Policy for the Clinical Management of Substance Misuse in the Community

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Partners in Care

Document Ratification

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Document title:	Policy for the Clinical Management of Substance Misuse in the Community		
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Is this document a direct replacement for another? *If yes please state which documents are being replaced:*	☒	☐
Substance Misuse Prescribing policy v 3.1		

Document Amendment History

Date	Version no.	Amendment summary	Ratified by:
20 April 2014	4	Adaption of DPT policy	Service Manager
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30 October 2017	4.1	Review date extended – 6 months	Care and Clinical Policies Group
5 October 2018	5	Revised	Care and Clinical Policies Group Clinical Director of Pharmacy

Quality Impact Assessment (QIA)

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Contents

Acknowledgement: Torbay and South Devon NHS Foundation Trust is thankful to Devon Partnership Trust for sharing their original policy and allowing its adaptation for use within this organisation.

Introduction

The effectiveness of evidence-based treatment for drug misuse is well established. UK and international evidence consistently show that drug treatment covering various drug problems, using different types of treatment interventions, and in different treatment settings impacts positively on levels of drug use, offending, overdose risk and the spread of blood-borne viruses (BBVs).

In recent years there has been a change in the agenda of substance misuse treatment systems, moving from one of maintenance to one of recovery, with an aim of supporting people to live their lives free of substance dependence and enabling them to become personally fulfilled. Prescribing should only take place within a context in which co-existing physical, emotional, social and legal problems are simultaneously addressed and the need for positive therapeutic working relationships with individuals is essential. The social, physical, human and cultural resources that the person requires to start and sustain their recovery (recovery capital) must be utilised to enable them to stabilise recover and leave structured treatment. The purpose of prescribing for the management of substance misuse is to enable the person to be supported to develop their recovery capital. Individuals with longer-term and morecomplex problems may require longer in treatment to enable them to build their recovery capital.

This policy sets out the required processes and standards which should be provided by clinicians delivering a Substance Misuse Prescribing Service to eligible individuals.

1 Statement/Objective

1.1 This policy sets out the standards and incorporates the procedures that all staff working within Torbay Drug and Alcohol Service (TDAS) adhere to in order to ensure the provision of safe, timely and personalised care in an appropriate setting for individuals accessing this service in the community.

1.2 The intention of the policy is to support staff and ensure that the correct processes are followed prior to the initiation of a prescribing intervention.

1.3 The policy reflects current legislation, best practice recommendations and professional codes for registered practitioners.

2 Roles & Responsibilities

2.1 **Service Managers:**
The service managers are responsible for the management and delivery of safe, timely, evidenced based and cost-effective clinical services in accordance with local commissioning arrangements and contractual agreements, for example ensuring that supervision requirements are met. Service managers will ensure that all staff are aware of, and have access to this policy. Monitoring staff compliance with this policy, including undertaking audits and sampling of prescribing practice

2.2 **Recovery-Coordinator:**
The Recovery-Coordinator is not equivalent to a mental health care-coordinator. They are not responsible for the collection or holding of medication on behalf of the individual. They are responsible for:

- Develop and coordinate recovery plans to meet the individual's needs.
- Playing a role in the management and monitoring of the community stabilisation or detoxification under the supervision and guidance of the non-medical prescriber / clinical lead / medical staff.
- The recovery-plan will integrate any prescribed treatment with psychosocial interventions.
- Contacting the prescriber to request a review of prescribed medication, alert them to potential treatment related adverse effects and/ or to request dose/dispensing adjustment.
- Ensuring that accurate information and guidance is provided to the prescriber.
- Ensuring the individual is monitored in accordance with this policy and essential information communicated to the prescriber.
- Maintaining contact with the individual and liaising with others involved in the recovery-plan and any relevant outside agencies.
- Liaising with local pharmacies and other health and social care professionals if appropriate e.g. Mental Health services.

2.3 Prescribers:

- The nominated prescriber will be responsible for assessment, diagnosis and safe, clinical and cost effective prescribing of medication for the management of substance misuse for individuals eligible for treatment in accordance with this policy. They will:
- Have a working knowledge of, and adhere to, the Trust Medicine Policy, Controlled Drugs Policy and Non-medical Prescribing Policy as well as any other guidance and policy within the organisation concerning the prescribing of medicines, particularly Controlled Drugs.
- Only clinically work (and prescribe) within their expertise to a level of practice at which they feel competent and confident, and seek further specialist advice where needed.
- Prescribe safely using prescribing guidelines and record clinical reasons, including discussion with other relevant professionals as appropriate.
- Document and maintain the prescribing-plan which will outline the prescribed treatment.
- Refer individuals with complex physical/psychiatric problems to a specialist medical prescriber.
- Undertake medication reviews/amend prescribed medication as appropriate.

2.4 In the event that the nominated prescriber is unavailable for any reason, then the Service Manager will be responsible for the identification and allocation of another qualified and experienced prescriber working within the service to fulfill the above role.

3 Treatment Setting

3.1 Following a comprehensive risk assessment, the least restrictive treatment environment where safe and effective, recovery-focused care can be provided should be selected. Treatment settings vary according to local commissioning arrangements, and will depend upon the individual's presentation and complexity.

3.2 In situations where there is difficulty in reaching a clear conclusion around treatment setting or situations where there are significant risk factors identified, this must be discussed at a multi-disciplinary team meeting and a decision recorded.

4 Standards for Safe and Evidenced-Based Practice

4.1 All individuals treated for drug dependency must be registered with the National Drug Treatment Monitoring System (NDTMS) and is essential because regional funding is dependent upon accurate returns to the NDTMS.

4.2 This policy should be followed by clinicians responsible for the delivery of care and clinical interventions to support the recovery of individuals with substance misuse disorders, although it is recognised that in exceptional circumstances, rigid adherence may not always be clinically appropriate or in the best interests of the individual. In situations where it is considered necessary to act outside this policy:

- The reasons and rationale must be discussed with the multi-disciplinary team and have the full agreement of both the clinical team lead and GP with Special Interest in Substance Misuse (GPwSpI) for the service.
- Where a decision on care is needed before a multi-disciplinary team review is possible, and delaying treatment would be associated with significant clinical risk, the full agreement of the relevant manager, prescriber and recovery co-ordinator is needed.
- All reasons for the final decision, including varying opinions, will be documented on HALO (the recognised electronic patient record system for substance misuse in Torbay) along with robust treatment plan and clear rationale for need in variation of standard care.

4.3 Except in exceptional circumstances (e.g. unexpected prison release), when the rationale must be fully documented, medication for the management of substance misuse should only be prescribed following the completion of:

- A comprehensive assessment and recovery-plan.
- A prescriber assessment and on-going treatment review.
- A detailed assessment and review of the individual's physical, psychological, social, and criminal justice involvement which should also be monitored and reviewed during and after this intervention has ended using agreed outcome measures for the service.
- Confirmation of any prescribed medications including any psychoactive medicines from other sources.

4.4 Dose stabilisation may take several weeks. It is important that this is achieved as quickly but as safely as possible to prevent the individual disengaging from treatment. The ideal dose is achieved when the individual reports feeling comfortable and is no longer using illicit substances. It should be noted that for substitute prescribing:

- Higher doses tend to be more effective
- Ceiling doses are inappropriate
- Individuals can determine their own dose levels within limits
- Individuals will not always push for the highest possible dosages
- Flexible dosing contributes to retain individuals successfully in treatment

4.5 Medication for indications other than the management of substance misuse should usually only be prescribed by the GP/specialist mental health service. They may only be prescribed by suitably experienced prescribers within the drug service in exceptional circumstances.

4.6 The individual and their relatives/carers should be made aware of the risks of their medication and of the importance of protecting children from accidental ingestion. This must include that all medication should be stored securely within a locked box issued by this service and kept out of reach and out of sight of children, and therefore it is recommended that medication is not administered in front of them.

4.7 Prescribing arrangements should aim to reduce risks to children. The importance of safe storage of illicit drugs, prescribed medication and drug-using paraphernalia must be emphasised at the first appointment and repeatedly to the individual thereafter. Lockable boxes are issued by the community drug team for use during treatment for all clients under-going a prescribed intervention.

4.8 The Trust Standard Operating Procedure for **lost or suspected stolen prescriptions** must be followed

5 Initial assessment.

5.1 The assessment process must help individuals to consider their current and potential future 'recovery capital': their personal skills, availability of safe accommodation, presence of supportive relationships, current levels of personal responsibility, engagement with a supportive local community, and positive participation in wider society.

5.2 The individual should not be under the acute intoxication effects of alcohol/drugs for an accurate assessment. They must be provided with information about medication, psychosocial interventions, sexual health (including contraception), and harm minimisation including safer injecting practice, Blood Borne Viruses (BBVs), overdose, sleep hygiene and nutrition and smoking cessation, and offered naloxone where appropriate.

5.3 The initial assessment should identify if there is a need for a prescribing intervention and should also highlight the clinical priority for this intervention.

5.4 Where a prescribing intervention is indicated, the individual should be allocated a recovery-coordinator who should undertake a comprehensive assessment of the individual. The comprehensive assessment should always be undertaken prior to any prescribing intervention being instigated.

5.5 Risks identified at the initial assessment must be reviewed by the recovery-coordinator to determine how the person will be managed, and a review date set. Staff should also refer to the care coordination policy for substance misuse services in Torbay.

5.6 The prescriber will be consulted as issues are identified and treatment interventions managed accordingly. Their assessment must be documented and should build upon information already obtained, including:

- Details of past and present drug use, including alcohol/cannabis/tobacco use, previous treatment response and experiences, overdose history and injecting behaviour including sharing of equipment.
- Confirmation of drug/alcohol use using the history provided by the individual but also from objective sources including accounts from other people, evidence of withdrawal, injection sites and drug testing. Examination of injection sites should outline any evidence of recent or previous injection sites, venipuncture marks, palpable lumps around veins, injection tunnels covered by epithelia, areas of inflammation, abscesses and scars.

- Details of any blood borne virus testing and immunisations.
- Identification of any additional support required e.g. with housing, employment/education, counselling, social services, finances, GP/dentist registration, support networks available, isolation, probation/supervision orders, presence of other substance misusers or safeguarding issues particularly regarding children and domestic violence.
- Establish current driving licence status and informing the individual of the need to contact the Driver Vehicle Licensing Agency if appropriate.
- Psychiatric history including current mental health, risk to self/others, family history of substance misuse/severe and enduring mental health condition
- Previous medical history, medication prescribed/bought/recently stopped or initiated and any allergies/intolerances. Physical health assessment should include consideration of contraception/pregnancy, nutritional status, history of seizures, head injuries, problems with memory (e.g. blackouts), respiratory (e.g. chronic obstructive pulmonary disease), gastrointestinal (e.g. haematemesis), cardiovascular (e.g. prolonged QT interval, hypotension, cardiomyopathy, past cardio vascular event, deep vein thrombosis), renal/hepatic impairment (e.g. chronic kidney disease, hepatitis) and a family history of severe physical health conditions.
- Referral if required for BBV testing, Hepatitis B immunisation or assessment of renal/hepatic/cardiac impairment. The GP and other services involved in the persons care (e.g. palliative care) must be advised not to prescribe benzodiazepines, opioid analgesics, hypno-sedatives, gabapentin, pregabalin, quetiapine or sedative psychotropic medication without discussion with the drug service to reduce the risk of drug-related death. The drug service should work with the GP to advise regarding management of psychoactive substances so as to minimize risk of drug related death.

5.7 The prescriber is responsible for ensuring that any relevant baseline physical monitoring has been requested. Alcohol breath tests should also be considered if alcohol use is of concern. These should be regularly re- assessed as clinically indicated.

5.8 A non-medical prescriber must refer (e.g. for a medical assessment where there are concerns about the physical or psychological wellbeing or assistance required in interpreting blood results) if it is outside of their level of competency. In circumstances in which a delay in arranging a medical assessment may prove hazardous, (e.g. deteriorating medical condition or increasingly chaotic drug use behaviour,) the recovery-coordinator/non-medical prescriber should discuss their concerns with a senior member of the multidisciplinary team and document the decision.

5.9 The person (and their relative/carer if appropriate) must be provided with contact names and telephone numbers of treatment provider and given the opportunity to ask questions so they are able to provide informed consent to treatment.

5.10 At the prescribing assessment a decision will be made as to what medication(s) will be prescribed and details documented in the prescribing- plan (to include medication name, strength, formulation and anticipated dosing schedule). The prescriber must discuss a dosing schedule and inform the individual about the process of titration, stabilisation/detoxification, making sure they are aware of strategies to prepare for and to manage this process, including concurrent reduction of illicit drug use and medication dispensing arrangements and planned details of the next review.

5.11 Where there are complex presenting needs, significant risk management issues or where the individual has had recent failed treatment intervention, a decision to prescribe for the individual will only be made following multi-disciplinary team discussion.

5.12 The persons' motivation to stop substance misuse, what they need/want, and if it can be delivered by the service must be checked and documented in a recovery-plan. Circumstances in which the prescription may be suspended or withdrawn and chosen treatment environment must also be discussed and documented.

5.13 The prescribing-plan must be documented, including the proposed start date, dosing regime, target dose which is subject to subsequent review if signs of intoxication/continued opiate withdrawal are observed. Any prescribing intervention initiated must be clearly recorded by the prescriber in HALO.

5.14 Agreement should be reached with the individual from where they are to collect any prescribed medication. The recovery-coordinator will liaise with the community pharmacist to agree dispensing arrangements. The recovery-coordinator will ensure that this is an agreed and commissioned pharmacy for supervised consumption, and that a 4-way agreement is completed between the individual, the prescriber, the recovery-coordinator and the community pharmacist, including a photograph of the individual. Copies will be provided to the pharmacy and client.

5.15 If the person is to receive 'home' (community) detoxification, detoxification charts *(see Appendix 2)* should be used to record administration. The individual must be made aware of symptomatic treatment of withdrawal and a prescription for specific treatment should be provided if required.

5.16 Information should be provided regarding the risk of overdose during titration. If the individual attempts to overcome buprenorphine/naltrexone blockade or following detoxification resulting in loss of tolerance it is recommended that the individual is provided a copy of the 'After a break' leaflet: http://www.harmreductionworks.org.uk/resources/pdf/HRPUB6.pdf

5.17 When the person is transferred from another setting (e.g. prison) it must be assumed that they have already received their dose for the day unless independent evidence can be obtained to confirm that this is not the case.

5.18 No new prescriptions should start on a Saturday or Sunday or on bank holiday weekends except in exceptional circumstances.

6 Choice and Duration of Treatment

6.1 Different prescribing/non-pharmacological treatment interventions that are available must be discussed and documented with the individual, including detoxification vs. substitute prescribing.

6.2 Consideration will be given to the most appropriate evidence based intervention suited to the individual. Choice of medication used must take into account previous response to treatment, interactions, cautions, contra-indications and the persons' preference. The prescriber's opinion (based on severity of

withdrawal, required level of medication and additional interventions anticipated), opinion of all

professionals involved in the provision of care and the risk assessment of the person must also be taken into account. A therapeutic alliance addressing these different considerations should be outlined in the prescribing-plan.

6.3 Medication should always be prescribed as monotherapy or in the simplest effective combination, at the effective dose consistent with the evidence and based upon the presenting clinical assessment of the individual's need, whilst avoiding the potential for overdose.

6.4 A careful risk-benefit analysis must be completed and clearly documented prior to prescribing opiates/benzodiazepines where poly-substance misuse is an issue. Overdose risk must be considered, taking into account illicit use, prescribed medication and alcohol.

6.5 Use of decision aids where appropriate and (written) information must be provided to support the person (and their relative/carer if appropriate) to make an informed choice and provide informed consent to treatment (see User- friendly Resources for Information about Managing Substance Misuse in the Trust Prescribing Guideline on the Pharmacological Management of Substance Misuse in Community). Assessment of capacity must be implemented and appropriately documented if indicated.

6.6 If medication is used off-label the person must be informed, and the Trust's Non-Medical Prescribing policy (sections 7.3-7.5) must be followed. There must be a clear rationale for this method of prescribing, and the responsible prescriber will be held accountable for their actions in this respect, this accountability may **not** be delegated. Unlicensed prescribing should be avoided wherever possible.

7 Treatment Review and Monitoring

7.1 At all times the GP should be kept informed in writing of the proposed recovery-plan and informed of the outcome of any interventions.

7.2 Consumption of medication for the management of substance misuse should usually be supervised daily for the first 3 months of treatment, unless stabilisation can be achieved beforehand or there are difficulties in community pharmacy access.

7.3 Supervised consumption should be relaxed **only** when the person'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 twice weekly and then to once weekly collection).If after the initial 3 months of supervised consumption the person is unable to stabilise then consideration should be given to the safety and effectiveness of continued prescribing to avoid prolonged prescribing with concomitant illicit drug use. Consideration should also be given to low intensity prescribing.

7.4 Moving from a liberal pick up regime to supervised consumption requires careful consideration due to the risk of overdose and it is therefore recommended that prescribed doses are 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.

7.5 Assessment of withdrawal should be conducted using clinical experience of the prescriber or alternatively assessed and documented using the Clinical Opiate Withdrawal Scale (COWS) for opiates or the CIWA-B withdrawal schedule rating scale for benzodiazepines alongside their associated monitoring forms.

7.6 Dose adjustments will be advised based on clinical symptoms of withdrawal/rating scale scores/over-sedation as well as taking into account the persons views (see Trust Prescribing Guideline on the Pharmacological Management of Substance Misuse in Community).

7.7 An individual recovery-plan will be discussed and agreed with the individual. This will incorporate both short and long term goals in respect of the individual's treatment and care.

7.8 After initiation of prescribing, the individual should 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.

7.9 The recovery-coordinator will regularly review the recovery plan in conjunction with the prescriber and involve the individual in all decisions. It is their responsibility to systematically assess and record response to treatment on behalf of the prescriber and to ensure that any changes in the individual's physical, psychological, social and criminal justice involvement are documented, monitored and reviewed regularly.

7.10 At least once every twelve months the individual and their prescribing-plan should be reviewed by the care coordinator and ongoing treatment discussed with the prescriber.

7.11 If a prescription change is considered necessary this must be appropriately communicated to the prescriber (usually by e-mail). Amendments to a prescription will usually require a minimum of 7 days' notice and will only be completed after authorisation has been received from the prescriber and all changes will be recorded in HALO. Amended prescriptions will usually be posted but if in exceptional circumstances an earlier delivery is required the recovery-coordinator will arrange for the client to collect, or hand deliver to the pharmacy.

7.12 If a prescriber is requested to provide a prescription on behalf of another prescriber (e.g. due to sickness/annual leave) they must only do so if an urgent prescribing decision is required and after they have satisfied themselves that it is safe and appropriate to do so.

7.13 During treatment, particularly during titration the recovery coordinator/ dispensing community pharmacist will alert the prescriber if there is evidence of intoxication, sedation, emergence of withdrawal symptoms or concerns regarding possible treatment related adverse effects.

7.14 Avoid giving individuals large quantities of medication to prevent overdose or diversion. Supplies can be limited by arrangement for installment dispensing. The prescribing period is usually no greater than 2 weeks. Community pharmacy pick-up should not be less frequent than once weekly unless for a holiday prescription.

7.15 Prescribing should only be continued with extreme caution where illicit drug use on top of prescribed medication, particularly benzodiazepines, NPS (novel psychoactive substances) and alcohol in conjunction with opiates, is known to occur. Risks (social, clinical, financial and criminal) are increased, particularly in relation to overdose. If risks factors for prescribing drug treatment outweigh potential benefits then more motivational work is needed and, prescribing may be reconsidered as soon as the individual engages in reducing risks (i.e. alcohol use/stopping polydrug use). Risk of drug related death is increased with poly pharmacy prescribing gabapentin/pregabalin, hypnotics and other opiates.

7.16 If there is no alteration of addictive behaviour or sustained stabilisation, persistent non-attendance, missed doses/collections, lack of efficacy, evidence of diversion, significant illicit drug misuse or if the person contravenes behavioural agreements the recovery-plan must be reviewed and supportive strategies implemented. The prescribing plan should be reviewed with consideration for dose reductions, low intensity treatment or a period of non-prescribed treatment.

7.17 It may be necessary, on the basis of a careful assessment and documentation of the risks/benefits, to come to the conclusion that a prescription must be suspended or in rare cases withdrawn as a last resort. Such a course of action can put the individual at an increased risk of overdose, contracting a BBV or offending. It may also increase the level of risk to children and vulnerable adults in the home. Such decisions must be clearly documented, regularly reviewed and involve the prescriber. Such decision should also be communicated to other professionals, agencies and services providing support and interventions to the client.

7.18 For individuals for who prescribing has been discontinued alternative interventions and support must be offered in a way that minimises risks and maximises opportunities for the individual to be retained in treatment. If necessary, arrangements for ongoing medical supervision for other medical/psychiatric problems must be made.

7.19 When pharmacological treatment is withdrawn/completed follow up must be provided, with a supportive empathetic relationship for motivational interviewing/relapse prevention, and facilitation of further psychosocial treatment if required.

7.20 Post-detoxification there is a risk of lapse or relapse which requires pre-detoxification contingency planning so that the drug use can be controlled as much as possible, and risks of loss of tolerance and overdose avoided. Further

support in the community should be prepared with the individual's full participation, with the involvement of relevant community agencies, usually facilitated by the recovery-coordinator.

8. Maintenance of Abstinence in Opiate Dependence

8.1 Treatment with naltrexone must be initiated by a competent prescriber

8.2 Where treatment was offered but declined, the discussion and reason must be clearly documented.

8.3 Naltrexone should only be used as an adjunct to psychosocial interventions (e.g. cognitive behavioural therapies, behavioural therapies or social network and environment-based therapies, focused specifically on substance misuse). In these circumstances effectiveness of treatment is improved for motivated individuals.

8.4 Naltrexone may be useful when craving is a major factor or just after detoxification if psychosocial interventions alone have failed previously.

8.5 Well motivated individuals with a history of relapse, because of persistent craving or impulsive use later regretted because of conditioned behaviour, and without histories of major psychiatric illness and neurological damage are generally considered to be the most suitable for naltrexone.

8.6 Treatment with naltrexone may be inappropriate where the individual has a strong motivation to use only psychological methods.

8.7 Prior to initiation, the specialist prescriber must check:

- Screen for opiate use
- Current/recent alcohol/ substance misuse
- Engagement with psychosocial support, their views and willingness to continue
- Friend/relative to support regular dosing of Naltrexone

8.8 At each prescription review check:

- Side-effects
- Efficacy
- Adherence
- Current/recent alcohol/ substance misuse
- Engagement with psychosocial support, their views and willingness to continue

8.9 If the individual discontinues treatment they should be advised about recovery support opportunities such as tier 2/mutual aid (e.g. narcotics anonymous groups, SMART recovery, community recovery support and TRIP).

8.10 If no friend or relative is available, supervision of naltrexone may be provided by a community pharmacist but only where they agree to provide this service. (Refer the pharmacist to the Local Pharmacists Committee for guidance on payment of supervision).

8.11 When recommending the use of naltrexone, consideration must be given to the individual needs, expectations and acceptability of treatment, as well as contraindications, cautions and interactions.

8.12 The individual (and their relative/carer involved in supervision of naltrexone) should be provided with (written) information to make an informed choice so they can provide informed consent to treatment.

8.13 Efficacy and details of supervision, expected benefits and possible side effects of treatment must be discussed and documented to ensure that the person and their friend or relative understand the information provided. A supervision letter, *(see Appendix 3)* must be completed and given to the allocated supervisor and a copy scanned onto HALO record.

8.14 Written, informed consent to treatment should be obtained *(see Treatment agreement)* and a copy retained by staff for uploading onto HALO. Assessment of capacity must be implemented and appropriately documented if indicated.

9. Drug Testing

9.1 Drug testing collection procedures should aim to ensure the integrity of specimens and routinely check for the presence of illicit drugs as well as prescribed medication to ensure concordance with treatment

The time of sample collection should be noted and related to the consumption over the last few days of both prescribed and illicit drugs and the presence of prescribed medication.

9.2 **It is essential to obtain at least two drug test before starting a substitute prescription.** In situations of doubt it may be useful to repeat a drug test to confirm dependence before prescribing (usually separated by at least 4 days).

9.3 Drug testing provides an opportunity to reflect back to the individual real evidence of progress and share the risks and concerns, such as the negative consequences of use on top, polydrug misuse and missed pickups.

9.4 Frequency of regular testing should be decreased after the titration period if progress with stabilisation is achieved, but should be implemented every 12 weeks.

9.5 Random testing may be helpful, and may be used at any time.

10. Driving

10.1 The person 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 and is regarded as a disability *(see Appendix 4).*

10.2 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. They 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 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.

10.3 Further advice including when a second opinion may be indicated is available from http://www.dvla.gov.uk. (last accessed 11/12/17).

11. Holiday requests

11.1 The person must be provided with information regarding the usual notice period for prescription changes and holiday prescription requests. A minimum of 10 working days are required for requests for prescriptions for supplies of medication to travel abroad, as well as additional information about travel requirements/ considerations.

11.2 Prior to the issue of a prescription for a holiday request, the prescriber should satisfy themselves that the request is safe and appropriate and will need to see copies of travel documents. Individuals should be stable and if possible pick-up in a local pharmacy at the holiday location.

11.3 Transfer from methadone liquid to tablets for the purpose of travelling via aircraft should not be routine but may be used in exceptional circumstances. This will usually be for the period the individual is overseas only (due to restrictions on amount of liquid permitted in hand luggage).

11.4 When travelling abroad for any length of time, medication is carried at the risk of the individual, who is subject to legal requirements and restrictions of the country or countries of transit and destination. It is the individual's responsibility to check and enquire about any restrictions with the Home Office, carriers/security and relevant consulates/embassies before departure (for example restrictions on volumes of liquids in hand luggage on aero planes).

11.5 Contact details can be found at: www.drugs.gov.uk (last accessed 11/12/17).

11.6 In general medicines should be carried in original packaging and with a letter from the prescriber confirming the person's name, destination, and details and amounts of medicine.

11.7 A Home Office license is not necessary for planned stays of 3 months or less. Maximum amounts that individuals may travel with are outlined by the Home Office on a case by case basis. The export license 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 license has the right to take the medicine into the country to be visited. The person should complete a form at least two weeks in advance of travel, which is available from Home Office Drugs Licensing, and return it to them along with a letter from the prescriber. The form can be downloaded from: www.drugs.gov.uk/publication-search/drug-licences/Personal (last accessed 11/12/17).

11.8 If the person is travelling for more than three months they should be advised to register with a prescriber in the country they are visiting for the purpose of receiving further prescriptions.

12. Missed Doses

12.1 Missed doses can lead to loss of tolerance so prescribers should be kept informed of them and **must** be informed after 3 consecutive missed doses for re-titration (including by the community pharmacist).

12.2 On a daily dispensing regimen a single missed pick up should not be replaced that day but the following day daily pick up of the dose can continue as usual. On twice weekly pick up then the missed dose(s) (instalment prescription minus the missed dose(s)) should not be replaced but the following day(s) pick up of the dose can continue as usual.

12.3 If the person misses/has not collected doses for more than three consecutive days the prescription must not be dispensed by the pharmacist until advice has been sought from the drug service, who must establish if any significant risks have been reported and an automatic prescribing review is conducted.

12.4 Following 3 days or more of non-collection of doses then the individual must be contacted to ascertain the reason for this 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. If this occurs during titration the individual should be seen by the prescriber and if it is repeated again during titration the motivation for prescribing should be questioned and result in an automatic prescribing review appointment.

13 Training

13.1 All staff (clerical, non-registered and registered professionals) required to undertake a task and/ or deliver care to support the individual needs and recovery of a person with a substance-use disorder will receive appropriate training on local procedures and prescribing guidelines to ensure they are confident and competent to deliver clinical care to the standards described within this policy.

13.2 The clinical evidence base and best practice guidance may change over time. It is therefore essential that all practitioners keep up to date with current practice.

13.3 Education and training requirements should be identified through continuing professional development (CPD) and annual appraisals. Appropriate forms of learning to achieve these requirements (e.g. reflective practice, private study, formal courses) will be agreed between the individual and their line-manager and included in the Personal Development Plan.

13.4 Staff will be informed and, if necessary receive additional training when procedures are revised or amended and when new systems are introduced.

13.5 Professional Leads and Managers will identify service specific training needs.

13.6 All Non-Medical Prescribers must be registered as a practicing NMP with TSDFT

and attend the Trust's medico legal update on an annual basis.

13.7 All staff working in addiction services (clinical and non-clinical roles) should be aware of the symptoms of opiate intoxication and what to do in an emergency.

Recommended links for further information:

- Leaflet: http://www.harmreductionworks.org.uk/resources/pdf/HRDVD6N.pdf (last accessed 11/12/17).
- http://www.harmreduction.org/issues/overdose-prevention/tools-best-practices-manuals-best-practice/od-manual (last accessed 11/12/17).

14 Monitoring, Auditing, Reviewing & Evaluation

14.1 The provision of community drug management will be subject to rigorous clinical governance arrangements. All aspects of the guidelines and practice will be scrutinised and agreed by the Trust governance group (Quality Service Performance, MCDSG).

14.2 All near misses, serious and untoward incidents must be reported via the online incident reporting form found on the front page of the Trust intranet and the Trust Risk Incident Reporting Policy must be followed.

14.3 All Trust staff involved in the delivery of drug treatment will receive regular clinical and line management supervision in accordance with the Trust Supervision Policy.

14.4 Community drug management completed by Trust staff will be reviewed as part of clinical and managerial supervision arrangements to ensure that policies are being adhered to and specific service evaluations will be conducted where a need is identified.

14.5 The Trust Addictions Governance Group, known as (QSP) will advise the Trust's Clinical Effectiveness Lead on audits, relating to the management of substance misuse, to be included in the Trust's Annual Clinical Audit programme.

14.6 Audits will be conducted to ensure Trust-wide adherence to this policy, and related policies, procedures and prescribing guidelines covering the management of substance misuse, to ensure that all personnel involved with any aspect of the service are aware of them and have received the necessary training. This will be managed within an agreed annual audit programme through the Trust Governance Group and theTrust Audit and Effectiveness Group.

14.7 There will be regular reviews (quarterly) of prescribing reports with all prescribers with support from the Medicines Optimisation Team to help ensure safe and evidence based prescribing.

15 References

- BAP (2012) Guidelines: Lingford-Hughes AR, Welch S, Nutt DJ Evidence based guidelines for the pharmacological management of substance misuse, harmful use, addiction and comorbidity: recommendations from the British Association for Psychopharmacology, *Journal of Psychopharmacology* 0(0) 1-54.

- Department of Health Drug Misuse and dependence: UK guidelines & clinical management (July 2017).
- NICE (2010) *Drug Misuse: Opioid Detoxification.*NICE clinical guideline 52. London: National Institute for Health and Clinical Excellence.
- NICE (2007) *Methadone and Buprenorphine for the Management of Opioid Dependence.*NICE technology appraisal guidance 114. London: National Institute for Health and Clinical Excellence.
- NICE (2007) *Naltrexone for the Management of Opioid Dependence.* NICE technology appraisal guidance 115. London: National Institute for Health and Clinical Excellence.
- RCGP (2011) *Guidance for the use of substitute prescribing in the treatment of opioid dependence in primary care.* Royal College of General Practitioners.
- Strang, (2012). *Medications in recovery re-orientating drug dependence treatment.* National Treatment Agency for Substance Misuse.
- Widening the availability of Naloxone: www.gov.uk August 2017 (last accessed 11/12/17).

16 Distribution

16.1 A link to this policy will be distributed to:-

- All prescribers within the Torbay Drug and Alcohol Service (TDAS)
- The Medical Director/CD accountable Officer for TSDFT
- All other staff working within the TSDFT substance misuse service

17 Appendices

17.1 Consent to treatment
17.2 Home detoxification monitoring chart
17.3 Supervisors letter for naltrexone administration
17.4 Drink, drugs and driving leaflet

Consent to Treatment

Name: …… NHS no: ……..……..……..

Recovery-Coordinator: …… Prescriber: ……..……..……

- I have had the treatment explained to me and I understand the potential benefits and risks.
- I understand the alternative pharmacotherapies and psychosocial interventions available to me.
- I have received written information about the medication which will be used, which I have had the opportunity to read and understand.
- I understand that use of illicit drugs or alcohol must be discussed with my recovery - coordinator/prescriber and may result in stopping the prescription. I understand that such behaviour would increase my risk from overdose and could be lethal.
- **I am aware that overdose deaths are more common after any period of abstinence.**
- I will give specimens for testing when asked to do so. If drugs/alcohol is detected, my prescription may be stopped in accordance with the treatment plan.
- I have agreed that my GP will be informed that I am on this programme.
- I understand that my medication will not be replaced for any reason.
- I understand that my medication is for **my use only** and must be kept in a safe place and out of sight and reach of children. I am aware that lockable boxes can be provided during my treatment and will use one if requested by the drug service. I understand that if someone else takes my medication it may be fatal and I must help them to seek urgent medical attention immediately.
- I understand that any attempts to obtain medication by deception, including approaching other prescribers or altering prescriptions, **will** result in my prescription being stopped.
- I understand that any verbal or physical aggression towards any member of staff, including community pharmacy staff, will result in my prescription being stopped.
- I understand that if I do not attend for appointments my treatment may be stopped.
- **I will take my medication as directed and as agreed:**

Drug name:	**Formulation:**
Initial/Target dose and frequency: **I understand that the dose will be titrated to my symptoms.**	

- **For females:** I understand that I need to take precautions against pregnancy whilst in treatment even if I do not have periods and that if I become pregnant I will discuss this with my prescriber.
- **Forbuprenorphine/methadone stabilisation:** I understand that supervised consumption will be required for at least the first 3 months of treatment.
- **For buprenorphine/naltrexone:** I understand that if I take opiates whilst receiving this medication this will cause me to experience withdrawal symptoms.
- **For diazepam:** I understand this is being used outside the licensed indication, based on evidence of effectiveness, for the purpose of managing my drug dependence.
- **For community detoxification/stabilisation:** I agree to complete a home detoxification and nominate …… to look after this medication for the duration of my treatment and for them to dispose of any unused doses upon completion.

If the individual refuses/is unable to provide blood tests: I understand that whilst I am taking this medication I should have blood tests for …… This is important because this may be affected by this medication. Regular blood tests will help to identify if this is becoming a problem at the earliest opportunity so that it can then be managed appropriately. I have had the potential risks and benefits of continuing treatment **without blood tests** explained to me which I understand and agree to.

Signed…… (individual)……Date……..

Upload this document on to HALO/file in paper notes as appropriate when completed.

Appendix 2

COMMUNITY (HOME) DETOXIFICATON CHART

Name: …… **Date of Birth: ……**

NHS no: …… **GP: ……**

Care-Coordinator: …… **Prescriber: ……**

Drug name:	
Target dose and frequency:	**Form**

	Date	**Pulse & Blood Pressure** (for lofexidine)	**Dose** …….AM	…….AM	…….PM	…….PM	……	**Signature**
Day 1								
Day 2								
Day 3								
Day 4								
Day 5								
Day 6								
Day 7								
Day 8								
Day 9								
Day 10								
Day 11								
Day 12								
Day 13								
Day 14								
Day 15								
Day 16								
Day 17								
Day 18								
Day 19								
Day 20								
Day 21								

		Staff signature/date
Total amount prescribed:		
Total amount administered:		
Total amount disposed of:		

If you experience any problems with your treatment 9am-5pm, Monday to Friday, please contact …… at the Drug Service on ……...

For advice outside these times please contact your GP.

Appendix 3

SUPERVISOR'S LETTER
For the administration of NALTREXONE
(for opiates)

Dear Sir/ Madam,

Your relative / friend has recently seen me because of problems related to their opiate use. They have agreed to take a drug called Naltrexone. I have already explained the potential benefits and side-effects of the medication. It has been proven to be effective in reducing relapse rates in people with opiate problems. Please be aware that if they take any opiates whilst taking this medication it is likely to cause withdrawal symptoms, causing them to feel very unwell.

I am writing to enlist your help by supervising your relative / friend when they take the medication. This is one of the most important aspects of the treatment. It is essential that the medication is taken regularly. To be effective one tablet must be taken once a day OR two tablets taken on Monday and Wednesday and three tablets on a Friday.

If you are willing to help, I would be grateful if you would follow these instructions: when the dose is due, watch your relative / friend swallow it and visually check their mouth afterwards. Alternatively, the required amount of tablet(s) may be dissolved in half a glass of water which you must then watch them swallow.

One common problem is that after a few weeks the supervisor is so pleased with progress that problems are forgotten, trust is restored and the administration is left unsupervised. This usually leads to immediate relapse, and loss of faith in the drug and the person.

The procedure to which your relative / friend has consented is to take the medication under your supervision and NOT to agree with him/ her to take the medication by themselves even if there has been sustained abstinence. They have, of course, an absolute right to refuse to take the drug when you offer it to them. If they stop treatment prematurely it is likely that they may start using again at the earliest opportunity. Please contact the service for support but supervision does not mean that you should pressurise or force the individual into taking the medication without their consent since this is not effective. It is consistency in taking the tablet with emotional support from the supervisor which improves the treatment outcome.

Further information about this medication can also be obtained from your prescriber.

Please accompany your relative / friend to their next clinic appointment if you wish.

If you believe that the medication is causing side effects or if you have any further questions or are unclear about what to do, please do not hesitate to contact either myself, the persons' GP or the drug service.

Your relative / friend has agreed to take the medication for a period of ……. months in the first instance.

Yours sincerely,

……Date: ……

Recovery Coordinator and contact number:

……

Appendix 4

Linked to Patient Information Leaflet 25469 – Drugs, Alcohol and Driving

The Mental Capacity Act 2005

The Mental Capacity Act provides a statutory framework for people who lack capacity to make decisions for themselves, or who have capacity and want to make preparations for a time when they lack capacity in the future. It sets out who can take decisions, in which situations, and how they should go about this. It covers a wide range of decision making from health and welfare decisions to finance and property decisions

Enshrined in the Mental Capacity Act is the principle that people must be assumed to have capacity unless it is established that they do not. This is an important aspect of law that all health and social care practitioners must implement when proposing to undertake any act in connection with care and treatment that requires consent. In circumstances where there is an element of doubt about a person's ability to make a decision due to 'an impairment of or disturbance in the functioning of the mind or brain' the practitioner must implement the Mental Capacity Act.

The legal framework provided by the Mental Capacity Act 2005 is supported by a Code of Practice, which provides guidance and information about how the Act works in practice. The Code of Practice has statutory force which means that health and social care practitioners have a legal duty to have regard to it when working with or caring for adults who may lack capacity to make decisions for themselves.

"The Act is intended to assist and support people who may lack capacity and to discourage anyone who is involved in caring for someone who lacks capacity from being overly restrictive or controlling. It aims to balance an individual's right to make decisions for themselves with their right to be protected from harm if they lack the capacity to make decisions to protect themselves". (3)

All Trust workers can access the Code of Practice, Mental Capacity Act 2005 Policy, Mental Capacity Act 2005 Practice Guidance, information booklets and all assessment, checklists and Independent Mental Capacity Advocate referral forms on iCare

http://icare/Operations/mental_capacity_act/Pages/MCA.aspx

Infection Control

All staff will have access to Infection Control Policies and comply with the standards within them in the work place. All staff will attend Infection Control Training annually as part of their mandatory training programme.

Clinical and Non-Clinical Policies – New Data Protection Regulation (NDPR)

Torbay and South Devon NHS Foundation Trust (TSDFT) has a commitment to ensure that all policies and procedures developed act in accordance with all relevant data protection regulations and guidance. This policy has been designed with the EU New Data Protection Regulation (NDPR) in mind and therefore provides the reader with assurance of effective information governance practice.

NDPR intends to strengthen and unify data protection for all persons; consequently, the rights of individuals have changed. It is assured that these rights have been considered throughout the development of this policy.

Furthermore, NDPR requires that the Trust is open and transparent with its personal identifiable processing activities and this has a considerable effect on the way TSDFT holds, uses, and shares personal identifiable data. The most effective way of being open is through data mapping. Data mapping for NDPR was initially undertaken in November 2017 and must be completed on a triannual (every 3 years) basis to maintain compliance. This policy supports the data mapping requirement of the NDPR.

For more information:

- Contact the Data Access and Disclosure Office on dataprotection.tsdft@nhs.net,
- See TSDFT's Data Protection & Access Policy,
- Visit our GDPR page on ICON.