caveats as prescribing for benzodiazepine dependence in the adult population
- Benzodiazepine dependence and withdrawal can be associated with self-harming and suicidal behaviours in young people so close monitoring is required

38.6 Acamprosate

- Not licensed in under 18s
- Consider (off-license) where the young person has support from their family

38.7 Disulfiram

- Not licensed in children

38.8 Nalmefene

- Not licensed in under 18s

39. Under and overweight clients

- With the exception of acamprosate (see section 28) there are no specific dose adjustments recommended for clients based on their weight.
- Underweight clients may be adequately treated with lower doses than “usual” but should not be denied “usual” doses if these are required. Extremely underweight or malnourished clients may be at increased risk of some adverse effects (e.g. QT prolongation).
- Overweight / obese clients should not be given higher doses for this reason.

40. End of life

- Substance misuse clients with a palliative diagnosis should have access to the same range of end of life services as patients without substance misuse problems.
- Substitute prescriptions can continue, although may need to be reviewed in the light of other problems e.g. constipation, swallowing difficulties and use of other

opiates.
- Close liaison with the palliative care team is required to promote a “good death”.
- Seek advice from Medical lead/clinical lead as needed.

41. Training implications

- Include in local induction and appraisal for all relevant Livewell SW staff
- All relevant Livewell SW staff will demonstrate understanding of this policy through line management and appraisal
- Livewell SW staff to deliver training to Harbour staff as part of on-going medicines management training. Livewell SW staff will be available to train other providers within the Plymouth treatment system as required.

42. Monitoring compliance

- Medicines incidents will be reviewed by relevant managers and the Medicines Governance Group
- Specific audits related to aspects of this policy may be co-ordinated by the substance misuse governance pharmacist, results being fed back to relevant teams and the Medicines Governance Group.

Organisational Approval

All policies are required to be electronically signed by the Lead Director. Proof of the electronic signature is stored in the policies database.

The Lead Director approves this document and any attached appendices. For operational policies this will be the Locality Manager.

The Executive signature is subject to the understanding that the policy owner has followed the organisation process for policy Ratification.

Organisational Approval		
Senior Clinician Approval	**Title**	Medical Lead – Harbour Substance Misuse Service
	Organisation	Livewell Southwest
	Name	*Names & Signatures on Electronically Signed Copy*
	Signature	
	Date	
Controlled Drugs Accountable Officer	**Title**	Controlled Drugs Accountable Officer
	Organisation	Livewell Southwest
	Name	*Names & Signatures on Electronically Signed Copy*
	Signature	
	Date	
Governance Approval	**Title**	Governance & Patient Safety Pharmacist
	Organisation	Livewell Southwest
	Name	*Names & Signatures on Electronically Signed Copy*
	Signature	
	Date	
Board Approval	**Title**	Medical Director
	Organisation	Livewell Southwest
	Name	*Names & Signatures on Electronically Signed Copy*
	Signature	
	Date	

Appendix A- Plymouth's Treatment System Including Plymouth Alliance

(The Plymouth Alliance in Plymouth, England)

Services for drug and alcohol treatment are multiple and diverse with a mixed economy of statutory NHS and Social Care alongside voluntary sector providers with some directly commissioned by Public Health England. The key agencies are listed below.

Prescribing

Clinical Governance demands that prescribers are trained, work within competency and participate in on going professional development to sustain quality of care. In Plymouth, the care of drug users is provided by either the Livewell SW prescribing service within Harbour or by GP's working under the Local Enhanced Service known as **LES GPs**. These two groups largely provide prescribing for clients in treatment and some GP's have undertaken training through RCGP accredited courses.

Livewell SW prescribing service within Harbour

Livewell SW employs this small team whose offices are on Floor 1, Hyde Park House, Mutley Plain being hosted by Harbour. The team is a mixture of medical and non-medical nursing prescribers (NMP). Administrative support is provided.

LES GP Scheme

This scheme has been running since 2002 and involves 30 GPs from the following 20 surgeries:

Beaumont Villa/Pathfields Group, Devonport HC, North Road West MC, Southway Surgery, St Levan Surgery, St. Neots Surgery, Wycliffe Surgery and Adelaide Health Centre.

Harbour drug & alcohol services www.harbour.org.uk

Founded in 1988 Harbour is a voluntary sector charity that employs drug and alcohol practitioners within teams for Community Drugs & Alcohol; Criminal Justice and Family & Young People (SHARP). The first two operate from Hyde Park House on Mutley Plain and the latter from Seymour House in Devonport.

Please note that whilst Harbour play a central role with the commissioners in managing the provision of prescribed interventions and hosting the Livewell SW prescribing service, they do not employ prescribers. Harbour drug and alcohol workers are often the first port of call from outside agencies such as Derriford Hospital and with their extensive experience will do their best to care co-ordinate on behalf of clients. However, the expertise for prescribing resides within the **Livewell SW prescribing service** and the LES GP scheme and these prescribers will need to be consulted directly for specific prescribing issues.

Hamoaze House www.hamoazehouse.org.uk

Day services based in Devonport behind the Scott Memorial for Adults and Young People.

Shekinah Mission www.shekinahmission.co.uk

Services for the homeless and provides employment training courses.

Sunflower and Trevi House www.trevi.org.uk/

Women's and children's charity based in South West England which provides safe and

nurturing spaces for women in recovery to heal, grow and thrive.

Inpatient treatment may be available out of area as needed, including Boswyns, Cornwall.

Appendix B- Treatment Goals and Example Treatment Outcome Measures

Treatment goals	Example treatment outcome measures
Engagement with service	Attending appointments Use of volunteers and peer support Use of day services Use of counselling/therapeutic services/groups Use of mental health services Attendance at preparation for Rehab groups Use of self-help groups (AA, NA, SMART etc.)
Harm reduction	Safer injecting behaviour Needle Exchange Cessation of injecting Reduced amount/frequency of drug use Reduced/controlled drinking Increased knowledge of consequences of drug or alcohol use Awareness of overdose risks, prevention and management
Health promotion	Hepatitis B/C/HIV testing Hepatitis A&B vaccination Safer sex Engagement with Primary Care services Weight management Smoking cessation Promote physical health checks
Stabilisation of drug use	Improved social relationships Improved housing Reduced debt Increased daily activity Reduced criminal activity
Maintenance on medication	Reported cessation of problem drug use Negative drug and alcohol screening
Detoxification	Cessation of substitute prescribing Continued recovery without relapse
Abstinence	Drug free after 1,3,6 months Continued relapse prevention activity

Appendix C- Windows of detection in urine samples

Note: Detection times are only very approximate and highly dependent upon dose, frequency, route of administration and urine excretion and concentration

Drug or its metabolite(s)	**Duration of detectability**
Amphetamines including methylamfetamine and MDMA	1-4 Days (sure screen) 2 Days (orange book)
Benzodiazepines: • Ultra short acting (half life 2hrs) e.g. midazolam • Short-acting (half life 2-6hrs) e.g. triazolam • Intermediate acting (half life 6-24hrs) e.g. temazepam. • Long acting (24hrs+) e.g. diazepam, nitrazepam	(orange book) 12 hours 24 hours 2-5 days 7 days +
Buprenorphine and metabolites	8 days (orange book) 3-6 weeks (sure screen)
Cocaine metabolite	2-3 days (orange book)
Cocaine	2-5 days (sure screen)
Methadone (maintenance dosing)	7-9 days (orange book) 1-7 days (sure screen)
Codeine, dihydrocodeine, morphine (heroin detected in sample as the morphine metabolite)	1-4 days (sure screen)
Cannabinoids: • Single use • Moderate use (three times a week) • Heavy use (daily) • Chronic heavy use (more than three times a day)	30 days (sure screen) 3-4 days 5-6 days 20 days Up to 45 days (orange book)

Appendix D- The Short Opiate Withdrawal Scale (SOWS)

Please put a check mark (√) in the appropriate box if you have suffered from any of the following conditions in the last 24 hours:

	None	Mild	Moderate	Severe
Feeling Sick				
Stomach Cramps				
Muscle Spasms/Twitching				
Feelings of Coldness				
Heart Pounding				
Muscular Tension				
Aches and Pains				
Yawning				
Runny Eyes				
Insomnia/Problems Sleeping				

Place the completed procedure record and accompanying documents in the client's notes. (This questionnaire is published in Addictive Behaviours 1990, 15, 487-490. The development of a short opiate withdrawal scale by Michael Gossop)

Appendix E - Clinical Opiate Withdrawal Scale (COWS).

For each item, write in the number that best describes the patient's signs or symptoms. Rate on just the apparent relationship to opiate withdrawal. For example, if heart rate is increased because the patient was jogging just prior to assessment, the increased pulse rate would not add to the score.

Patient's Name:_____ Date: _____ Times: _____ _____ _____ _____				
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				
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				
Restlessness *Observation during assessmen*t 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				
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				
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				
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				
GI Upset: *over last ½ hour* 0 no GI symptoms 1 stomach cramps 2 nausea or loose stool 3 vomiting or diarrhoea 5 Multiple episodes of diarrhoea or vomiting				
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				
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				
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 pilo-erection of skin can be felt or hairs standing up on arms 5 prominent pilo-erection				
Total scores with observer's initials				

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

Appendix F - Clinical Institute Withdrawal Assessment for Alcohol Revised (CIWA – Ar)

Patient:_____Pulse or heart rate, take for 1 minute:_____

Date_____Time_____Blood pressure_____

Nausea and Vomiting: Ask, "Do you feel sick to your stomach? Have you vomited?" Observation: 0 No nausea and no vomiting 1 Mild nausea and no vomiting 2 3 4 Intermittent nausea with dry heaves 5 6 7 Constant nausea, frequent dry heaves and vomiting.	**Tactile Disturbance:** Ask, "Have you any itching, pins and needles sensations, any burning, any numbness, or do you feel bugs crawling under your skin?" Observation: 0 None 1 Very mild itching, pins and needles, burning or numbness 2 Mild itching, pins and needles, burning or numbness 3 Moderate itching, pins and needles, burning or numbness 4 Moderate severe hallucinations 5 Severe hallucinations 6 Extremely severe hallucinations 7 Continuous hallucinations
Tremor: Arms extended and fingers spread apart. Observation: 0 No tremor 1 Not visible but can be felt fingertip to fingertip 2 3 4 Moderate, with patient's arm extended 5 6 7 Severe, even with arms not extended	**Auditory Disturbances:** Ask, "Are you more aware of sounds around you? Are they harsh? Do they frighten you? Are you hearing anything that is disturbing to you? Are you hearing things you know are not there?" Observation: 0 Not present 1 Very mild harshness or ability to frighten 2 Mild harshness or ability to frighten 3 Moderate harshness or ability to frighten 4 Moderately severe hallucinations 5 Severe hallucinations 6 Extremely severe hallucinations 7 Continuous hallucinations
Paroxysmal Sweats: Observation: 0 No sweat visible 1 2 3 4 Beads of sweat obvious on forehead 5 6 7 Drenching sweats	**Visual Disturbances:** Ask, "Does the light appear to be too bright? Is the colour different? Does it hurt your eyes? Are you seeing anything that is disturbing to you? Are you seeing things you know are not there?" Observation: 0 Not present 1 Very mild sensitivity 2 Mild sensitivity 3 Moderate sensitivity 4 Moderately severe hallucinations 5 Severe hallucinations 6 Extremely severe hallucinations 7 Continuous hallucinations

Blood Pressure:**Anxiety:** Ask, "Do you feel nervous?" Observation: 0 No anxiety, at ease 1 Mildly anxious 2 3 4 Moderately anxious, or guarded, so anxiety is inferred 5 6 7 Equivalent to acute panic states, as seen in severe delirium or acute schizophrenic reactions	**Headache, Fullness in Head:** Ask, "Does your head feel different? Does it feel like there is a band around your head?" Do not rate dizziness or light-headedness. Otherwise, rate severity. 0 Not present 1 Very mild 2 Mild 3 Moderate 4 Moderately severe 5 Severe 6 Very severe 7 Extremely severe
Agitation: Observation 0 Normal activity 1 Somewhat more than normal activity 2 3 4 Moderately fidgety and restless 5 6 7 Paces back and forth during most of the interview, or constantly thrashes about	**Orientation and Clouding of Sensorium:** Ask, "What day is this? Where are you? Who am I?" Observation: 0 Oriented and can do serial additions 1 Cannot do serial additions or is uncertain about date 2 Disoriented for date by no more than 2 calendar days 3 Disoriented for date by more than 2 calendar days 4 Disoriented for place and/or person

Total **CIWA – Ar** Score _____
(maximum possible score = 67)

Patients scoring less than 10 do not usually need additional medication for withdrawal.

Rater's Initials

Note: The CIWA – Ar is not copyrighted and may be used freely. Source: Sullivan JT, Sykora K, Schneiderman J, Naranjo CA & Sellers EM (1989) Assessment of alcohol withdrawal: The revised Clinical Institute Withdrawal Assessment for Alcohol scale (CIWA – Ar) British *Journal of Addiction 84:1353 – 1357*

ASAM Patient Placement Criteria, Second Edition – Revised

Revised- March 2009

Appendix G- THE PLYMOUTH MEDICATION FOR RECOVERY AGREEMENT

We know that making changes is often challenging, and can cause fear and anxiety. We understand that swapping illicit opiates for prescribed opiates is a step of trust. Our goal when providing you with medication is to keep you safe, to avoid overdose and to support you in your recovery.

A prescription is only a part of your treatment and we expect for you to engage in a broader package of care to support your recovery journey.
A prescription comes with expectations and these include:

- **Taking your own medication as prescribed each day.**
1. **Attending your appointments with your worker.**
2. **Attending regular prescribing reviews.**
3. **Having screens for drugs or alcohol, and having relevant blood tests or ECGs**
4. **Being registered with a GP who we will communicate with**

There are some additional expectations where there are <u>children</u> in your household.

- **All medication MUST be stored out of sight and out of reach of children at all times. We can provide a safe medicines storage box for FREE.**
- **YOU must NEVER give any of your medication to children as they may die.**

There may be times when we make changes to your prescribing. This might include, holding your prescription at the pharmacy until we hear from you or see you, returning to more regular medication collection, asking you to consume your dose at the pharmacy, reducing your dose or stopping your medication.
Some of the situations which may lead to your prescription being changed:

- **When we do not see you.**
- **Intoxicated or aggressive behavior which includes behavior at the pharmacy.**
- **If your behavior leads to pharmacies refusing to dispense to you.**
- **If it is unsafe for you to have your medication e.g. if you are on opiate medication and you have repeated opiate overdoses while taking it.**

If you have 3 consecutive missed collections of your medication at your pharmacy, the pharmacist is not allowed to give it to you without discussing it with us. We have asked all Community Pharmacists not to dispense medication to you if they observe you to be intoxicated.

PREGNANCY

- **Medication can affect pregnancies, so family planning is essential. Please let us know immediately if you are pregnant, we can provide a test and we can advise you on next steps**

DRIVING

- **It is your responsibility to inform the DVLA of any medication or treatment impacting on your ability to drive safely, THIS TREATMENT.**
- **We have a duty to take actions if we are concerned enough about your safety to drive and the safety of others.**

HOLIDAY REQUESTS and doses in advance of normal routines, will only be approved if it is safe to do so and travel arrangements are in place and safe.

- **Speak to your worker immediately if you are going away or your routine changes and you cannot collect.**
- **Give at least 5 working days' notice for UK holidays**
- **Give 10 days' notice if travelling abroad.**
- **We cannot prescribe for a holiday out of area if it exceeds 2 weeks, other arrangements may need to be made.**

AT THE PHARMACY you must:

- **Collect your own prescription and take it exactly as directed.**
- **Prescriptions can only be released to another person in exceptional circumstances and with your worker and prescriber's agreement. You must also write a letter to the pharmacy with your instructions.**
- **Daily doses missed cannot be replaced.**
- **Any unused medication must be returned to the pharmacy and not stockpiled at home as this is unsafe.**
- **Lost or stolen prescriptions (with a police log) or lost medication may be replaced, at the discretion of the prescriber. It will not be replaced repeatedly.**
- **All prescription fraud will be reported to the Police and may result in your medication being stopped.**
- **It is illegal to take someone else's medication or give your medication to someone else. If this happens and someone comes to harm you are likely to be investigated. We are also likely to review your medication.**

I have had my treatment explained to me in terms of the potential benefits and risks and received written information on my medication.
I am aware of the increased risk of overdose after a period of abstinence due to loss of tolerance.

CLIENT NAME:	DOB:
PHARMACY:	
PRESCRIBER:	CARE CO-ORDINATOR:

Signature: _____ Date: _____

Witnessed by: _____ Date: _____

Copies to: 1. CLIENT 2. PHARMACY 3. CARE CO-ORDINATOR & PRESCRIBER

Appendix H- Harbour & Livewell SW Joint Non-attendance Policy for clients in receipt of Controlled Drugs

<table>
<tr><td colspan="3">Standard Operating Procedures Harbour and Livewell SW Joint Non-Attendance Policy clients in receipt of Controlled Drug medication (methadone, buprenorphine or diazepam)</td></tr>
<tr><td colspan="3">Author: Hazel Roberts/Harry Waters/ Adrian Edwards</td></tr>
<tr><td colspan="3">Sponsor: Hazel Roberts, Clinical Manager, Livewell
Adrian Edwards, Head of Operations, Harbour</td></tr>
<tr><td colspan="2">Creation Date: March 2021
Review Date: 3 years time</td><td>Next Review: March 2023</td></tr>
<tr><td>Links to policies and other guidance:</td><td colspan="2">Operational Policies for Criminal Justice

Comprehensive Assessment Standard Operating Procedure

Recovery Planning Standard Operating Procedure

DIP screening tool.

Livewell Prescribing Policy</td></tr>
</table>

Purpose of the Document

This policy looks to unify the position of both the pharmacological and the psychosocial elements of treatment as levers for change and engagement in the client's recovery. This includes a proactive system to support clients to attend appointments.

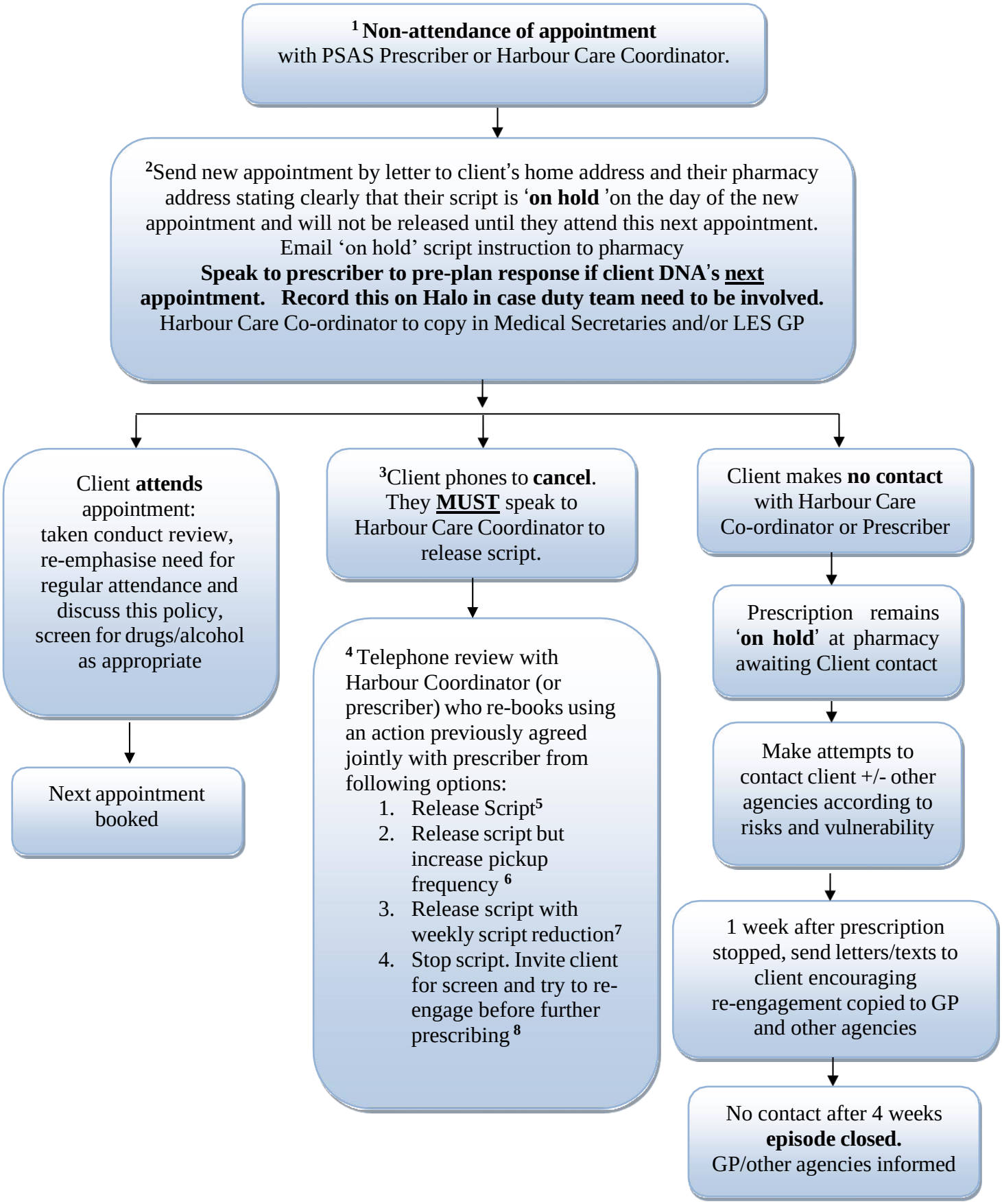
The aim of the document is to empower practitioners with more options if clients do not attend by enhancing client motivation to become engaged in their treatment. It is not a punitive or blaming process that will alienate clients but, it will generate new conversations with clients about their responsibility to make choices if they want to continue in treatment with our service. It is important that clients are seen on a regular basis and engage with the treatment process.

This document complements existing and evolving policies and all practitioners will need to remain informed of their responsibilities to clients, children and vulnerable adults that they work with particularly regarding mental health and capacity issues. The right balance has to be struck between the different elements that comprise treatment.

Note that withdrawal of treatment is not a decision to be taken lightly. When necessary, consultation with others directly such as supervisors or managers, LES GP's, PSAS staff or at meetings such as the Clinical Forum, Child Protection or Risk Management meetings will need to inform decisions as well.

Client Groups

This policy is for any clients in receipt of Controlled Drug medications as part of their treatment within the partnership in whatever part of the service if such medicines are prescribed as part of the package, the policy applies.



PLEASE FOLLOW NOTES LINKED TO NUMBERED BOXES ON THE FLOWCHART

1. Any non-attendance at a prescriber or Harbour Care Co-ordinator appointment triggers this process.

2. Think carefully about your accessibility on the next appointment day as you may need to field a call from the client. The scheme works best with morning appointments as there is more time to react so avoid appointments after 2pm or on Friday. When a client picks up routinely after 5pm then to avoid a conflict in the pharmacy, release the script on the day of the non-attendance but hold it thereafter until you have contact from the client.

IN ADVANCE of this date - mindful of holidays for you and prescriber - discuss jointly with the prescriber planned script changes if the client later fails to attend again (e.g. reduced pickup, dose reduction, stop script). The plan needs to be recorded on Halo in case the Duty team have to be involved. PLEASE NOTE: no one wants to handle a crisis call with an irate client on the phone at the pharmacy demanding their script!

3. Clients ringing to cancel or apologise for missing an appointment are to put through to their Harbour Care Co-ordinator or the Prescriber.

4. Telephone Review: when the client calls, new approaches can now occur to motivate engagement in treatment from a menu of options depending on the individual client's context and risks. A decision has to be reached - involving the client - as to the most appropriate way forward from the four choices **No. 5 to 8** below. Please note that **No. 6 and 7** require new scripts from the prescriber to be generated, signed and sent to the pharmacy, so safety risks demand a more urgent response, **allow 1 week** for this process to activate and inform the client of this.
   This can also be expedited if it is appropriate for the client to transfer the new prescription directly to the pharmacy.

5. Release script: rebook and release the script if client presents a genuine reason for non-attendance and demonstrates a motivation to attend next time. Remind client that script will be put **'on hold'** next time and return to **No.2** above.

6. Daily pick up: return to daily pickup (or a lesser form of previous interval dispensing) and release script. This helps a less well motivated client to re-engage, reinforcing the fact that reduced pickup is a privilege earned by recovery progress and not an entitlement. Remind client that script will be **'on hold'** next time and return to **No.2** above.

Email LES GP or PSAS Prescriber/Medical Secretary of new script request.
Inform pharmacy**.**

NOTE: Re-introduction of supervised consumption without seeing clients is prone to dangers as without honest dialogue or screening we cannot be certain that a client is actually taking their script rather than diverting or stockpiling it.
ALWAYS SPEAK TO A PRESCRIBER BEFORE CONSIDERING THIS OPTION who will arrange a phased transfer to daily supervised consumption
See Prescribing Policy section 14 for more detail

7. Weekly script reduction: rebook, establish daily pickup, institute a weekly script reduction and release the script. This approach suits the more ambivalent client who is not sure if they want to stay in treatment. Weekly reductions will usually be Methadone by 10ml, Buprenorphine by 2mg and Diazepam by 5mg. Remind client

that script will be put **'on hold'** next time and return to **No.2** above.

Email LES GP or PSAS Prescriber/Medical Secretary of new script request.
Inform pharmacy**.**

8. Stop script: rebook appointment (if possible) but stop script. These situations are rare but might occur if a client discloses that they have been collecting but not taking their script for some time or the service becomes aware of high risk poly-drug or alcohol use on top of a prescription to the danger of the client or others. Urgent discussion with a supervisor, manager or prescriber is required in this scenario.

Email LES GP or PSAS Prescriber/Medical Secretary of new script request.
Inform pharmacy**.**

Multiple attempts to contact client or other involved agencies must be made to try and re-engage them in treatment.

Additional Notes

Harbour Specialist Workers will take responsibility for their own client appointments whilst the Medical Secretaries will deal with all matters concerning PSAS prescriber appointments e.g. calling pharmacy and rebooking client.

Harbour Specialist Workers will work alongside Prescribers and attend prescribing reviews.

ALL exceptions to this policy will need managerial approval.
In the case of managing high risk clients (e.g. pregnant women) a decision to not follow this policy will need both managerial and prescriber support before such changes are enacted e.g. not putting a prescription on hold after non-attendance.
A very limited flexibility can be given to clients newly engaging in treatment but only with managerial approval.

If there is professional disagreement about following the policy e.g. a disagreement between Prescriber and Care Coordinator, and it is unable to be resolved between individuals, then the case should be taken to relevant managers for clarification.

LES GP's have been requested to follow this policy by the Commissioners and will support Harbour Specialist Workers in implementing this policy.

It's EVERYBODY'S responsibility to keep the pharmacy informed.

All actions and communications should be recorded on Halo.

Appendix J- The symptomatic relief of opioid withdrawals

Adjunctive therapy may be required for the management of opioid withdrawal symptoms. These medications can be prescribed on an “as required” basis.

Symptom	Treatment options
Insomnia	Zopiclone 7.5mg at night (7.5mg x 5 tablets prescribed by detox team)
Agitation / anxiety	Diazepam 5-10mg three times a day when required for up to 3 days (5mg x 10 tablets prescribed by detox team) Specialist advice should be sought in the event of severe agitation or anxiety
Diarrhoea	Loperamide (2mg tablets): 4mg initially, then 2mg after each loose stool up to a maximum of 16mg in 24 hours
Stomach cramps	Mebeverine 135mg three times a day
Nausea and vomiting	Metoclopramide 10mg every eight hours OR Prochlorperazine 5mg three times a day
Muscular pains or headaches	Paracetamol Ibuprofen Algesal (topical rubefactant) for muscle pain

Refer to current BNF for further drug details.

Untreated heroin withdrawal symptoms typically reach their peak 36-72 hours after the last dose and symptoms will have subsided substantially after 5 days. Untreated methadone withdrawal typically reaches its peak at 4-6 days after last dose and symptoms do not substantially subside for 10-12 days.

For further details refer to the LSW Detox Policy.

Appendix K- Holiday Request Form

Client Name	
Date of Birth	
Halo Number	
Name of SMS making request	
Name of usual prescriber	
Date attended last prescribing review	

1	Are you the client's regular Harbour SMS? If not who is?		
2	Date of LAST collection in Plymouth before travel		
3	Date of collection on RETURN to Plymouth		
4	Reason for holiday		
5	Holiday destination		
	If holiday is in UK, can existing arrangements be replicated at another pharmacy? Please supply contact details of temporary pharmacy. If not why not?		
	For a holiday OUTSIDE UK (support letter requirement) Date of OUTWARD travel from UK Date of RETURN travel to UK		
6	Date last seen by SMS or prescriber: Brief summary of client's level of treatment engagement in past 3 months and risk profile.		
7	Date and result of last drug/alcohol screen		
8	Holiday relevant risk assessment: Are risks identified in any of the following areas?	YES	NO
	Child Safeguarding		
	Adult Safeguarding		
	Safe storage of medicines		
	Alcohol misuse		

	Drug misuse		
	Overdose		
	Mental health		
9	Confirm what advice has been given to client to reduce above risks		
10	On grounds of clinical safety, do YOU support this request? Detail any conditions required.		

Appendix L- Harbour Take Home Naloxone Procedure

Please refer to the most up-to-date Take Home Naloxone SOP on Harbour Drive G:\Harbour

Appendix M- DVLA notification leaflet

Alcohol, drugs and driving - DVLA notification

As a driver, you have a legal responsibility to inform the DVLA of any condition that is likely to affect safe driving.

DVLA guidelines state this includes anyone with:

- Persistent alcohol misuse
- Alcohol dependence
- Alcohol related disorders (e.g. hepatic cirrhosis with chronic encephalopathy, alcohol induced psychosis, cognitive impairment)
- Drug misuse or dependence
- Seizures associated with alcohol or substance use.

The DVLA can be informed by completing a questionnaire from their website at https://www.gov.uk/health-conditions-and-driving

In each case the DVLA will review your information and advise whether or not you can continue to hold a driving license. In some cases the DVLA will issue a driving license with a shorter expiry (e.g. 1, 2, 3 or 5 years).

Alcohol clients: Continued alcohol misuse may lead to your driving licence being revoked.

Drug Clients: Being stable on prescribed methadone or buprenorphine will not normally lead to your driving licence being revoked unless you continue to use drugs (including benzodiazepines or alcohol) on top of your prescription.

If the DVLA cancels your driving license (known as 'revoking' your license), you cannot continue to drive but may be able to re-apply for a license in the future. Full details will be provided to you by the DVLA.

As well as informing the DVLA **you are also required to inform your car insurance company.**

If we are aware that you are continuing to drive under the influence of drugs or alcohol, we may be obliged to inform the statutory authorities including the DVLA. This could negatively affect their decision to approve your driving license.

Further information is available on the DVLA website:
https://www.gov.uk/driving-medical-conditions