Prescribing and Treatment Review Guidelines DQ399

Summary

These guidelines summarise the procedures and processes that should be followed to ensure safe and effective prescribing within Addaction.

Prescribers are expected to take the recommendations in these guidelines fully into account when exercising their judgment alongside the individual needs, preferences and values of our clients.

These guidelines do not override the responsibility to make decisions appropriate to the circumstances of the individual client and do not override the need for the prescriber to be competent to make clinical decisions appropriate to the individual client.

The reader is also referred to the Orange Book, from which these guidelines have been established, as well as further reading that can be found at the end of each section.

Drug misuse and dependence (Orange Book) : UK guidelines on clinical management https://www.gov.uk/government/publications/drug-misuse-and-dependence-uk-guidelines-on-clinical-management

Other relevant policies and guidelines:

- Addaction Formulary (DQ231)
- Substance Misuse Medication Guidelines
- Alcohol Guidelines
- Smoking Cessation Guidelines
- Drug Testing Policy
- Medicines Code
- Medicines Reconciliation Policy
- Non-Medical Prescribing Policy
- Safeguarding Policy
- Case Management Policy and Standard Operating Procedure
- Resource Library - Harm Reduction

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Issue	Page(s)	Issue Date	Additions/Alterations	Initials
1.0	All	19/9/2019	New guidance. Replaces: DQ105 - Prescribing and Treatment Review Policy DQ076 – Pain management and substance misuse DQ096 – Missed doses DQ104 – Prescribing after overdose DQ103 – Prescribing in pregnancy DQ159 – Medication and overseas travel	RB

Contents

1.0 Prior to Prescribing

Prior to prescribing taking place, the client must have had a full, comprehensive assessment which should include:

- ➔ Drug and alcohol use
- ➔ Physical health
- ➔ Mental health
- ➔ Blood borne virus status
- ➔ Children and child protection
- ➔ Adult safeguarding / domestic violence and abuse
- ➔ Offending / involvement in criminal justice system
- ➔ Family and social relationships
- ➔ Employment, training and education
- ➔ Recovery Capital (personal strengths and resilience)
- ➔ Housing
- ➔ Finance and debt
- ➔ Next of kin information

For more information on the comprehensive assessment please see DQ163 - Case Management Policy and Standard Operating Procedure (SOP).

Should a need for prescribing be indicated, the client must be booked in for a separate clinical assessment. This can take place immediately after the comprehensive assessment or at a later date.

In exceptional circumstances prescribing may be commenced before a comprehensive assessment has taken place, where individual risk assessment suggests that there are risks to the client if OST is not started immediately.

Whilst any unnecessary delay for clinical assessment and prescribing should be avoided it is sometimes useful for clients to attend a key working session so that they can be clear on their goals for treatment and the expectations of the service.

1.1 Clinical Assessment

The purpose of the clinical assessment is to ensure that prescribing carried out within Addaction is safe, effective and is in line with the care plan for the individual. It should last up to an hour.

It is important to ensure that this process avoids unnecessary steps, particularly in patients who need to stabilise on Opioid Substitution Therapy (OST) to reduce harm. Patients already known to the service can usually be safely re-assessed and re-started on treatment rapidly after a short lapse (usually less than two weeks).

Pharmacological management must be provided alongside psychosocial interventions (PSI) and support, including risk management. Addaction may not be the sole organisation to provide all of these interventions but may work in partnership with other organisations to develop a joint care plan and multi-disciplinary approach.

The prescribing assessment should include:

1. Assessment of capacity to make treatment decisions
2. Confirmation of the client's dependency including drug and alcohol history (including any previous episodes of treatment/periods of abstinence). Look for risks associated with poly-drug use.
3. Observation of opiate use (such as injecting sites or signs and symptoms of physical withdrawal)
4. Urine drug testing (usually two tests, at least five days apart)
5. BBV status and vaccination record and offer of Hepatitis A & B vaccination if appropriate
6. Urine screen results
7. Medical history including mental health
8. Examinations and testing that may be required include:
    - injecting site assessment
    - weight and height
    - urine testing for common conditions such as diabetes and infection
    - respiratory or cardiac function
9. Known allergies
10. Current medication prescribed by the client's GP and any over the counter remedies taken must be confirmed and noted (see DQ234 - Medicines Reconciliation Policy for more information), however, prescribing should not be delayed in the absence of this information.
11. Risk of harm (e.g. overdose) and consideration to the mitigation of those risks (e.g. supervised consumption and provision of take home naloxone)
12. Social circumstances and risks (housing, children, support, employment, domestic violence, safeguarding concerns)
13. Forensic history including current status
14. Driving regulations
15. Safe storage of medication
16. Agreed treatment plan and next review

Depending upon the presence of history, risks symptoms and physical signs other tests may include, pregnancy confirmation testing, liver function tests, thyroid and renal function, and full blood count. An ECG may be required if the client is taking interacting

medication and methadone is being considered as a treatment option.

In cases of transfer from outside of area, prison releases, or hospital discharge, confirmation of the last dose consumed and written confirmation of drug/dose and preparation (e.g. sugar free/split daily dosing) must be available to the prescriber for continuation of prescribing (see DQ234 - Medicines Reconciliation Policy).

A template for the initial clinical assessment and ongoing review can be found here. It is expected that all prescribers (medical and non-medical) use this template to ensure a standard approach across clinical services.

1.2 Treatment Plan

A clear treatment plan, including the goals of pharmacotherapy must be recorded in the client's record. Clinicians should assist clients in making their own informed choices about treatment goals and priorities, and agree the actions needed to best achieve these.

As part of the treatment plan, the service user should be screened for blood borne viruses and offered hepatitis A & B vaccination. Harm minimisation options should be reviewed.

The plan should be shared (with consent) with others involved in the client's care (mental health team, obstetrician/midwife and GP).

Consider initiating a multiagency needs assessment, including prescribing for comorbidities, safeguarding issues, and communication issues so that the client has a coordinated treatment plan and the necessary support networks.

The treatment plan should be reviewed regularly (by the clients Recovery Worker at each appointment and with the prescriber during the 12 week review).

1.3 Opioid Substitution Therapy

A prescription for OST should normally only be considered if:

- Opioids are being taken on a regular basis, usually daily
- There is convincing evidence of current dependence
- The assessment clearly supports the diagnosis and need for treatment
- The prescriber is satisfied that the client is likely to be able to comply with the prescribing regime
- The client is not receiving an opioid prescription for the management of dependence from another clinician.

1.3.1 Substance Specific Guidance

Information on prescribing individual medications can be found in the Substance Misuse Medication Guideline and the Alcohol Guidance.

1.3.2 Driving

All psychoactive drugs can impair driving. Similarly, drug misuse whether amounting to dependence or not, is regarded as a disability in this context.

1.3.2.1 Driver licensing requirements:

If a client drives, they must be advised to declare their drug or alcohol use to the Driver and Vehicle Licensing Agency (DVLA) as this may affect their capacity to drive safely.

In cases where the prescriber believes that the individual has failed to notify the DVLA and persists in driving under the influence of psychoactive drugs every reasonable effort should be made to persuade them to stop. The prescriber should inform the DVLA if it becomes clear that the person is continuing to drive contrary to advice. Relevant clinical information should be passed immediately, in confidence, to the Medical Advisor at the DVLA. If possible, before giving information to the DVLA the person should be informed and have confirmation in writing once the disclosure has been made.

Once on a prescription for OST, the client may re-apply for their license, providing that they are complying fully with either a methadone or buprenorphine maintenance programme. This is subject to a favourable assessment and annual medical review. There should be no evidence of continuing use of other substances, including cannabis.

Further advice including when a second opinion may be indicated is available from http://www.dvla.gov.uk

1.3.2.2 Offences related to drug use:

In England and Wales it is an offence to drive when certain controlled drugs are above a specified blood level. However, a medical defence exists for those 'over the limit' on their medicine, as long as they were taken 'in line with professional advice'.

Clients driving whilst taking medication covered by this offence (and this includes methadone, buprenorphine and diazepam) may wish to consider keeping some proof of treatment with them whilst driving.

1.4 Further Reading

1. Drugs and Driving - the Law available at: https://www.gov.uk/drug-driving-law

2.0 Treatment Optimisation

Treatment optimisation refers to the strategies employed by the Clinician and Recovery Workers to support the client in working towards and achieving aspects of their personal recovery plan. It involves the union of psychosocial interventions, medical management (e.g. opioid substitution therapy) and harm minimisation approaches which is reviewed as part of the recovery planning process and altered according to client need.

2.1 Dose Optimisation

The aim of dose optimisation of methadone or buprenorphine is to achieve complete cessation of illicit opioid use.

The evidence suggests that the optimal dose range for methadone is between 60mg and 120mg a day, whilst for buprenorphine it is between 12mg and 24mg per day. At these doses, not only are withdrawal symptoms suppressed, but also the cravings for opioids.

It is important to note that the dose at which a client feels 'comfortable' (i.e. not experiencing withdrawal symptoms) is likely to be lower than the dose that suppresses cravings. Therefore, during any clinical review, the clinician should investigate any reported cravings for the drug.

Dose optimisation should be the aim during titration of OST, and is best achieved with regular clinical review in the early stages of treatment.

2.1.1 Barriers to dose optimisation

All staff must be aware that there are barriers to dose optimisation that need to be understood in order to achieve a dose that stops illicit opioid use. For example, clients may not be aware that the dose needed to reduce cravings is likely to be higher than that which stops any withdrawal symptoms. There is a common misheld belief that it is 'harder' to come off higher doses than lower ones.

It is important to understand why an individual is reluctant to increase their dose of OST, and the risks/benefits of choosing not to do so. Additionally the role of all staff involved in the care of clients is to identify misconceptions about OST and educate clients on the evidence based reasons for dose optimisation. A leaflet to support this discussion is available at:

https://www.choiceandmedication.org/addaction/generate/handyfactsheetmethadonevsbuprenorphine.pdf

3.0 Supervision and dispensing arrangements

Supervised consumption by a community pharmacist is the best guarantee that a medicine is being taken as prescribed. It is preferable for all clients to be offered supervised consumption at a pharmacy to support induction onto OST and provided for a length of time appropriate to their individual needs and risks.

The service should be delivered in a way that protects clients' privacy and dignity. Supervision should take place in a private consultation room or a suitably discreet area of the pharmacy. There should also be due regard to maintaining confidential communication with clients in the open pharmacy area before and after any supervised use.

While supervision of prescribed medication, even if directed on the prescription, is not a legal requirement, any deviation from the prescriber's intended method of supply should be documented and the justification for this recorded. Any such decision should be made in the best interests of the client, ideally always involving the prescriber.

Supervised consumption must be considered a supportive and risk management based approach. It should be recognised that for many, a reduction in the frequency of pick up arrangements is an excellent reinforcer of progress made in an individual's treatment journey. It should never be used as a punitive measure and the decision to relax or increase supervised arrangements must be made on the basis of risk and in

full consultation with the client.

3.1 The process of supervision of medication

Oral methadone solution consumption can most easily be observed, whereas buprenorphine sublingual tablets can be more difficult to supervise because of the length of time taken for the tablet to dissolve.

Some pharmacists will (on direction from the prescriber) crush buprenorphine tablets before consumption to make the supervision process more straightforward. This practice, whilst common in some areas and services is technically off-licence. Therefore pharmacies should have appropriate clinical governance arrangements and protocols in place.

Other medication such as benzodiazepines, antidepressants, antipsychotics and medication for conditions such as tuberculosis and HIV can be prescribed to be dispensed in instalments and consumption supervised where local contracts are in place.

3.2 When and how to use supervision

- Levels of supervision should be based on an individual risk assessment
- Duration of supervision is dependent on individual clinical need
    - Long term, daily supervision is usually not appropriate for patients in regular, full-time work or education, where supervision is a clear barrier to retention in treatment and recovery
- The Addaction Prescribing Treatment Agreement (PTA) should be completed with the client, and a copy sent to the pharmacy who have agreed to provide a supervised consumption service to the client.

3.3 Stopping supervision

Supervised consumption should be relaxed only when the client's adherence is assured and should be actively reviewed thereafter with the aim of moving them to a decreasing frequency of non-supervised pick-up (e.g. from daily to thrice weekly, twice weekly and then to once weekly collection)

Take-home doses should **not** normally be prescribed where:

- The patient has not reached a stable dose, shows continued unstable drug misuse and excessive alcohol intake, or has an unstable psychiatric illness or is threatening self-harm
- There are concerns about diversion or inappropriate use
- There are concerns about possible risk to children, young people and vulnerable adults

3.4 Reinstating supervision

Supervision arrangement may need to be reinstated where tolerance may have been reduced and the risk of overdose is higher, for example:

- Clients restarting methadone or buprenorphine after a break in treatment

- If a significant dose increase is received
- During periods of instability
- Recent overdose
- Recent discharge from hospital or release from prison

Moving from a liberal pick up regime to supervised consumption requires careful consideration of dose due to the risk of overdose.

Prescribed doses could be split between supervised and take-home (e.g. a maximum of 40mg of methadone should be prescribed supervised and the remainder of the daily dose dispensed for taking-home). This can then be titrated up to the target dose being fully supervised unless there are significant clinical reasons for an alternative approach which must be documented.

Decisions on reducing or increasing supervision should include consultation with the multidisciplinary team, the client and the dispensing pharmacist.

3.5 Requests to alter dispensing arrangements

Careful consideration should be given to clients currently on supervised consumption who request special or exceptional arrangements for travel, holidays or family events.

Clients should be advised at the outset of treatment that they will need to give advance notice of holiday, travel, or other events that require altered prescribing or dispensing arrangements.

Urgent requests will inevitably arise and services need processes to assess and respond to such requests, for example, by arranging for a pharmacy close to the client's destination to pick up supervision arrangements for a short period of time.

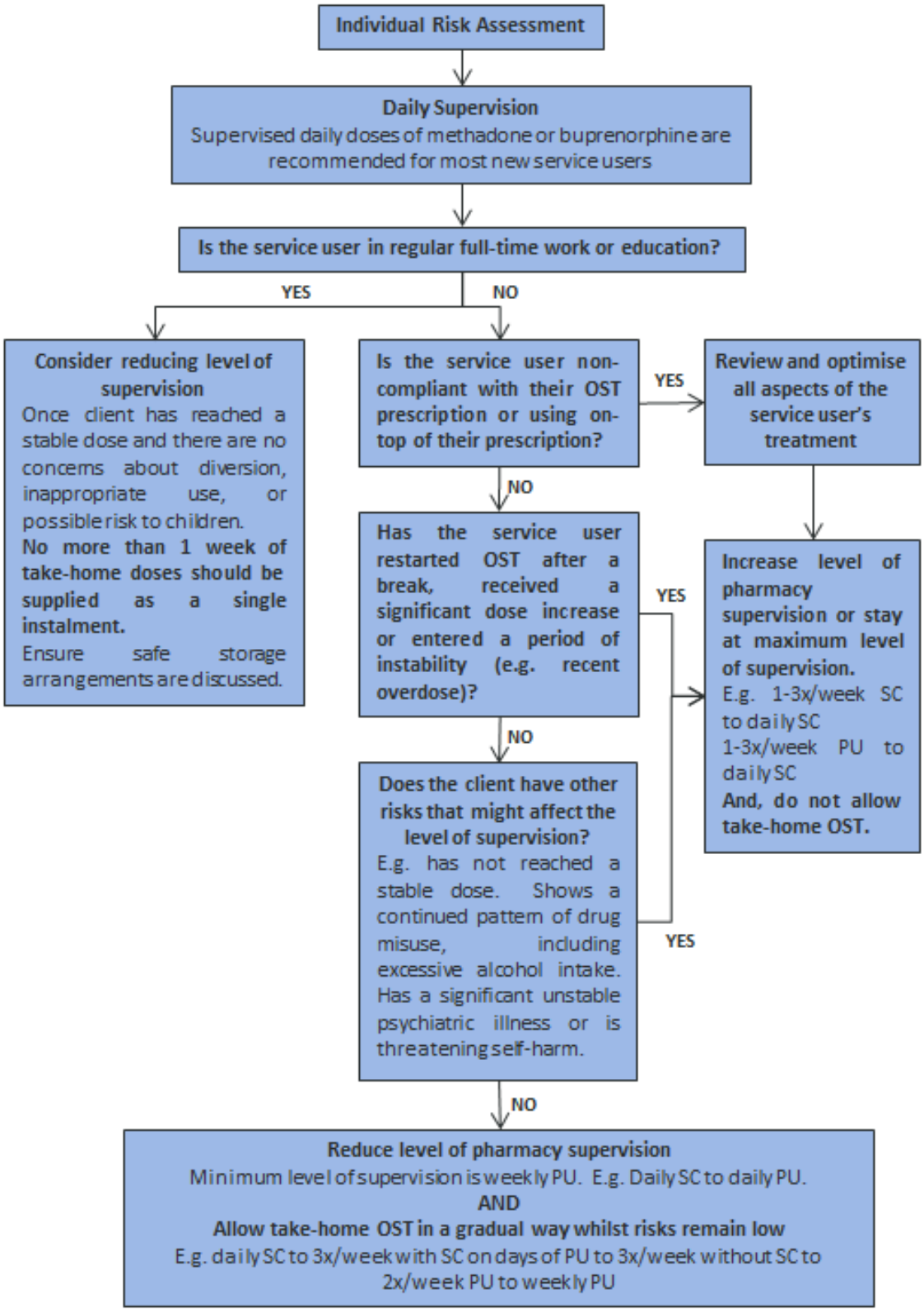
In some circumstances, even with advance notice, and especially for those early in treatment or significantly unstable, the prescriber may not feel able to safely provide a supply of medication to cover the event.

The clinical rationale for this decision should be clearly explained to the client, and documented in their record.

Arrangements relating to travelling abroad with controlled drugs are discussed in section 8.5 below.

Decision Making Algorithm

Key
OST = opioid substitution therapy
PU = pick up
SC = supervised consumption



4.0 Clinical Review

After initiation of prescribing, the client must be seen at least weekly for the first two weeks and after this at intervals tailored to their clinical need so they can maximise their recovery capital. The planned frequency of reviews must be documented.

Once stable, the client should be reviewed by a prescriber at least every 12 weeks, so that the treatment plan can be updated.

4.1 Contents of the review

This will be individualised according to clinical need, however, it is expected that the review will cover the areas detailed in 1.1 above, utilising the clinical assessment and review template. The outcome of the review must be recorded in the client's record and a copy sent to the GP.

The review should last 30 minutes (including recording of notes onto the client record)

5.0 Detoxification

In dependent opiate users, detoxification is usually thought of as being a clearly defined process, supporting safe and effective discontinuation of opiates while minimising withdrawals. The process varies in duration from person to person, but usually lasts up to 12 weeks as an outpatient.

5.1 Assessment and Planning

Prior to detoxification from OST there should be a period of stability, during which time there is no (or at least very infrequent) illicit drug use before a decision to detoxify is made. This decision should be made between the client, Recovery Worker and prescriber, including other agencies as necessary.

The following factors can guide the clinician’s and patient’s opinions about whether the patient is suitable for detoxification:

- the patient is fully committed to and informed about the process and the patient is fully aware of the high risk of relapse
- the patient is either in a stable and supportive social situation or able to go into one
- following detoxification, plans for continuing support and treatment are in place

Clinicians should give detailed information to service users about detoxification and the associated risks, including:

- the physical and psychological aspects of opioid withdrawal, including the duration and intensity of symptoms, and how these may be managed by the use of non-pharmacological approaches
- the loss of opioid tolerance following detoxification, and the ensuing increased risk of overdose and death from illicit drug use that may be potentiated by the use of

alcohol or benzodiazepines
- the importance of continued support, as well as psychosocial and appropriate pharmacological interventions, to maintain abstinence, treat comorbid mental health problems and reduce the risk of adverse outcomes (including death)

It is important that detoxification from opioids is carried out in a planned way. It is not usually appropriate to make small ad-hoc reductions in the dose of OST until the client is ready to detoxify, and plans, including aftercare have been made.

In addition, detoxification from prescribed opioids should not usually take place if the client is still using illicit opioids on-top of the prescription (on-top use usually indicates a need for the dose of OST to be increased, not reduced).

5.2 Choice of setting for detoxification

Clients considering opioid detoxification should be offered a community-based programme.

Exceptions to this may include clients who:

1. have not benefited from previous formal community-based detoxification
2. need medical and nursing care because of significant comorbid physical or mental health problems
3. require complex polydrug detoxification, for example, concurrent detoxification from alcohol or benzodiazepines
4. are experiencing significant social problems that will limit the benefit of community-based detoxification

5.3 Dosing

The rate of reduction of OST will vary according to the client, and suggested rates of reduction can be found in the individual drug guidelines here. Very slow reduction regimes (e.g. 2mg methadone per month) are not appropriate for most clients as it can take many months to complete, and may lead to the re-emergence of cravings.

NICE guidelines found that neither opioid substitute medicine was more effective than the other in achieving good outcomes from detoxification. Therefore detox should usually be carried out with the medication on which the client has been stabilised.
Methadone
Following stabilisation on methadone the dose can be reduced at a rate which will result in zero in around 12 weeks. This is usually a reduction of around 5mg every one or two weeks. Patients often prefer a faster reduction at the beginning although there is no research evidence to indicate the superiority of a linear or exponential dose reduction.
Buprenorphine
Buprenorphine doses can be reduced initially by 2mg every two weeks or so, with final reductions being around 400 micrograms. Patients report being able to reduce buprenorphine doses more quickly than methadone.

5.4 Adjunctive medication

Adjunctive medicines may be prescribed near the end of a detox in order to help with physical withdrawal symptoms. These medications are listed in the Addaction Formulary.

5.5 Review

During detoxification the level of clinical review should be increased to ensure that the client is coping with the planned reduction and to allow for the detox plan to be reviewed if necessary.

5.6 Aftercare

Following successful detoxification from opioids there should be a programme of aftercare in order to continue to support the client's abstinence. This should include contingency planning and relapse prevention techniques.

As the risk of overdose is high immediately following detox, the client should be provided with a naloxone kit.

Naltrexone can be offered as a way of supporting abstinence. Prescribing guidance can be found in the Substance Misuse Medication Guidelines.

6.0 Failure to benefit from treatment

While drug treatment has been shown to be effective in reducing drug misuse, and opioid substitution treatment at adequate doses can help maximise cessation from illicit heroin use, clients may not cease all illicit drug use or intoxication-seeking behaviours immediately on starting OST treatment.

Eliminating all illicit drug and alcohol misuse may take months or years. Often this ongoing drug use is balanced by objective improvements in other domains.

Furthermore, it is unlikely that optimal behaviour change will occur unless there is a good therapeutic alliance, together with suitable psychosocial interventions, peer support and mutual aid, alongside OST.

6.1 Actions to take

It is common to be faced with decisions concerning what action to take if a client is failing to maintain benefit from a treatment programme.

Any response should be based on the assessment of relative risks to the client and staff, while maintaining the integrity of the treatment programme.

If a patient appears not to be benefiting adequately from treatment it is important that clinicians endeavour to understand the reason for the failure to progress. All clients are unique and failure to re-assess the individual person's goals and circumstances may mean

that clinicians will not identify and address the main obstruction to progress in that case.

The patient should be actively engaged in this process of re-assessment and once concluded, a new plan should be proposed and agreed with the client.

Prescribing regimes, arrangements for supervision, and the availability of take home doses can all be adjusted to incentivise and support recovery.

Clinicians should always consider optimising treatment by increasing the intensity of the programme, rather than reducing it.

6.2 Common scenarios in failure to benefit

6.2.1 Illicit opioid use on top of OST

One of the aims of OST is the cessation of illicit opioid use, therefore, the identification of on top use should trigger a review of prescribing.

The following points should be considered:

- ➔ Increase dose of current OST
- ➔ Change OST medication
- ➔ If client is on a reducing regime, re-stabilise on a higher dose and review support/treatment goals
- ➔ Reintroduction of daily supervision
- ➔ Increase psychosocial interventions e.g. frequency of keyworking, motivational support
- ➔ Ensure access to safe injecting equipment
- ➔ Reinforce advice and support for overdose prevention, and offer naloxone

6.2.2 Crack cocaine use on top of OST

There is evidence that optimal doses of OST can help to reduce the use of crack cocaine. This is thought to be because at optimal doses cravings tend to reduce.

Other points to consider are:

- ➔ Confirm stability on current OST dose, if unstable consider need for supervision
- ➔ Increase keyworking or other psychosocial interventions
- ➔ Review overdose risk and reinforce advice on reducing risk
- ➔ Assess for comorbid mental health problems

6.2.3 Alcohol or benzodiazepine use on top of OST

Alcohol consumption is common in people who take illicit opioids. For more information on this please read the section on ‘Poly-drug use’

Points to consider are:

- ➔ Review need for additional keyworking support and/or assisted withdrawal.
- ➔ Reintroduce daily supervised consumption with careful titration and agree progress before relaxing arrangements
- ➔ Consider whether breathalyser testing may be useful in monitoring progress
- ➔ Do not reduce opioid dose simply because of alcohol/benzodiazepine use but

review opioid tolerance and any evidence of opioid intoxication

➔ Complete AUDIT/SADQ as appropriate, and refer for alcohol detox

Note that poly-drug use should not be a barrier to consideration for alcohol detox.

6.2.4 Client misses appointments

It is important that clients attend appointments with both their Recovery Worker and prescriber, so that they may benefit from the interventions offered. However, thought should be given to the reasons why an individual might miss scheduled appointments, and these should be mitigated against wherever possible.

It may be helpful to consider the following points:

- ➔ Offer incentives to encourage attendance
- ➔ Offer more suitable appointments (evening/weekend if client works)
- ➔ Offer locations for contact if normal times/arrangements are inconvenient
- ➔ Consider if the client has any caring responsibilities e.g. parenting, carer for elderly relative.
- ➔ Consider comorbid health problems e.g. poor physical health that makes travel difficult

Addaction's DNA Policy (DQ084) should be referred to to ensure a consistent approach to clients who frequently miss appointments.

6.2.5 Holding prescriptions

Prescribers may consider 'holding' a prescription on the day of an appointment to encourage attendance. However, this should be done as a last resort, and where there is concern regarding the ability of the prescriber to safely continue prescribing in view of repeated non-attendance.

It is important to ensure appropriate communication with the dispensing pharmacy, including the reason that the prescription is 'on hold' and any relevant risks. This must be documented on the client's clinical record. Note that the pharmacist can use their professional discretion and choose to dispense, however they should always inform the service if this has been the case.

Particular attention should be paid when the decision to hold a prescription covers a weekend or Bank Holiday. This may cause a client to miss a number of doses with the subsequent risk of relapse or overdose on illicit opioids.

6.2.6 Missing daily pick up for more than 3 days

It is important that the client takes their OST as prescribed. Failure to do so may lead to a drop in tolerance, increasing the risk of overdose if the usual dose is taken and a re-emergence of symptoms of craving.

Risk of loss of tolerance is lower with buprenorphine than methadone.

Actions to be taken:

1. The pharmacist should not normally dispense the 4th days dose unless they have confirmed with the prescriber that it is appropriate to do so.

2. The prescriber would usually review the client and retitrate OST
3. Missed pick-ups should be documented in the client's record.

It is good practice for the pharmacist and prescriber to communicate about a patient failing to collect methadone or buprenorphine doses, even if they do not miss three consecutive days, as it may be an indicator of instability or increasing risk.

Please see section on Missed Doses for more information.

6.3 Managing clients who continue 'on-top' use

It is likely that there will be a cohort of clients who make the decision not to take higher prescribed doses within the recommended range, despite still using heroin on-top.

Consider the following:

- ➔ Remember that there are still benefits of being on OST and engaging in treatment
- ➔ Remember informed consent. Explore why clients don't want higher doses.

  "I'll have further to come back down" "If I need a higher doses I've failed"

- ➔ Remember to offer NALOXONE.

Opioid substitution therapy is associated with large reductions of illicit heroin use, so some continued, intermittent on-top use should not be used to undermine continued positive feedback to such clients that recognises all the other improvements in their stability.

6.4 Managing clients who do not engage

It may be necessary, following a careful assessment of the risks to the client and staff, to conclude that a prescription must be suspended or in rare cases withdrawn. For example:

- ➔ Following repeated attempts at induction on to OST that have continued to fail to achieve a stabilisation phase.
- ➔ Continuing concerns about risks of overdose from unstable tolerance in cases of repeatedly unsuccessful attempts at stabilisation.

Such decisions must involve the prescribing clinician and other members of the multidisciplinary team.

Clients must be forewarned of the potential actions that the prescriber and the team may take where there is a failure to achieve suitable, usually minimum, treatment goals, and they should be offered the opportunity to set new goals or identify contingencies that might influence their progress from this point.

7.0 Poly-drug use

The risk of overdose is significantly higher in clients who use multiple substances (including prescribed medication).

The risks associated with poly-drug use must be assessed at the initial clinical assessment, and at each review thereafter. Clients must be given information about the risks of poly-drug use and overdose. These should be re-visited with the client at regular intervals.

Combinations of respiratory depressants such as heroin, benzodiazepines and alcohol are particularly risky, as is the combination of any/all of these with prescribed antidepressants, anti-psychotics, other opioid based analgesics (such as tramadol), pregabalin/gabapentin and other drugs such as zopiclone.

7.1 Alcohol in drug treatment

A significant minority of those in drug treatment drink at hazardous or harmful levels. Around one-third of patients receiving methadone have been found to have a current drink problem and a further one-sixth to have a history of a drinking problem.

Alcohol treatment should be integrated with the treatment of drug misuse, so that clinicians working with people who use drugs and alcohol must:

- ➔ give educational and harm reduction messages about hazardous, harmful and dependent use of alcohol
- ➔ detect drinking problems and dependence (see below for more on the level of dependence)
- ➔ manage drinking problems alongside pharmacotherapies such as substitute prescribing.

7.1.1 Patterns of drinking

It can be clinically helpful to categorise patterns of drinking associated with drug misuse:

1. Lower level drinking that is largely independent of other drug misuse
2. Drinking that is linked to the misuse of other drugs and that may be used interchangeably with drugs
3. Dependent drinking that occurs on top of other drug misuse or dependence, including by those on a substitute prescription.

Clients who use drugs and who are dependent on alcohol should be offered alcohol treatment interventions.

This involves support for alcohol reduction and cessation either in the community or as an inpatient followed by psychological and pharmacological interventions to prevent relapse.

The standard treatments for alcohol dependence and misuse apply to those who also misuse other drugs. These include psychological interventions specifically directed at alcohol misuse, and pharmacology to prevent relapse, such as acamprosate or disulfiram or, if not maintained on OST, naltrexone.

7.1.2 OST and heavy drinking

Concern often arises about heavy drinking on top of OST. Because of the protective effect of tolerance to opioids as a protection against respiratory depression, there is unlikely to be any advantage to keeping doses of OST low because of alcohol misuse.

A likely effect of inadequate doses of OST is to increase the risk of greater topping up with heroin alongside a less effective tolerance to opioids. Therefore, ensuring safer consumption of OST, usually by daily supervised consumption, becomes particularly important to consider for such situations.

If heavily-drinking clients are attending the pharmacy, it is important to communicate relevant aspects of the treatment plan to the pharmacist in advance.

There is no contraindication to providing OST to a patient who has simply been drinking, and strategies to deal with situations of gross intoxication and significant impairment should be agreed with the client and pharmacist in advance and the client informed that in these circumstances supervised or take-home doses will not be dispensed.

8.0 Prescribing in Special Circumstances

8.1 Missed doses

Missed doses can lead to a loss of tolerance so prescribers should be kept informed of them and **must** be informed after 3 consecutive missed doses for re-titration.

When dealing with missed medication the clinical management focuses on minimising the risk of accidental overdose because the tolerance of the service user might have dropped in the interim.

With the above in mind, the following schedule is safe and effective, if the service user has:

- ➔ Missed One Day's Dose: No change required to dosage: pharmacist to dispense as usual (unless specific instructions given due to levels of risk)
- ➔ Missed Two Days' Doses: No change required to dosage: pharmacist to dispense as usual (unless specific instructions given due to levels of risk)
- ➔ Missed Three Days' Doses: No medication to be dispensed at all. Prescription must be stopped. Pharmacist to inform the Service.

Instalment prescriptions covering more than one day's dose should be collected on the specified day, however if this collection is missed the remainder of the instalments can be

dispensed in the specified instalments, providing no more than 3 days of medication are missed (as above). For example, if a client is prescribed a take home instalment that covers 3 days doses and they do not collect the first 2 days, the pharmacist will be able to dispense the remaining ONE day dose only.

Prescriptions for titration doses should be more tightly controlled, so that if a client misses one dose, the prescription should alert the pharmacist to notify the prescriber before issuing the next (higher) dose.

8.1.1 Procedure following 3 or more missed doses

The client must be contacted to ascertain that they are safe and well, and to check for any risk factors (e.g. if they are intoxicated). A visual check of the individual should be performed and the prescriber and community pharmacist informed of the outcome.

Medication should only be restarted by a prescriber after a thorough re-assessment of the client has taken place by a worker and should include drug testing, Recovery Plan review, and update to risk management plan, prescribing treatment agreement and confirmation of any new prescribed medication since the last clinical review.

It may be appropriate to continue the prescribed dose without a 'restart', particularly if the dose of methadone prescribed is low. This decision should be made on an individual basis by a prescriber.

It is always important to consider whether the need to restart medication is a "response to failure to benefit from treatment" and therefore other appropriate measures should be put in place to minimise the risk of further missed doses. The response to failure to benefit from treatment is discussed in section 6 of this guideline.

8.2 Preventing deaths from overdose

Identification of risk factors for overdose and appropriate prevention strategies should be a continuous process that is reflected in a client's individual risk management plan.

Clients should be offered and trained on the use of take-home naloxone at the earliest opportunity.

8.2.1 Identification of at-risk clients

Overdose is a potential risk for anyone using illicit substances, however the following groups are at greater risk:

- ➔ Older clients
- ➔ Male clients
- ➔ Illicit opioid users in the first four weeks of treatment
- ➔ Co-existing alcohol and mental health problems
- ➔ Recent overdose and/or risk of suicide
- ➔ Polypharmacy (prescribed,OTC and illicit)
- ➔ Co-morbid physical health problems
- ➔ Social isolation
- ➔ Recent release from prison/discharge from hospital following a long stay

8.2.2 Risk to children

The risk posed to children by ingesting prescribed medication and the importance of safe storage must be emphasised at the first appointment and repeatedly thereafter.

Recovery Workers or prescribers should use the 'Assessment of Safe Storage document' (App17 DQ 131) as a method of discussing safe storage with a client.

If children, young or vulnerable adults are in the home, the client should be required to demonstrate that they understand the risks of medication to these groups of people, and actions needed to address this. It is recommended that completion of the 'Safe Storage document' takes place in the home. In addition the client should be advised to prevent the children from observing consumption to avoid copying behaviour.

8.2.3 Client education

At the first suitable opportunity, and at regular intervals thereafter clients should be supported to understand how the risk of overdose can be reduced. For example:

1. Providing advice to clients considering OST on the protective effects of optimal doses of OST for reducing their risk of overdose.
2. Providing advice early on about the future risk of overdose after any subsequent loss of opioid tolerance (such as after missing prescribed doses for three days or more, or after a planned detoxification or period of abstinence from all opioids.)
3. Providing advice on the dangers of combining OST with other drugs, including benzodiazepines, opioids and alcohol, as well as newer drugs, particularly in the early stabilisation phase of treatment.
4. Providing information and advice on sudden death due to cardiac effects from cocaine/crack cocaine use
5. Educating clients that the use of their methadone by others is extremely dangerous.

8.2.4 After an overdose

A review with the prescriber should be arranged at the earliest opportunity.

- ➔ The client should be provided with harm reduction advice and information tailored to their specific needs/circumstances. This should focus on the circumstances of previous accidental overdose, raising awareness of risks associated with accidental overdose and establishing individual risk factors and how to address these. Particular attention should be paid to the risks associated with loss of tolerance and those associated with combining drugs, especially benzodiazepines and alcohol.
- ➔ **Where possible, and with the client's consent, carers (friends, family members, significant others) should be provided with accidental overdose awareness training and take-home naloxone.**
- ➔ If there is evidence to suggest that the overdose was an intentional rather than an accidental act, an urgent assessment of the service user by the local mental health service should take place.

8.2.5 Appropriate client management and support

1. Ensure careful induction and dose optimisation, and access to flexible supervision (the intensity of supervision may need to increase after an overdose, for example from thrice-weekly pick up to daily supervised consumption, for seven days if possible)
2. Respond to illicit drug use by reviewing OST optimisation
3. Provide careful monitoring for clients with evidence of compromised respiratory function
4. Ensure that clients moving on to take-home methadone or buprenorphine understand the need for safe storage if they have children in the home. Clients must be made aware of the risks of their medication and the importance of protecting children and others from accidental ingestion.
5. Actively liaise with any other specialist services and the GP for complex cases, and provide same day access to community assessment and treatment for those leaving custody or who are otherwise high risk.

8.3 Prescribing in pregnancy

The management of substance misuse in pregnancy needs a multi-disciplinary approach with consideration of antenatal, peripartum and postnatal medical care as well as addressing social needs.

Ultimately the aim of treatment in pregnancy is to provide pharmacological, social, medical, and psychological stability and prevent injecting. Whilst stability is generally regarded as being of primary importance, under certain circumstances abstinence is desirable.

8.3.1 Early liaison with local pregnancy care services is vital

As soon as possible after a pregnancy is confirmed, the client should be encouraged to contact the local midwives in order to book antenatal care, and to tell the midwives that she is in treatment with Addaction. If necessary, and with the client's consent, this initial booking contact can be facilitated via an Addaction clinician or recovery worker.

There is evidence that the risk of domestic violence increases during pregnancy, therefore in order to facilitate discussion of sensitive issues, each client should be offered a one to one consultation, without her partner, a family member or a legal guardian on at least one occasion.

8.3.2 Clinical care

All pregnant clients should be offered an appointment with a prescriber in order to review current medication, and so that they may be advised about the risks/benefits of prescribed medication in pregnancy and breastfeeding. The discussion must be recorded in the client's clinical notes, and should include:

- ➔ the possibility that stopping a drug with known teratogenic risk after pregnancy is confirmed may not remove the risk of malformations

- ➔ the risks from stopping medication abruptly
- ➔ the need for prompt treatment because of the potential impact of substance misuse on the foetus or infant
- ➔ the increased risk of harm associated with drug treatments during pregnancy and the postnatal period
- ➔ treatment options that would enable the client to breastfeed if she wishes, rather than recommending she does not breastfeed

A treatment plan should be developed that is tailored to the drug use, the preferred prescribed treatment following the advice above and the needs of the client. This should be shared (with consent) with others involved in the client's care (obstetrician/midwife and GP). As part of the treatment plan, the client should be screened for blood borne viruses and harm minimisation options reviewed.

Consider initiating a multiagency needs assessment, including prescribing for co-morbidities, safeguarding issues, and communication issues so that the client has a coordinated treatment plan and the necessary support networks. This is to reduce risks to children of drug misusing parents

8.3.3 Substitute prescribing

Substitute prescribing can occur at any time in pregnancy and carries a lower risk than continuing illicit use. Clients whose babies were exposed to methadone and illicit drugs during pregnancy delivered earlier and had more severe neonatal withdrawal than those who were on methadone only.

Substitute prescribing has the advantage of allowing engagement and therefore identification of health and social needs, as well as offering the opportunity for brief interventions and advice to improve outcomes.

Many mothers request detoxification during pregnancy, and the risks/benefits of this should be discussed, however maintenance, at a dose that stops or minimises illicit use is most appropriate for ensuring continuity of management of pregnancy and aftercare.

8.3.3.1 Choice of OST in pregnancy

The research evidence demonstrates no difference in adverse effects between methadone and buprenorphine with both having no adverse effects on the pregnancy or neonatal outcomes, with incidence of neonatal abstinence syndrome (NAS) similar for methadone and buprenorphine exposure. However, there is some evidence that buprenorphine use results in NAS of lower severity.

Therefore, a pregnant client who is informed of the risks can be reasonably allowed to remain on methadone or buprenorphine.

- Transfer to buprenorphine during pregnancy is not advised because of the risk of precipitated withdrawal and the risk of inducing withdrawal in the foetus.

If detoxification is unsuccessful and the client's drug use becomes uncontrolled at any stage of pregnancy, reduction should be stopped or the opioid dose increased until stability is regained.

8.3.3.2 Considerations in the first trimester

The client should be stabilised on the lowest dose of OST that prevents illicit use. Detoxification during this trimester is not recommended due to the increased risk of spontaneous abortion.

8.3.3.3 ...second trimester

If illicit opiate use continues, strenuous efforts should be made to stabilise the client on a prescribed opioid, which may involve increasing its dose.

Detoxification may be undertaken in small frequent reductions (e.g. 2-3mg methadone every 3-5 days), as long as illicit opioid use is not occuring.

8.3.3.4 ...third trimester

Further detoxification should not generally be undertaken because maternal withdrawal is associated with foetal stress, foetal distress and even stillbirth.

- However, slow, carefully monitored reductions may be continued safely in some clients, as long as there are no obstetric complications and illicit drug misuse is not resumed.

Methadone metabolism is increased in the third trimester of pregnancy, and it may occasionally be necessary to increase the dose or split it, from once-daily to twice-daily consumption, or both.

8.3.4 Other drugs

8.3.4.1 Cocaine, other stimulants and cannabis

Clients using cocaine, other stimulants (such as methamphetamine) or cannabis during their pregnancy should be advised to stop altogether, as there is no safe drug for substitute prescribing.

Psychological therapies, including family interventions, should be offered to this group of clients.

8.3.4.2 Benzodiazepines

Clients who are dependent on benzodiazepines should be stabilised on diazepam and, where this can be tolerated without restarting illicit use, the dose reduced.

A client being maintained on methadone or buprenorphine should have her dose maintained during benzodiazepine reduction.

8.3.4.3 Tobacco

There is evidence that maternal smoking can increase susceptibility to sudden infant death syndrome in the newborn. Smoking cessation programmes in pregnancy reduce smoking and the incidence of low birth weight and preterm delivery, and should therefore be offered to all pregnant clients.

There is some evidence that contingency management may be useful in reducing smoking in pregnancy.

8.3.4.4 Alcohol

Updated Department of Health alcohol advice (2016) says that “pregnant women should not drink alcohol at all.''

Pregnant clients who drink alcohol at hazardous and harmful levels have high rates of comorbidity and social problems and while the neonates of very heavy drinkers are well known to be at risk from fetal alcohol syndrome, there may be a significant risk of related problems (such as described by fetal alcohol spectrum disorder) at lower levels of consumption.

Pregnant clients using alcohol should be offered brief and, if appropriate, extended interventions to reduce their alcohol use completely, or to very low levels.

There is evidence that mothers taking methadone during pregnancy also commonly drink excessive alcohol. Long-acting benzodiazepines, such as diazepam, should be used for alcohol detoxification if needed, and is best carried out in a specialist, residential detox unit.

Drugs for alcohol relapse prevention have not been shown to be safe in pregnant women.

8.4 Pain management and substance misuse

Substance misuse services are primarily commissioned to address problems related to drug dependency, rather than the management of chronic pain. However, it is recognised that there is a complex relationship between these two clinical areas, and an increasing number of referrals into Addaction services are for problematic use of prescribed analgesia.

Unresolved pain management must be addressed as part of the holistic assessment of the client and identified as a clinical problem which needs to be appropriately addressed.

The service user should be signposted to alternative health care providers as appropriate, for example their community pharmacist, GP or, in an emergency, A&E.

8.4.1 Referrals to Addaction for clients on opioid analgesia

It is important to recognise that sufferers of chronic pain are likely to have underlying pre-morbid conditions such as anxiety, depression or more serious mental health disorders; or may have underlying trauma such as previously undisclosed childhood sexual abuse. These are very similar characteristics to those clients who have developed dependence to illicit opioids.

Therefore, if a client is referred for problematic use of the prescribed opioid analgesia it may be appropriate to offer psychosocial interventions with careful liaison with the GP/pain clinic.

Opioid analgesics are relatively ineffective in managing chronic pain (only around 30% of patients prescribed will get any benefit), and there is strong evidence that high dose opioids (above 120mg/day morphine equivalent) are associated with adverse outcomes that include opioid induced hyperalgesia. Therefore a process of deprescribing may be

appropriate alongside suitable psychosocial interventions.

8.4.1.1 Principles of chronic pain management in the patient receiving opioid substitution therapy

- ➔ Medications should be part of a wider plan to support self management
- ➔ Mental health diagnoses and emotional difficulties need to be identified and managed
- ➔ Physical rehabilitation, exercise and psychological treatments are essential to support chronic pain management
- ➔ Close collaboration with pain services and the patient's GP is mandatory
- ➔ Regimens should avoid prescription of multiple opioids
- ➔ For patients on methadone: Split dose (consider part supervised, part take home as appropriate) and give 12 hourly
- ➔ For patients on buprenorphine: Split dose and give 8-12 hourly

8.4.2 Further reading

1. Opioids Aware: https://www.rcoa.ac.uk/faculty-of-pain-medicine/opioids-aware
2. [Presentation] Pain and problematic use of opioids (2013) - Dr Cathy Stannard: https://www.addiction-ssa.org/symposium/presentation/pain-and-problematic-use-of-opioids

8.5 Holiday prescriptions and overseas travel

Every client has the right to request a supply of prescribed medication for the duration of a holiday in the UK or overseas, however, this request must be made in good time (at least two weeks prior to departure) so that the client's arrangements for travel can be reviewed.

Agreeing to such a request is a decision that should always be made on clinical grounds and risk assessment, and it is recommended that the decision to supply medication be taken by more than one person (e.g. in a service MDT meeting).

Prescribers must satisfy themselves that:

1. the client is stable in treatment and has not vocalised recent suicide ideation
2. the medication will not be taken by others
3. the safe storage arrangements have been discussed and that any children or young people accompanying the client will not be put at risk from accidental ingestion.

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 and, where applicable, the airline or similar transport provider.

These can be checked with the relevant embassies and consulates to ascertain any restrictions in the country to be visited (contact details can be found at www.gov.uk/travelling-controlled-drugs).

In general medicines should:

1. be carried in original packaging (with pharmacy dispensing labels in place)
2. be carried with a letter from the prescriber confirming the patient's name, destination, and details and amounts of medicine
3. meet carriers' requirements for hand and hold luggage. Quantities of methadone over 100ml will be allowed provided that the client has a supporting letter from the prescriber (see here for further information)

Methadone tablets may need to be provided for longer trips if the volume of methadone mixture required is unmanageable.

8.5.1 Travelling for less than three months

People in receipt of a prescription for a controlled drug can travel abroad with their supply. A Home Office licence is not necessary for planned stays of less than three months. The requirements listed previously still apply.

8.5.2 Travelling for three months or more

A Home Office personal export licence is required for planned stays of three months or more. The client should complete a form, available online and from the Home Office Licensing Section, and return it to them along with a letter from the prescriber stating:

1. the name and address of the person
2. the person's date of birth
3. the strength, formulation and quantity of the medicine, and the daily dose prescribed
4. the person's date of departure and return, and country/countries being visited.

There is nothing laid down about the maximum amounts that individuals may travel with and the Home Office advises that each case is treated on its merits. 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 client checks with the embassy or consulate before departure, to establish that the country or countries to be visited will accept the Home Office licence.

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.

A licence is obtainable from the Home Office Licensing Section. Email: DFLU.ie@homeoffice.gsi.gov.uk

The form can be downloaded from www.gov.uk/travelling-controlled-drugs The requirements described are similar for all/most prescribed medicines contained in Schedules 2, 3 and 4 of the Misuse of Drugs Regulations 2001 (as amended).

As an alternative to taking large quantities of medicines out of this country and trying to take them into another, clients might be better advised to enquire about registering with a

doctor in the country they are visiting for the purpose of receiving further prescriptions.

8.5.3 Further Reading

1. Substitution [medication] Travel Guide. Available at: https://indro-online.de/en/methadone-worldwide-travel-guide/

8.6 Prescribing following release from a secure environment

Transitions to, from, and between criminal justice settings, such as between police custody and courts or at prison release, or release from such settings into the community create the potential for interruptions in the delivery of required treatment and heighten the risk of relapse and of overdose deaths.

The period immediately following release is a time of considerable vulnerability. For clients expected to leave prison receiving maintenance opioid substitution treatment, contact should be established with a community service at the earliest opportunity after reception, with ongoing discussion to facilitate release planning, so that, for example, an appointment is already scheduled in the community before release.

Close working between the prison and community drug treatment providers is central to the securing of good integrated care. This should include arrangements for out-of-hours or late Friday/weekend releases.

It is the responsibility of the prison healthcare/drug team to ensure that the community service/prescriber is notified of a client's release from prison.

8.6.1 Procedure for managing clients released from prison

There must be good joint working arrangements between local prisons and Addaction services so that care can be handed over in a safe and seamless manner

1. Services should plan ahead for prison releases and consider holding assessment and prescribing review slots open at times where prison releases are common (for example on Friday afternoons)
2. For planned releases the individual should have a Comprehensive assessment and a Prescribing Appointment on the day of release or where this is not possible the following day.
3. For unplanned/last minute prison releases Addaction services may provide a bridging prescription to ensure continuity of prescribing.

   In this scenario and where possible the client should have a comprehensive assessment on the day of release or the following day.

   The Recovery Worker must then have a case discussion with the prescriber and a bridging prescription issued to tie into a Prescribing appointment. During the case discussion the prescriber must assess the risks to determine the length of the bridging prescription with the maximum duration being 14 days.

4. For unplanned releases where a comprehensive assessment is not available on the day or day following release a bridging prescription can be provided until this assessment appointment.

   This should be a maximum duration of 3 days. Where a prescribing appointment is not available on the same day as this assessment then a further bridging prescription can be issued to tie into a prescribing appointment.

   In total the bridging prescriptions should be for a maximum of 14 days from the date the client was released.

5. Where a bridging prescription is issued the prescriber must be aware this is 'blind' prescribing. The prescriber must carefully assess individual risk factors and prescribe the minimum duration possible.
6. Prior to any ongoing prescribing the prescriber must have reviewed the prison treatment plan which also confirms the last dose of OST.
7. The prison treatment plan, must be requested prior to the prescribing review.
8. In exceptional cases, and where the treatment plan together with verbal confirmation of assessment, history, condition, etc. has been received by the service, a 'bridging prescription' of up to 3 days may be given prior to the comprehensive assessment taking place. The client must then be booked into the next available prescribing review slot.
9. Bridging prescriptions should not be repeated unless this is absolutely necessary, and the reason for doing so must be documented in the client's record.
10. If not issued on release from prison, clients must be offered naloxone during the comprehensive assessment, along with overdose awareness training.

8.6.2 Re-toxification (re-induction) onto opioids

Prior to release some clients who have stopped opioid prescription while in prison request re-induction onto opioid substitution treatment. Re-toxification is considered for those who are about to leave prison, with a clearly identifiable risk of overdose, and high likelihood of relapse.

Those with the most significant risk include those with a history of injecting opiate misuse immediately prior to custody, long-standing opioid dependence and polydrug dependence, and often a history of overdose. Given the high relapse rates for heroin dependence and the high mortality rates from overdose following prison release, it is important to recognise this request may be a sound judgement and may support effective re-engagement with community services.

It is important that Addaction services are aware that a client has been 're-toxified' onto methadone or buprenorphine so that they can be followed up appropriately once released into the community setting.

8.7 Prescribing following discharge from hospital

Addaction services should develop links with local hospitals to ensure that the service is notified when a client is admitted to or is discharged from hospital. The interface between

secondary care services (such as hospitals) and the community must be carefully managed to ensure that treatment is continued without gaps.

Further guidance on the information that must accompany a discharged client can be found in DQ234 - Medicines Reconciliation Policy.

On the day of discharge it is important to ascertain if the client has been:

1. given their dose of OST that day
2. given a supply of OST to take away/out (TTA/TTO) and if so how many days

Clients who have been discharged from hospital should be reviewed by an Addaction prescriber as soon as is conveniently possible. This is to ensure that any medication changes made by the hospital have been taken into account by the prescriber.