PUBLIC HEALTH
LOCAL SERVICES AGREEMENTS 2016/17
SERVICE SPECIFICATION SIGN-UP

GP Practice
Substance Misuse

Contract expiry date: 31 March 2017

Specific Training/Accreditation: None required for GPs delivering this service.

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I declare that I am competent to provide this service.
Name and designation:

Signature:

To be signed only by the contractor or authorised person

For and on behalf of **EAST SUSSEX COUNTY COUNCIL**
County Hall, St Anne’s Crescent, Lewes, East Sussex BN7 1UE

Signed ..............................
Authorised Signatory
Payment:
Annual retainer: £1,099 (£274.75 / quarter)
Detoxification: £11.00 per client each week
Maintenance: £7.70 per client each week

How to claim: Claims for this service will be requested by Public Health shortly before the end of each quarter and should be received by the following dates:

Quarter 1  Friday 8 July 2016
Quarter 2  Friday 7 October 2016
Quarter 3  Friday 13 January 2017
Quarter 4  Friday 7 April 2017

Late submission of claims will result in delayed payments.
This service specification should be read in conjunction with the Public Health Local Service Agreement (PHLSA) contract document. In addition to the service specific elements set out in this specification all Terms and Conditions set out in the PHLSA must be adhered to by providers delivering this service.

GP Practice
Substance Misuse

**Contract length:** This service specification runs from 1 April 2016 up to 31 March 2017

1. **Introduction**

1.1 The Government’s Drug Strategy (2010) describes the national policy about treatment for drug use disorders. Treatment is focused on engaging people in effective treatment quickly, and enabling recovery. This national strategy informs the East Sussex commissioning strategy for substance misuse (2012 - 2015), ‘Developing Recovery Communities’. The strategy describes the local vision for treatment services:

“Local people who need help for drug or alcohol misuse can quickly access effective treatment services and recovery communities that are shaped by the people they support.”


2. **Key Service Outcomes**

2.1 Services promote visible recovery. The Provider is required to actively promote visible recovery. Information about services must have a clear ‘recovery’ focus. Staff are required to be ambitious in promoting recovery outcomes as an achievable aim for all clients. The Provider is required to promote peer-led recovery and mutual aid groups including ‘self-help’ support and 12-step (‘anonymous’ or ‘fellowship’) groups to all clients.

2.2 Services are acceptable to all clients. Clients of the SHARED CARE SERVICE should be involved in any activity led by the CRI STAR SERVICE to evaluate client satisfaction with the service.

2.3 Services are provided equitably to populations across East Sussex.

2.4 All clients will be provided with information at the earliest point in the treatment pathway and throughout treatment about their rights and responsibilities, how services work, how to make a complaint and the help available to make a complaint.

2.5 Information provided to any client must be sensitive to that client’s culture and ability. Information will be provided in plain English and translated as required, using ‘easy read’ and other reasonable adjustments as appropriate.
3. Aims and objectives of service

3.1 The aim of the SHARED CARE SERVICE is to rapidly engage people with a drug or alcohol use disorder in effective structured treatment that enables them to recover and live free from drug dependence. The objectives of the service are to achieve this overarching aim by:

- promoting recovery from drug misuse
- maximising the number of people who are engaged in effective treatment
- providing good quality, evidence based treatments for drug use disorders
- ensuring recovery plans are regularly reviewed with clients to address changing needs
- reviewing treatment effectiveness with each client at regular reviews, at least once every three months, and adjusting recovery plans accordingly
- ensuring clients are discharged from treatment in a planned way
- ensuring effective links with mutual aid, peer support and any other aftercare provision
- empowering people to integrate into recovery communities and developing social capital

4. Service description/pathway

(i) The SHARED CARE SERVICE is provided through joint work with CRI STAR. CRI STAR coordinates the delivery of drug treatment for clients across East Sussex. The SHARED CARE SERVICE is a managed access service. Each participating practice has an agreed quota of patients.

(ii) GPs refer any patient requiring treatment for a drug use disorder to the CRI STAR service.

(iii) CRI assesses the client.

(iv) A care plan is agreed with the client.

(v) Clients suitable for primary care based treatment are referred to practices providing the SHARED CARE SERVICE based on availability of treatment places and patient choice.

(vi) The shared care liaison nurse will coordinate an agreement to be jointly signed by the prescribing doctor, community pharmacist, CRI STAR Service and patient setting out the ‘patient attendance and compliance’ requirement (see below).

(vii) The CRI STAR SERVICE will provide shared care support and psychosocial interventions via the specialist shared care liaison nurses.

(viii) The prescribing doctor will provide prescriptions using the practice code supplied by the CRI STAR SERVICE.

(ix) Daily supervised consumption of opiate replacement therapy will be arranged with community pharmacists for the first three months where appropriate.

(x) If a client’s needs become more complex and they no longer meet the criteria for the SHARED CARE SERVICE they must be referred back to the CRI STAR SERVICE, which will prioritise a return of the patient to their care within five to ten working days.
5. **Client attendance and compliance requirements**

5.1 Clients must enter into a three-way agreement with the SHARED CARE SERVICE (the prescribing doctor and the CRI nurse) and the dispensing pharmacy. A sample agreement is included as an appendix A. The care plan will indicate where appointments are and how often they happen. The location and frequency are negotiated with the doctor and the client.

5.2 Clients must attend regular appointments with the shared care liaison nurse.

5.3 Urine or mouth swabs need to indicate adherence with prescribed medication. Inconsistent adherence or increased illicit drug will require re-assessment and may mean return to the care of the CRI STAR Service.

5.4 The client or any person accompanying them must not at any time cause a disturbance at the doctor’s practice, the dispensing pharmacy or the CRI STAR Service.

5.5 No lost prescription will be replaced. Once collected, the prescription is the client’s responsibility.

5.6 Any of the following actions will lead to the agreement being withdrawn. Responsibility for the client’s care will return to the CRI STAR Service. If an offence may have been committed then the police will also be informed:

- Attending any appointment or the dispensing pharmacy heavily intoxicated by illicit drugs or alcohol
- Any attempt to obtain further amounts of the prescribed medication from any other practice, or fraudulent change to any prescription
- Theft of property from doctor’s practice, the dispensing pharmacy or the CRI STAR Service, their premises or employees
- Aggressive behaviour (whether verbal or physical), threats of aggression or any abuse or intimidation

5.7 The prescribing doctor may issue a written warning for any behaviour deemed to be inappropriate, which will remain on record. Any reoccurrence of such behaviours may result in the agreement being withdrawn and return to the care of the CRI STAR Service.

5.8 Emergency appointments and house calls must not be requested in relation to medication issues.
6. Any acceptance and exclusion criteria

The criteria for the SHARED CARE SERVICE are:

**Acceptance criteria:**
- Ordinarily resident in East Sussex
- Aged at least 18
- Registered with a General Practice in Eastbourne, Hailsham and Seaford Clinical Commissioning Group (CCG), Hastings and Rother CCG or High Weald, Lewes and Havens CCG
- Drug use disorder involving the illicit use of controlled drugs or substances that have an effect similar to controlled drugs such as New Psychoactive Substances.

**Exclusion criteria:**
- Clinical assessment indicates that there is unlikely to be any benefit from treatment
- A risk assessment indicates that there is a significant risk of harm to self or others but the clinical assessment indicates that treatment will not significantly reduce the level of risk.
- Exclusions are exceptional and may be reviewed on the direction of the commissioner.

The following criteria are applied to identify clients who are suitable for treatment in the SHARED CARE SERVICE
- Shows motivation to reduce or abstain from illicit drug use.
- Not pregnant.
- No severe and enduring mental health issues that could affect ability to attend appointments and engage effectively with the service.
- No severe alcohol use that could adversely affect prescribed medication. Methadone, diazepam and heavy alcohol use could possibly potentiate unintentional overdose.
- Clients taking benzodiazepines should be willing to convert to an appropriate level of diazepam and be willing to engage in a reduction programme.
- If the client is under 19 they should be assessed by the specialist under 19’s team, which will need to co-ordinate care if the client is managed by that team.
- Only prescribed medications approved in the Department of Health Clinical Guidelines would be accepted into shared care. Dihydrocodeine is not acceptable, physeptone tablets or injectables would not be considered appropriate.
- Clients must be willing to undertake a prescription on daily collection and the dose negotiated with the individual GP via the GP Liaison Nurses. Frequency of collection may decrease on evidence of stability/compliance on an individual basis.
7. Interdependencies with other services

7.1 CRI STAR Service

This is a shared care service provided through joint work with the CRI STAR SERVICE Provider.

7.2 Community Pharmacies

The prescriber must ensure that appropriate dispensing arrangements are available, including supervised consumption of controlled drugs if the prescriber believes consumption should be supervised. A ‘three way agreement’ between the prescriber, dispensing pharmacist and client is included with this specification.

7.3 East Sussex County Council Children’s Services

- Children’s Social Care

In order to identify the level of risk to the child from familial substance misuse, the SHARED CARE SERVICE must consider the ‘risk indicators’ in relation to any parent’s substance misuse. When risk factors are present, as indicated within the Sussex child protection and safeguarding procedures, practitioners should refer to Children’s Social Care for further assessment. Further information is included at Section 8 of this specification, ‘Safeguarding Policies’.

When a parent is engaged in substance misuse treatment, and social work assessment identifies risks for the child resulting in child protection planning, the Provider must consult with the SWIFT Specialist Family Service (‘SWIFT’).

This may result in a SWIFT practitioner taking over delivery of the treatment programme or alternatively may lead to SWIFT reviewing the existing care plan and making recommendations to Children’s Social Care or the SHARED CARE SERVICE, to ensure that the care plan is sufficiently tailored to the needs of the parent and child.

If a child of a substance misusing parent is thought to be using drugs or alcohol, the SHARED CARE SERVICE must always refer to:
- (if the child is under 10 years) Children’s social care
- (if the child is aged 10 to 18) the Under 19’s Substance Misuse Service (‘Under 19’s SMS’).

If a young person under 18 years presents to the SHARED CARE SERVICE, they must be referred to the Under 19’s Substance Misuse Service for an assessment of their drug and alcohol use and the subsequent planning to meet those needs.

If a young adult aged 18 - 21 years presents to the SHARED CARE SERVICE and they are a care leaver or subject to a current youth offending order, the Provider must consult with the Under 19’s SMS about how assessed needs will be met.

If a female client has been identified by Children’s Services as requiring an enhanced care coordination service, by virtue of previous children being subject to care proceedings, the Provider must liaise with the designated Children’s Services lead professional in order to ensure a holistic and integrated care plan is designed. The focus of the care plan will be to reduce substance misuse risk and the risk of further pregnancy and/or repeat care proceedings.

The Provider is required to identify and share information with services working with families of service users, using the Children Index to find out who to make contact with.

The Provider must consider the caring responsibilities of children of service users during assessment, and work with the Young Carers service when appropriate to ensure young carers are identified and supported.
• **SWIFT Specialist Family Service**

The East Sussex SWIFT Specialist Family Service is a multi-agency service that works with families in the child protection process.

East Sussex County Council is developing services that provide specialist support for mothers subject to removal of infants in care proceedings. The SHARED CARE SERVICE is required to work with the SWIFT Specialist Family Service to ensure female clients receive appropriate and effective help post-proceedings. This will include ensuring that care plans consider referral to the Long Acting Reversible Contraception (LARC) nurse employed by East Sussex Community Healthcare NHS Trust, and other services identified as appropriate during care proceedings.

8. **Safeguarding policies**

**SAFEGUARDING ADULTS AT RISK:** The Provider must have a written policy and procedure that conforms to the Sussex Multi-Agency Policy and Procedures for Safeguarding Adults at Risk.


**SAFEGUARDING CHILDREN:** The Provider must have a written policy and procedure that conforms to the Sussex Child Protection and Safeguarding Procedures.


9. **Any activity planning assumptions**

9.1 Planned activity will be agreed with any practice that provides the service.

10. **Applicable standards**

Applicable national standards e.g. NICE

Drug treatment must be provided in line with the standard guidance published by the Department of Health (2007) Drug misuse and dependence: UK guidelines on clinical management. Public Health England assumed responsibility for leading substance misuse prevention and treatment from 1 April 2013. All relevant standards and guidance published by Public Health England (or formerly the National Treatment Agency, NTA) are applicable.

The National Institute for Health and Clinical Excellence (NICE) has published a suite of quality standards and clinical guidelines for services that help people with drug use disorders. The full range of standards, quality measures for each standard, the clinical guidelines and the background evidence is all published on the NICE website, [www.nice.org.uk](http://www.nice.org.uk)

Applicable standards include:
- Drug use disorders – Quality Standard 23 ([www.nice.org.uk/QS23](http://www.nice.org.uk/QS23))
- These quality standards reference a wide range of NICE guidance including:
  - CG51: Drug misuse: Psychosocial interventions
  - CG52: Drug misuse: Opioid detoxification
  - PH43: Hepatitis B and C: ways to promote and offer testing to people at increased risk of infection
  - TA114 Drug misuse: Methadone and buprenorphine
  - TA115: Drug misuse: Naltrexone

Other relevant NICE guidance includes:
- PH24: Alcohol-use disorders: Preventing harmful drinking
Service requirement for practices that provide the SHARED CARE SERVICE

- The Provider is required to develop and maintain information sharing protocols that will enable it to meet the requirements of this service specification, and the requirements of the Data Protection Act (1998).
- The practice staff must maintain effective communication with the shared care liaison nurses who support the practices engaged in the scheme.
- There must be an accurate register of clients receiving treatment for a drug use disorder.
- Treatment must be provided in line with relevant standards and guidelines. Treatment includes prescribing substitute (opiate and non-opiate) drugs including antagonists.
- Prescribing should be provided as part of a care plan that also addresses co-existing physical or mental health, social and legal problems.
- The client’s care must be reviewed with an appropriate frequency. As a guide, this should be no less than every six weeks for maintenance patients and every week for detoxification patients. Clients may need their care reviewed more frequently, for example if there are any concerns about co-morbid physical or mental health problems or social issues.
- Safe and secure practices must be maintained, appropriate for the provision of the services.
- A risk assessment must be completed by the practice. The practice is responsible for the safety and training of clinical and non-clinical staff (including reception staff).
- The practice must provide facilities and administrative support sufficient to enable the shared care liaison nurses to undertake regular client reviews within the practice.
- Any doctor providing the service is required to maintain a good knowledge of, and effective liaison with, local drug services and other agencies including dispensing pharmacies, mental health teams and non-statutory services.
- Any doctor providing the services is expected to act as a resource to practice colleagues in the care of drug users.
- If a patient being treated under the scheme remains on the list of their own general practitioner for the provision of primary medical services there must be an effective means of communication between practitioners.
- The specification includes opiate and benzodiazepine prescribing protocols.
- Clients are required to sign an ‘attendance and compliance’ agreement. Any client who does not adhere to the requirements of the agreement must be discussed with the Shared Care Liaison Nurse at the earliest opportunity and their suitability for the service reassessed.
- Any client whose situation changes such that they no longer meet the criteria for the Shared Care Service must be discussed with the Shared Care Liaison Nurse at the earliest opportunity and their suitability for the service reassessed.
- Any doctor providing the service must complete the RCGP Certificate in the Management of Drug Misuse Part 1 course within twelve months of starting to provide the service.
- Any doctor providing the service must attend at least one annual update meeting for doctors providing the ‘shared care’ service, led by the CRI STAR SERVICE Provider.
- If the SHARED CARE SERVICE is provided to patients who are registered for primary care with another practice then the SHARED CARE SERVICE will share copies of written reviews of the patient’s care with the patient’s own practice. A ‘Treatment Outcomes Profile’ (TOP) review completed at least every six months and at discharge is sufficient.
11. Accreditation and appraisal

11.1 Doctors who have previously provided services similar to this enhanced service and who satisfy at appraisal and NHS England revalidation that they have such continuing medical experience, training and competence as is necessary to enable them to contract for the enhanced service shall be deemed professionally qualified to do so.

11.2 A doctor providing the service will be supported by a shared care liaison nurse, provided by the CRI STAR SERVICE. The doctor is required to:
- Identify and treat the common complications of drug misuse
- Carry out an assessment of a patient’s drug use.
- Provide harm reduction advice to a current drug user or his or her family.
- Test (or refer for testing) for other viruses, including HIV, Hepatitis B and C, liver function tests
- Provide immunisation for hepatitis A and B to at risk individuals.
- Provide drug information to carers and users as to the effects, harms and treatment options for various common drugs of use
- Assess and refer appropriately, patients for drug misuse substitution treatment
- Utilise the range of commonly used treatment options available for treatment including pharmacological interventions.
- Be aware of local policy.
- Work in an appropriate multidisciplinary manner.


11.3 Any doctor providing the service must complete the RCGP Certificate in the Management of Drug Misuse Part 1 course within twelve months of starting to provide the service. Any doctor providing the service must attend at least one annual update meeting for doctors providing the ‘shared care’ service, led by the CRI STAR SERVICE Provider.

12. Audit and monitoring

12.1 The following requirements apply to the SHARED CARE SERVICE:

- All client information must be recorded using an information system that is compliant with the requirements of the current National Drug Treatment Monitoring System (NDTMS) dataset and associated guidance. The Shared Care Liaison Nurse shall be responsible for ensuring information about the service provided is recorded in an appropriate information system.
- Patient reviews to an agreed frequency, no less than every six weeks for patients receiving maintenance prescription, weekly for patients undergoing withdrawal (detoxification).
- Completion of Treatment Outcome Profile (TOP) reports and Sub Intervention Reviews to the timetable described by Treatment Outcomes Profile guidance.
- Completion of any additional training and continuing professional development needs identified when joining the scheme or upon appraisal or revalidation.
- Attending at least one annual update meeting for doctors providing the ‘shared care’ service, led by the CRI STAR SERVICE Provider.
- Activity audits to facilitate the payment of fees due for patients treated within the scheme (quarterly in arrears)
13. Location of Provider Premises

13.1 The Provider’s Premises will be the practice address unless otherwise specified.

14. Required Insurances

14.1 The Council may request copies of relevant insurance certificates.

15. Payment/Cost

Annual retainer: £1,099 (£274.75 / quarter)
Detoxification: £11.00 per client each week
Maintenance: £7.70 per client each week

The Retainer fee is payable during any quarter when the service is available, regardless of activity. The ‘detoxification’ fee can be claimed for any client when a reduction prescribing or detoxification care plan is agreed, for every week that the client remains in contact with the service.

The ‘maintenance’ fee can be claimed for any client when a maintenance prescribing care plan is agreed, for every week that the client remains in contact with the service.

Claims for this service will be requested by Public Health shortly before the end of each quarter and should be received by the following dates:

Quarter 1 Friday 8 July 2016
Quarter 2 Friday 7 October 2016
Quarter 3 Friday 13 January 2017
Quarter 4 Friday 7 April 2017

Late submission of claims will result in delayed payments.

Work is underway to develop a system to assist with data collection and automatic payments to cover payments to both GP Practices and Pharmacies. We will involve GP Practices at appropriate points to ensure compatibility with current systems and processes.

16. DBS Checks

16.1 A DBS check must be in place for all staff delivering this service. Providers should assure themselves that the appropriate DBS check, for the type of service being undertaken is in place for each member of staff providing the service. Please see guidance [www.gov.uk/disclosure-barring-service-check/overview](http://www.gov.uk/disclosure-barring-service-check/overview). The County Council policy is that DBS checks are refreshed every three years.

17. Contacts

Daniel Parsonage, Strategic Commissioning Manager Substance Misuse
Telephone: 01273 335110

Tracey Houston, Public Health Business Manager
Telephone 01273 481932
PREScribing GUIDELINES

The following protocols are included as guidelines in good clinical practice. Prescribing will normally be initiated by the Drug and Alcohol Recovery Service before responsibility for the client is transferred to a doctor providing the shared care service. Treatment will then be reviewed regularly with the shared care liaison nurses.

OPIATE PRESCRIBING PROTOCOLS

Responsibilities of the prescribing doctor:
- Substitute prescribing should not be undertaken in isolation. A multidisciplinary approach is essential.
- Prescribing is the ultimate responsibility of the doctor. The responsibility cannot be delegated.
- The doctor prescribing controlled drugs for the management of drug dependence must have an understanding of the basic pharmacology, toxicology, and clinical indications for the use of the drug, dose regime and therapeutic monitoring strategy to prescribe responsibly.
- To participate in a full assessment of the client, in conjunction with the substance misuse service and treatment goals set.
- No more than one week’s prescription should be dispensed at one time, except in exceptional circumstances.
- The client should be advised of safety in storage of medication and advised regarding driving and other risks. A patient information leaflet will be provided for participating practices. The CRI STAR SERVICE provider can supply lockable medication cabinets on request to clients who live with children.
- Thorough, clearly written computer records of prescribing should be kept.

Substitute prescribing should only be considered if:
- There is convincing evidence of current dependence (including objective signs of withdrawal) i.e. sweating, lachrymation and rhinorrhea, yawning, feeling hot and cold, anorexia and abdominal cramps, nausea, vomiting and diarrhoea, tremor, insomnia and restlessness, generalised aches and pains, tachycardia, hypertension, gooseflesh, dilated pupils, increased bowel sounds and
- The assessment clearly substantiates the need for treatment i.e. history, urine toxicology. The history would include the client’s verbal evidence of illicit drug use, type and amount of drug used, route of administration. Clinical evidence of track marks and recent injection sites. The urine toxicology to reflect illicit drug use (ideally more than one sample) and
- The doctor is satisfied the client will co-operate and demonstrate adequate compliance with the prescribing regime.

Do not initiate prescribing if any of the following apply:
- Drug test screening has not confirmed illicit drug use. One positive urine does not mean that the client is dependent and a full assessment is still necessary.
- At first contact with the client (unless already prescribed and details have been transferred).

Initiating prescribing:
The aim is to prescribe a dose of a substitute drug that will prevent withdrawal symptoms and reduce or eliminate illicit drug use. Note:
- Some clients may overestimate their usage to obtain a bigger prescription
- Some may underestimate their usage in order to please you.
• Some clients may have unrealistic expectation of the prescription he/she ought to receive.
• If in doubt, begin with low doses and titrate subsequent small increases against withdrawals.

**Drugs to prescribe For Opiate Dependence:**

• Substitution of heroin for a longer acting oral preparation has proven health and social benefits and is an accepted treatment of opiate dependence.
• Methadone or buprenorphine are the drug of choice as they are both long acting, straightforward to titrate, less likely to be diverted or injected and is backed by evidence of efficacy.
• More detailed information on the evidence that underpins these protocols are obtainable from:
  www.nice.org.uk/TA114 NICE TA114: Drug Misuse – methadone and buprenorphine
  www.nice.org.uk/QS23 NICE Drug use disorders – Quality Standard 23
  http://www.smmgp.co.uk Substance Misuse Management in General Practice
Protocol for Prescribing Methadone

Titration from heroin to methadone:

At this point a full assessment of the client's illicit drug use has been obtained and a recommended range of prescribed methadone has been established. It has been explained to the client that:

- It is a once daily liquid dose
- It will not cause euphoria
- That the initial dose may not be high enough and may need some adjustment
- It has been explained to the client to abstain from using heroin 6-8 hours prior to commencing methadone

Day 1

- Methadone should be prescribed in a mixture of 1mg in 1ml. The starting dose should be no more than 40-ml to reduce the risk of overdose.
- Ideally start at the beginning of the week to ensure that the client will get specialist support in the initial phase of their treatment allow easier titration and stabilisation and prevent overdosing.
- Advise the client against using on top of methadone due to the high risk of overdose and delayed stabilisation.
- Explain the methadone effects last for approximately 24 hours, and that the drug builds up over several days.

Day 2

- Discuss any withdrawal symptoms or over medication. If continued withdrawal symptoms the methadone may be increased 5-10 mls every 2-4 days.
- Discuss any illicit drug use, and the potential risks.

Day 3

- Continue to titrate upwards until stabilisation has been achieved.

Research has shown that:

- Higher dosing of methadone (i.e. 60-80mls) has higher retention rates in treatment.
- Higher dosing greatly reduces illicit drug use and offending behaviour.
- Higher doses may be required depending on tolerance and specialist advice is recommended.
- Fortnightly prescriptions can be issued using FP10 instalment prescriptions, stating supervised consumption if required.
Protocol for Prescribing Buprenorphine

Buprenorphine can be considered for patients
- Using up to 1.5g of heroin daily
- Using less than 30mls methadone daily (or can be reduced to this level).

Direct equivalence between buprenorphine and methadone is difficult to estimate and is not a linear relationship, 12 to 16 mg of buprenorphine is approximately as effective as 50 to 80 mg of methadone in reducing heroin use and retaining clients in treatment. Ideally baseline liver function studies should be obtained for those clients deemed to be at high risk if liver damage i.e. heavy drinkers who have established liver damages, symptomatic hepatitis, and any other disease affecting the liver.

About buprenorphine:
- It is a semi synthetic derivative of opium.
- It has an effective duration of at least 24 hrs with a half-life of 20-25 hrs.
- It is available in 0.4mg, 2mg, and 8mg tablets.
- Administration is via the sub-lingual route, and takes effect in 90-120 mins.
- It binds to morphine receptors and acts as a partial agonist; because of this effect it may lead to a greater chance of stabilisation and less illicit use on top.
- Less risk in overdose and lower risk of respiratory depression.
- It is a useful alternative to methadone and can be considered for detox or maintenance.
- It has lower euphoric effects at high doses.
- Blockade of other opiates.
- With doses between 8-16mg daily it reduces illicit use on top.

Consider buprenorphine for the following client categories:
- Clients new to treatment.
- Clients requesting a detoxification programme.
- Clients wishing for an alternative to methadone.
- Clients on low doses of methadone and wish to become drug-free, but may struggle with a methadone detox.
- Clients who are relatively stable on methadone but are using regularly on top.
- Clients who have long term opiate problems and have failed to stabilise on methadone.
- Clients who have previously been prescribed methadone but did not respond successfully to their treatment plan.
- Clients over 18 yrs.

Do not use buprenorphine for clients who:-
- Are pregnant or breastfeeding without specialist advice/experience.
- Have severe liver damage.

Note:
There is a risk of injecting buprenorphine as it is only available as sub-lingual tablets and highly soluble. Practitioners should ensure that this risk is fully assessed before buprenorphine is considered an appropriate treatment option and consideration be given to prescribing Suboxone (the buprenorphine/naloxone combination) to reduce the abuse potential.
Guidelines for prescribing buprenorphine:

- Clients using heroin should receive their first dose of buprenorphine at least 6-8 hrs after the last dose of heroin, and preferably experiencing as much withdrawal symptoms as tolerable. Taking buprenorphine soon after using heroin will increase the withdrawal symptoms due to the antagonist within it.

- Clients on methadone should be reduced to 30 mls or less daily prior to transferring to buprenorphine. They should receive their first dose of buprenorphine at least 24 hrs after the last dose of methadone and/or when experiencing withdrawal symptoms.

- Full explanation of how buprenorphine works explained to the client.

- Stabilisation on buprenorphine usually achieved over three days.

- Clients are usually unsettled for the first three days as the dose is titrated.

- Tablets are taken in one single dose daily sublingually.

- The shared care liaison nurse should see the client at least weekly for the first three weeks of treatment.

- Any serious side effects should be discussed with the shared care liaison nurse.

- Any missed doses of buprenorphine should not be replaced, as buprenorphine is long acting and the clients should not experience withdrawal symptoms if one day is missed.

- Buprenorphine can be prescribed by instalments on an FP10 and in the initial stages of treatment, daily supervised collection is advised.

Administration procedure for buprenorphine:

Day 1
- Start treatment early in the week to enable daily contact and monitoring for at least the first three days.
- Starting dose normally 4mg-6mg

Day 2
- Assess for signs of withdrawal or sedation (it is unusual to experience sedation) and titrate accordingly.
- For withdrawal the dose should increase by 4mg – 8mg.
- For sedation reduce by 2mg-4mg.

Day 3
- Repeat day two. The most commonly effective maintenance dose is between 8 -16mg daily, but lower or higher doses may be used (maximum 32mg).
BENZODIAZEPINE PRESCRIBING PROTOCOLS

The central aim of these guidelines is to reduce all benzodiazepine prescribing for this patient group to nil.

Key Considerations

• Long term benzodiazepine use may cause harm, particularly at doses greater than 30mg daily.
• They are frequently used as a secondary drug of abuse, either to enhance the effect of the primary drug, or to reduce withdrawal effects.
• They have a strong addictive potential and the withdrawal syndrome can be dangerous.
• Illicit benzodiazepine use is widespread and causes a wide variety of harm related to:
  – Ingestion (intoxication, bizarre behaviour)
  – injection (thrombosis, infection)
  – withdrawal (psychosis, fitting).
  – Overdose.
• Whilst there is no evidence to support the use for maintenance treatment, GPs should be able to accommodate and treat benzodiazapine users and prescribe where appropriate. When prescribed they should be withdrawn slowly and should only be used for detoxification from benzodiazapine addiction and not maintenance unless there are specific indications.
• The illicit market only exists at all because they are widely prescribed.
• Prescribing benzodiazepines to young people for the treatment of sleeping problems, anxiety or other psychological difficulties is rarely justified.
• Benzodiazapines are often taken in conjunction with opiates. For those clients prescribed methadone, the methadone dose should be kept stable throughout the benzodiazapine reduction period. Concurrent detoxification of both drugs is not recommended in community setting.
• There are no licensed indications for the prescription of benzodiazepines for more than 2-4 weeks.
• People who tend to “binges”, or overuse are not suitable for long-term prescribing. Long-term prescribing is sometimes justified, for example with clients who have had long-term prescriptions. However these clients should be encouraged to reduce from high daily doses to a safer dose (preferably not more than 30mg).
• The withdrawal syndrome is unpleasant and potentially dangerous. Sudden cessation of high-dose or long term regime (more than a few weeks) is not good practice. Withdrawal syndrome may start within hours, or be delayed a few weeks after withdrawing long-acting drugs. Symptoms may include:
  – Confusion, psychotic-like states.
  – Anxiety, insomnia, loss of appetite/weight.
  – Tremor, perspiration, tinnitus, perceptual disturbance.
  – Possibility of convulsions.
Guidelines for prescribing benzodiazepines

- Prescribing should only be initiated where there is clear evidence of dependency from the history and urine toxicology. Note that clients may exaggerate the amount they are taking. This will be in conjunction with a full comprehensive assessment via the drug and alcohol recovery service.

- In general, it is recommended that a prescribing regime should be negotiated and agreed with the client. If considering a detox or reduction it should be determined by the individual’s capacity to tolerate symptoms or, more often, by their anticipation of unpleasant withdrawals. Clients may be reassured that they will suffer less withdrawal symptoms on a regime where daily dose is reduced in small portions (range one-tenth to one-quarter) every fortnight. Normally clients are able to tolerate a reduction of 2.5mg-5mg every two weeks.

- For doses below 30mg reduce by 2mg - 2.5mg every 2 weeks.

- If withdrawal symptoms occur maintain the dose until symptoms improve.

- If severe withdrawal symptoms occur, increase the dose to alleviate symptoms and reduce by smaller increments.

- Convert all benzodiazapines to equivalent diazepam dose using the conversion chart below.

- Prescribe for daily collection using instalment contract (reduces risks of diversion of medicines, overusing of daily dose, or loss of medication)

- Daily doses should be divided to reduce the risk intoxication.

- Regular review of the client’s progress by the prescribing doctor and shared care liaison nurse.

- If carrying out a detox review the client six weeks after successful completion – consider whether there is a need of treatment for underlying mental health problems.

<table>
<thead>
<tr>
<th>DRUG</th>
<th>DOSE EQUIVALENT TO 5MG DIAZEPAM</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHLORDIAZEPoxide</td>
<td>15MG</td>
</tr>
<tr>
<td>LOPRAZOLAM</td>
<td>0.5MG</td>
</tr>
<tr>
<td>LORAZEPAM</td>
<td>0.5MG</td>
</tr>
<tr>
<td>OXAZEPAM</td>
<td>15MG</td>
</tr>
<tr>
<td>TEMAZEPAM</td>
<td>10MG</td>
</tr>
<tr>
<td>NITRAZEPAM</td>
<td>5MG</td>
</tr>
</tbody>
</table>
APPENDIX A – THREE-WAY AGREEMENT FOR SUPERVISED CONSUMPTION

Agreement Regarding the Provision of Medication Prescribed by the Shared Care Service in the Community Pharmacy

What the patient will do
- Provide the dispensing pharmacist with a signed copy of this agreement.
- Treat the pharmacy staff and other customers with respect.
- Attend the pharmacy (identified by name on the prescription) on the agreed dates and within the agreed times.
- Attend without being intoxicated with alcohol and/or drugs.
- Not smoke or consume alcohol within the pharmacy.
- Attend alone (unless assistance required due to impaired mobility) and leave pets outside.
- Wait or return later if the pharmacist is busy.
- Contact SMS/CRI if you are more than three days late in collecting your medication.
- Do not allow any other person to attend the pharmacy on your behalf unless previously arranged by SMS/CRI.
- Be aware that the pharmacist may have to pass on necessary information about you to SMS/CRI on a ‘need to know’ basis.
- If you have been asked to consume medication in the pharmacy this needs to be done under the supervision of pharmacy staff. Having taken your medication you will need to drink some water to confirm that your medication has been absorbed/swallowed.
- Choose a pharmacy that you wish to attend that provides the service that I require.
- On the rare occasion that you have agreed with the substance misuse service that someone can collect your medication on your behalf, provide the person collecting your medication with written permission signed and dated by you. The person collecting will need to provide some form of identification.
- Provide a breath/alcohol test if either specified on your prescription or if requested by the Pharmacist.

What the pharmacist will do
- Treat you with respect.
- Have responsibility for your care and keep records of your attendance.
- Provide a confidential, private place for you to consume your medication under supervision if this is what is specified on the prescription.
- Arrange and agree a convenient time for you to receive your medication.
- Dispense medication in accordance with prescription.
- Provide water to drink.
- Liaise when necessary with SMS/CRI with regard to your treatment or concerns about your health or behaviour.
- Provide health promotion and education at the discretion of the pharmacist.
- Contact the specialist service direct if you fail to attend any arranged pick-ups.
- Discontinue dispensing your medication if you are more than three days late in attending the pharmacy or if you behaviour causes any problems. Missed doses cannot be collected the next day.
- If you attend intoxicated, your substitute medication may be suspended and you will be asked to see your SMS/CRI care co-ordinator before the medication can be reinstated.
- Request a breath/alcohol test if indicated on your prescription or if you present as intoxicated.
- Your medication will be withheld if you give a reading above 0.35mgs/litre of breath.
What the shared care service will do

- Discuss the terms of the agreement with you
- If the terms of the agreement are not met reconsider where you obtain your medication and/or reconsider you continuing to receive treatment from the substance misuse service
- Make available a list of pharmacies that provides the service that you require
- Write a letter introducing you to the pharmacist who will be dispensing your medication.
- Provide prescriptions for the duration of your treatment
- Liaise with the pharmacist with regard to your treatment or concerns about your health or behaviour.
- Check with pharmacies on a daily basis of any patients who failed to attend a scheduled pick-up, or make available a process where it is easy for a pharmacy to report a non-attendance
- Review your care.

<table>
<thead>
<tr>
<th>Name</th>
<th>Signature</th>
<th>Contact No.</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Shared Care Service</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pharmacist</td>
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</tr>
</tbody>
</table>

**Pharmacy Name and Address:**