Prescribing Guidelines for the provision of Medication Assisted Treatment (MAT) within NHS Lanarkshire Addiction Services

TARGET AUDIENCE	Principally NHS Lanarkshire Addictions Service. Can be shared with wider primary care GP practices
PATIENT GROUP	Patients prescribed Opioid Agonist Treatment (methadone and buprenorphine) for opioid dependence

Clinical Guidelines Summary

This guidance is intended for use throughout NHS Lanarkshire to assess, agree and manage the care of patients who are dependent on opioids and/or non-prescribed benzodiazepines. It should be used as a reference for prescribers in all areas of substance use as part of a recovery orientated system of care.

Whilst prescribed therapy is often an important element in the recovery of patients who use drugs there is often a range of needs that include social, legal, medical, and psychological aspects. All of these should be addressed by an individualised treatment or care plan that is produced in consultation with the patient and other professionals involved in the patient's care.

Guideline Body

Prescribing Guidelines for the provision of Medication Assisted Treatment (MAT) within NHS Lanarkshire Addiction Services

Lead Author	**D Hill**	**Date approved**	**October 2025 ADTC**
Version	**1.2**	**Review Date**	**October 2027**

Contents

INTRODUCTION

This guidance is intended for use throughout NHS Lanarkshire to assess, agree and manage the care of patients who are dependent on opioids and/or non-prescribed benzodiazepines. It should be used as a reference for prescribers in all areas of substance misuse as part of a recovery orientated system of care.

Whilst prescribed therapy is often an important element in the recovery of patients who use drugs there is often a range of needs that include social, legal, medical, and psychological aspects. All of these should be addressed by an individualised treatment or care plan that is produced in consultation with the patient and other professionals involved in the patient's care.

Role and definition of Keyworker

Throughout this document reference will be made to the "keyworker" who may be a nurse, addiction worker, social worker, pharmacist, or other professional who is responsible for coordinating the individuals Recovery Care Plan for and with the patient. Input from other professionals, peers and volunteers may be necessary as part of a system of care in the journey towards recovery.

Key working helps to ensure the delivery and ongoing review of the treatment or care plan and normally involves regular appointments at which progress against the care plan would be discussed and, if appropriate, the agreed treatment goals would be revised.

Liaison with General Practitioners and Primary Care

Providing regular updates on medication prescribed by Addiction Services is a key patient safety issue.

Currently prescriptions issued by Addiction Services are not uploaded to the Emergency Care Summary (ECS) or GP systems automatically, creating a risk of potential harm from delayed/missed doses or unintentional drug interactions.

Whilst regular updates on all aspects of a patient's care are important, there is a requirement for services to update the patients GP in the following circumstances:

1. The initiation of any therapy by Addiction Services.
2. An update on current prescribed therapy at least twice per year.
3. Any change to therapeutic agent e.g., switch from methadone to buprenorphine
4. When a patient stops receiving prescribed therapy from the service.

All letters written to GP surgeries must ask for any regular medication from Addiction Services to be added to GP systems as an "out of practice repeat", and to explain that this is a requirement to ensure that medication is recorded both for the purposes of interaction checks and to ensure that the relevant information is present on the ECS. An example letter is attached (**Appendix 1**).

FRAMEWORK FOR ASSESSMENT AND MANAGEMENT OF OPIOID DEPENDENCE

Phase	Goals	Prescribing	Role of Keyworker	Other Interventions
Assessment & Initiation phase	Comprehensive assessment to establish opioid dependence Initiation of an agreed care plan Same day initiation of treatment where possible Discussion around other drug and alcohol use and goal setting Minimise opioid use by optimisation of OAT prescription. OAT not contingent on stopping use	Choice of appropriate opioid substitution involving patient Assess drug interactions and cautions/ contraindications using product literature Titration on to appropriate opioid agonist treatment (OAT) Dose optimisation involving the patient in all decisions.	Assessment of current and past drug use and treatment. Harm reduction advice, information & supplies Liaise with GP and other services Arrange Pharmacy Offer access to advocacy services & family involvement	Offer BBV testing and relevant immunisations Child Protection Assessment/ Adult Support and Protection Assessment Offer overdose awareness training and Take-Home Naloxone and IEP. Offer referral to appropriate services for co-morbidities and social care issues
Maintenance	Optimise dose to maintain abstinence/reduce use OAT prescribing not contingent on abstinence Discussion around other drug and alcohol use and goal setting	**Methadone** or **Buprenorphine** Assess drug interactions and cautions/ contraindications using product literature Patient involvement around treatment	Review adequacy of OAT dose Offer psychosocial support to assist recovery Drug testing if appropriate Offer access to advocacy services/family involvement Liaise with GP and other services	Offer BBV testing and relevant immunisations Offer referral to other agencies as required Offer overdose awareness training and Take-Home Naloxone and IEP

Phase	Goals	Prescribing	Role of Keyworker	Other Interventions
Reduction and Detoxification	To detoxify from opioid replacement when patient is ready	Negotiated and agreed OAT reduction regimen Symptomatic medication to aid detoxification Patient involvement around treatment	Relapse prevention techniques Drug testing if appropriate Liaise with GP and other services Offer access to advocacy services/family involvement	Offer overdose awareness training and Take-Home Naloxone and IEP Offer BBV testing and immunisations if needed

ASSESSMENT & INITIATION

Goals of Initiation

The purpose of **initiation and titration** with OAT is to establish the patient on a therapeutic dose in a safe manner and as quickly as possible, on a dose of opioid replacement that:

- Eliminates withdrawal symptoms
- Reduces the need to take additional illicit opioids
- Keeps side effects to a minimum
- Avoids sedation / intoxication

Assessment

Initiation of OAT by a suitably trained prescriber may be undertaken prior to completion of full assessment, however it would be **expected that sufficient information is obtained to allow for safe initiation of same day prescribing**. This would include:

- confirming the patient is dependent on psychoactive substances, which may involve point of care testing, where appropriate, which would inform the need for substitute prescribing.
- obtaining background, including past history of OAT and patient's understanding of treatment options.
- physical examination, assessing injection sites where applicable and signs of opioid withdrawal or dependence.
- assessment of current mental and physical health including prescribed medication. Discussions should take place around benefits and risks of OAT options, considering risks of polypharmacy, QTc prolongation, respiratory depression and altered liver function. Any testing required e.g.; ECG **should not delay initiation of treatment**.

Before initiating any treatment, **informed consent** should be obtained and documented with the patient, ensuring they have sufficient understanding of treatment benefits and risks of all treatment's options available and the opportunity to be involved in the choice of treatment.

Completion of the full assessment process would be expected as soon as practical thereafter by a competent, appropriately skilled member of staff. This should include:

- further exploring physical health including respiratory, cardiovascular, and liver function which may inform choice or maintenance dose.
- further assessment of mental health problems including past trauma and social isolation and/or risk of suicide.
- identifying social problems including parenting, pregnancy, and child protection.
- assessing family history for substance use and dependence and relevant medical, psychiatric, or psychosocial factors.
- assessing risk behaviours, including those associated with injecting and offering access to harm reduction advice and IEP if required. Blood Borne Virus testing should be offered.

- encouraging Overdose Awareness Training and Take-Home Naloxone.

Patients may have multiple unmet needs; therefore, one professional will rarely be able to meet all these. Sufficient information should be gathered to identify these and to facilitate input from, or referral to, a range of other professionals and services.

Access to and prescribing of OAT is not contingent on uptake of other interventions or abstinence from other drugs

Initiation

Safe commencement of OAT should be in line with the agreed Care Plan and patient's goals and aspirations.

- Patients should be aware of the risks of overdose during initiation onto OAT and after periods of loss of tolerance (including missed doses).
- The optimal dose achieved by titration is not always the lowest dose that relieves withdrawal symptoms, but the dose required for the patient to feel comfortable and experience less cravings. Patients should be involved in informed decisions around dosing.
- Patients should be aware insufficient dosing may increase the risk of additional illicit drug use, diminish treatment effectiveness, and increase accidental overdose risk.
- Safe storage of OAT is extremely important (especially if children at home) as it can be extremely dangerous to others, therefore this should be addressed as a priority.

During initiation and stabilisation:

- Patients should be offered regular contact with a Keyworker during stabilisation.
- If a patient misses prescribed doses on initiation and stabilisation this should be discussed by both the Keyworker and Prescriber and if necessary, appropriate actions taken and recorded to facilitate the continuation of treatment.

Role of the community pharmacy during Initiation

- Supervised self-administration should be available to all patients to support induction and stabilisation.
- The community pharmacy staff are expected to report missed doses to the prescriber / key worker.
- The pharmacy staff should monitor the appearance and behaviour of the patient and discuss any concerns with the keyworker/ prescriber.
- Community Pharmacists should refer to "Guidelines for supervised consumption of OAT in Pharmacies" for further information.

Initiation with Methadone

- Methadone has a long and variable half-life ranging between 13 – 55 hours.
- ***START LOW AND GO SLOW*** - too high an initial dose and/or too rapid an increase adds to the overdose risk because of the cumulative effect before steady plasma level is reached.
- Starting dose should be between 10mg and 30mg daily, depending on a person's opioid tolerance, frequency of use, route of administration and use of other drugs.
- Dose increase should be no more than 5mg to 10mg on one day and this dose should be maintained for at least three days before further increase. Acceleration of dosing schedule will require prior discussion with a medic.
- **Maximum of 20mg dose increase in any one week.**
- Patients should be informed of the increasing effect of multiple doses, as steady state is achieved, so that they do not excessively "top up" with illicit drugs.
- A therapeutic dose is usually between 60mg and 120mg daily.
- It is critically important to provide information regarding the recognition of methadone toxicity and its management to patients and to any carers involved.
- Methadone should be prescribed as the standard 1mg/ml formulation where possible. Sugar Free formulations should not routinely be prescribed as evidence suggests they have no influence on dental health.
- Full details of special warnings, precautions and interactions may be found in the Summary of Product Characteristics available at www.medicines.org.uk

Initiation with oral Buprenorphine

- Buprenorphine has a high affinity for opioid receptors and can cause ***precipitated withdrawal*** with the first dose by displacing opioids taken previously.
- The first dose should be taken when a patient is **experiencing opioid withdrawal** as measured using a validated opioid withdrawal tool. (Appendix 2 – Clinical Opiate Withdrawal Scale)
- Starting dose should be between 4mg and 12mg daily (depending on product licence and formulation).
- The first dose of buprenorphine should be supervised in a clinical setting where possible
- **Dose increases of up to 6-8mg daily**, depending on formulation prescribed, are safe.
- Patients should be informed that it may take several days to stabilise on their medication.
- A therapeutic dose is usually between 12mg and 16mg daily.
- See product literature for licenced maximum oral buprenorphine doses as these differ between preparation and formulation.
- Full details of special warnings, precautions and interactions may be found in the Summary of Product Characteristics available at www.medicines.org.uk

Initiation with long-acting injectable buprenorphine (LAIB)

- Before initiation with LAIB it is expected that the patient receives a test dose of oral buprenorphine or is currently prescribed oral buprenorphine
- It is important that the initiation process is explained fully to the patient, and they receive an information booklet and alert card. Full agreement should be obtained
- The use of the weekly preparation for at least three concurrent weeks (minimum 2 weeks) allows plasma steady state to be achieved more quickly, before switching to the monthly preparation

Buprenorphine naïve patients

- Those not previously exposed to buprenorphine should receive a single dose of 4mg oral buprenorphine and observed for an hour before first administration of LAIB.
- Patients can also be stabilised on oral buprenorphine for a week prior to initiation of LAIB, if felt necessary.
- When switching from methadone to buprenorphine see guidance transfer between OAT treatment options
- Recommended starting dose of Buvidal® is 16 mg weekly injection, with one or two additional 8 mg doses at least 1 day apart, to a target dose of 24 mg or 32 mg during the first treatment week. The dose in the second week should be the total dose administered in the first.
- When patient has been stabilised on weekly preparation, they should be switched to the equivalent dose of monthly preparation using table below

Table 1: Conversion table from weekly to 4-weekly administration formulations of LAIB

Weekly dose	Monthly dose
16mg	64mg
24mg	96mg
32mg	128mg

Patients established on oral buprenorphine

- Can be switched directly to weekly Buvidal® using equivalences in Table 2 below
- LAIB can be started on the day after last oral buprenorphine dose
- Patients should be monitored closely on initiation of LAIB

Table 2: Conversion table from oral buprenorphine to weekly and monthly administration formulations of LAIB

Daily dose S/L buprenorphine	Daily Dose orodispersible buprenorphine	Weekly dose LAIB	Monthly dose LAIB
2-6mg	2-4mg	8mg	
8-10mg	6-8mg	16mg	64mg
12-16mg	10-12mg	24mg	96mg
18-24mg	14-18mg	32mg	128mg
>24mg		32mg	160mg

LAIB Administration

- Buvidal® is administered by a sub-cutaneous injection in 4 regions on both sides of the body; upper arm, abdomen (not close to umbilicus), buttocks and thigh. The site used should be rotated for each administration.
- **Process:**
    1. Pinch the skin prior to administration. Injection is made at 90 degrees to the skin surface.
    2. Plunger should be slowly depressed.
    3. Once the full dose administered, wait for 2-5 seconds then start to remove the syringe (with the plunger still fully depressed) gradually.
    4. Once fully removed, release plunger and the needle will retract into the syringe barrel
    5. Dispose of device in a sharps container.
- It is important to record site of administration in patient notes. Please follow standard operating procedure for Buvidal® Administration.
- Full details of special warnings, precautions and interactions may be found in the Summary of Product Characteristics available at www.medicines.org.uk

MAINTENANCE

Maintaining a stable agreed dose of OAT which facilitates the patient to achieve their goals and aspirations.

Maintenance should be in accordance with a patients individual Care Plan which should be reviewed regularly looking at the following areas where appropriate:

- Drug and alcohol misuse
- Physical and mental health
- Participation in rehabilitation, counselling, relapse prevention and other psychosocial support programmes
- Progress with family relationships, training, and employment
- Housing
- Offending and criminal justice
- Child/Adult protection issues

Patients should be reviewed at regular agreed intervals as determined by clinical need.

If the patient has not achieved satisfactory clinical improvements, fails to make progress towards their goals or aspirations or deteriorates offer:

- increased intensity of pharmacological and psychosocial support
- a review of medication to ensure it is at an optimal dose
- change to a different OAT
- increased support from keyworker or other appropriate services
- increased supervised self-administration or collection frequency
- If significant concerns with a patient's presentation or progress arise, the keyworker should discuss this with a prescriber and organise a review if necessary.

Patients are at highest risk of death and/or overdose in the period just after stopping treatment and immediately prior to starting. All reasonable efforts should be made to retain patients in treatment and avoid any unnecessary delays in re-starting treatment.

Role of Supervised self-administration during maintenance

Supervised self-administration should be available, where appropriate, for a length of time appropriate to the patient's individual needs and risks. Relaxation of supervised self-administration should be made when clinically appropriate, considering factors such as:

- Illicit drug and alcohol use has been determined to be low risk
- Employment or educational status
- The patient's mental health is stable and there is low risk of self-harm
- Whether children at home and the ability to store medication securely
- Other medication prescribed
- There is no concern of inappropriate use or diversion of medication
- Patient preference, where applicable

Optimal dosing

- If a patient wishes complete cessation of illicit opioid use, the OAT dose required may be higher than the dose that makes them feel “stable.”
- It may take several weeks to reach optimal dose depending on OAT choice.
- In some cases, a patient may believe that intermittent lapses are due to lack of willpower. It should be explained that sub-optimal dosing could be the determining factor and a dose increase may be appropriate. It should be noted however that patient choice should be respected.
- Some patients may be unwilling to increase their dose because they intend to continue to use illicit opioids. This should be addressed, offering increasing support if needed, but should not prevent access to OAT.

Maintenance with Methadone

- Dose initiation and stabilisation are carried out first.
- Patients are usually maintained on methadone doses between 60mg and 120mg daily.
- Caution needs to be exercised balancing any assessed risk of increasing dose with the need to optimise treatment, where the patient continues to use illicit substances and or excess alcohol.
- Reassessment is required if methadone is missed for three days or more. **See missed doses guidance.**

Maintenance with oral Buprenorphine

- Dose induction and stabilisation are carried out first.
- Daily doses between 12mg and 16mg are usually used for long-term prescribing, although up to 32mg can be prescribed, depending on formulation used.
- Alternate day dosing may suit some patients.
- Reassessment is required if buprenorphine is missed for three days or more. **See missed doses guidance.**
- Hepatic function should be monitored in patients on buprenorphine:
  - With pre-existing liver enzyme abnormalities
  - Who are positive for viral hepatitis
  - Who use other potentially hepatotoxic medicines / substances such as alcohol.

Maintenance with LAIB

- Dose induction and stabilisation are carried out first.
- LAIB can be administered weekly or monthly.
- Doses may be increased or decreased, and patients can be switched between weekly and monthly products according to individual patient's needs and clinician judgement as per recommendations in **Table 1**.
- Following switching, patients may need closer monitoring initially.

- A maximum of one supplemental 8 mg dose may be administered at an unscheduled visit between regular weekly/monthly doses, based on individual patient's needs.
- The maximum dose per week for patients who are on weekly Buvidal® treatment is 32mg with an additional 8 mg dose.
- The maximum dose per month for patients who are on monthly Buvidal® treatment is 160mg with no supplemental dose.
- Reassessment is required if a patient does not attend for their usual scheduled dose. **See missed doses guidance.**

Maintenance with alternative oral opioids

Oral opioids such as dihydrocodeine and slow-release oral morphine preparations are not licensed in the UK for opioid dependence treatment. They should not normally be used in the community setting. They are occasionally used in some circumstances by specialist clinicians.

DETOXIFICATION

Achieving planned safe and effective discontinuation of opioids with minimal withdrawal symptoms, measured by becoming drug free and maintaining abstinence. Opioid detoxification should be offered as part of a package including preparation and post-detoxification support to prevent relapse.

For a patient to fully understand and consent they need information on:

- the physical and psychological aspects of detoxification, the duration and intensity of symptoms and how these may be managed.
- the use of non-pharmacological approaches to manage and cope with withdrawal symptoms.
- the importance of continued support during detoxification, to maintain abstinence and reduce the risk of adverse outcomes.

Psychosocial interventions and key working should be delivered alongside pharmacological interventions. If detoxification is unsuccessful, patients should have access back into maintenance treatment and other interventions.

The patient must understand that, as the dose of opioid is reduced, tolerance to previous doses is lost and any relapse into drug taking will carry a high risk of overdose.

Preparation for detoxification

During the preparation process for detoxification address the following points with the patient:

- Lessons learnt from previous treatments, detoxifications, and rehab programmes
- Expectations and acknowledgement of positive outcomes
- Motivation and readiness for detoxification
- Methods of detoxification, choice of medication
- Coping skills to deal with detoxification and strategies to maintain abstinence
- Support network during and after detoxification
- Care plan aimed at relapse prevention

Methadone Detoxification

- Negotiate a structured rate of reduction with the patient and review regularly, adjust when required, and pause if circumstances require.
- Aim to reduce the dose initially by approximately 10% at every reduction.
- Patients may tolerate a rapid dose reduction at higher doses.
- Complete detoxification is likely to be more successful if slowed to 1-2mg at each reduction when doses reach 20-30mg daily.

Oral Buprenorphine Detoxification

- Negotiate a structured rate of reduction with the patient and review regularly making adjustments when required and pausing if circumstances require.
- Aim to reduce by around 2-4mg at each reduction initially, slowing as the dose decreases.
- When the dose is reduced to 4mg, it may be necessary to change to buprenorphine 400microgram tablets to continue the reduction.

LAIB Detoxification

- Negotiate a structured rate of reduction with the patient and review regularly, making adjustments when required, and pausing if circumstances require.
- LAIB has a very long half-life. Elimination is reported to be very gradual and generally well tolerated by patients. LAIB can take up to 4 months to be eliminated completely and patients may continue to have a positive urine screen at 3 or 4 months.
- Two options are available to detox from LAIB. These should be discussed and negotiated with the patient.
- Patients may try to extend the period between doses, remember there is a 7-day extension between doses of the 28-day formulation, (and a 2-day extension with the 7-day formulation) which can be used and will retain the patient in treatment.

- **Ceasing LAIB treatment – gradual detox**
    - Stop LAIB at current dose.
    - Maintain regular contact during the detoxification process, at the usual frequency, to ensure patient continues to progress well.
    - If struggling, various options can be explored including giving an 8mg Buvidal® injection dose or re-commencing on either Buvidal® or oral buprenorphine. **This should be discussed with the Community Prescribing Service (CPS).**

- **Reducing LAIB dose**
    - Patients can reduce sequentially through the strengths of monthly Buvidal®: 160mg > 128mg > 96mg > 64mg
    - 64mg is the lowest monthly formulation available and, as such, is the stopping point for monthly formulation.
    - Can consider 16mg or 8mg preparations thereafter but this would require weekly administration. The duration of the administration interval may also be extended, with agreement from the patient.

- Please see Summary of Product Characteristics for further information available at www.medicines.org.uk. Advice should also be sought from CPS prescribers if required.

Detoxification – symptomatic relief

Opioid detoxification may also be undertaken with symptomatic relief only using the medications below. It is also likely, especially in the last phase of detoxification with OAT, that the patient will experience withdrawal symptoms, so symptomatic relief medication may also be required.

The following non-opioid medications may be helpful:

Symptom	Medication
Diarrhoea	loperamide 4mg initially, then 2mg after each loose stool (max. 16mg/day)
Stomach cramps	hyoscine butylbromide* 10 to 20mg four times daily, when required or mebeverine 135mg three times daily, 20 mins before meals
Nausea and vomiting	prochlorperazine 5 to 10mg two or three times daily when required
Agitation and Anxiety	psychosocial intervention
Muscular pain/headaches	paracetamol 1g four times daily or ibuprofen 400mg three times daily
Insomnia	promethazine 25-50mg at night or zolpidem* 5- 10 mg at night
*These drugs have the potential for abuse and/or dependence – prescribe for no more than 14 days	

Post-detoxification-After care

- The keyworker should continue to offer regular support to the patient during this phase.
- Newly detoxified patients ***remain at increased risk of relapse***. For this reason, they should retain their contact for as long as they feel they need support.
- If there is a relapse to opioid use after detoxification the patient should be offered rapid re-induction onto OAT for another period of stabilisation then maintenance, prior to another attempt at reduction.
- Support should focus on relapse prevention.
- Emphasis should also be on engagement in work related activity and meaningful occupations or activities to replace drug-using lifestyle. This increases the likelihood of staying drug free.

- It may be appropriate, in some cases, to use third sector partners and aftercare services to provide post-detoxification support. The key worker can help facilitate this transition prior to any discharge from Addiction Services.
- Overdose awareness training and Take-Home Naloxone should continue to be offered in the post-detoxification phase.

Naltrexone for relapse prevention post-detoxification

- Naltrexone is a long-acting opioid antagonist. If taken by an individual continuing to take opioids it will precipitate opioid withdrawal symptoms.
- Taken regularly after detoxification, it can help prevent relapse by blockade of opioid receptors. Supervision by either a family member or the pharmacy can aid success, however if this is not possible the decision to prescribe rests with the prescriber.
- Naltrexone should be used only as an adjunct to other forms of support and treatment for patients who have recently detoxed from opioids.

Transfer to naltrexone post-detoxification

- Wait for at least 7-10 days after the last dose of OAT or any other opioids to initiate naltrexone treatment.
- A negative urine test to confirm the patient's opioid free status should be obtained within 12 hours prior to initiation of naltrexone.
- The initial dose of naltrexone is 25mg daily followed by 50mg daily. Initial doses should be supervised by an experienced clinician.
- A three times a week dosing schedule may be considered if it is likely to result in better compliance (e.g. 100mg on Monday and Wednesday and 150mg on Friday).
- An initial treatment period of at least three months should be considered, however longer may be required in some individuals.

Caution with naltrexone

- Liver function tests should be carried out before starting, after one month and then six monthly. It should be discontinued if there is evidence of progressive hepatic impairment.
- Full details of special warnings, precautions and interactions may be found in the Summary of Product Characteristics at www.medicines.org.uk

TRANSFER BETWEEN OAT TREATMENT OPTIONS

Dependent on patient preference, treatment progress or health related factors there may be a requirement to change OAT medication. This should be carried out after an assessment and informed discussion with the patient to ensure that they are fully aware of the advantages and disadvantages of changing therapy and the potential period of instability/poor symptom control that this may cause.

Transfer from methadone to oral buprenorphine

Transfer from methadone daily dose of ≤ 30mg

- The first dose of oral buprenorphine should be administered at least 24 to 36 hours after the last use of methadone and with the onset of mild to moderate withdrawal symptoms.
- Increasing the time interval between the last dose of methadone and the first dose of buprenorphine reduces the incidence and potential severity of precipitated withdrawal

Table 3: Conversion table for switch from methadone daily dose ≤30mg to oral buprenorphine

Last methadone dose	Buprenorphine dose-Day 1	Buprenorphine dose-Day 2
20 to 30mg	4mg – 8mg	Up to 16mg
10 to 20mg	4mg	4-8mg
<10mg	2mg	2 to 6mg

Transfer from methadone daily dose >30mg daily

High Dose Transfer (HDT) from methadone to buprenorphine in the community setting has been successfully used in NHS Lanarkshire. This should only be considered following review by appropriately experienced clinical staff within CPS. Please refer to up to date local guidance for the process of switching.

Transfer from methadone to buprenorphine using micro-dosing method

Micro-dosing has been shown as an alternative transfer method from methadone to buprenorphine, but this must be done after discussion with experienced clinical staff within the CPS. Please refer to up to date local guidance for the process of switching.

Transfer from oral buprenorphine to methadone

The first dose of methadone should be given the day after stopping buprenorphine as per new induction. Due to the long half-life of buprenorphine any risk of withdrawal effects should be minimal whilst the methadone is titrated up to towards a therapeutic level.

Transfer from oral buprenorphine to LAIB

See Initiation chapter

Transfer from LAIB to normal daily oral formulation of OAT

- Oral methadone should be commenced at 30mg on the date the next LAIB dose was expected to be administered. The dose should then be titrated as per prescribing guidelines.
- Oral buprenorphine should be commenced on the date the next LAIB dose was to be administered. Recommence the oral formulation at the dose from the corresponding LAIB dose (**Table 2**). The dose should be assessed after 7 days and following patient assessment, adjusted accordingly.

MANAGEMENT OF BENZODIAZEPINE PRESCRIBING

The specialist prescribing service for substance use within NHS Lanarkshire is the Community Prescribing Services (CPS). This service is provided by GPs with special interest and Non-Medical Prescribing (NMP) nurses and pharmacists. The role and remit of CPS relates only to those who are prescribed Opioid Agonist Treatment (OAT), since the Primary Care GP practices opted out of this service in 2004/2005. Whilst there are prescribing nurses and pharmacists within this service the initiation of prescribing benzodiazepines is by the GPwSI only.

Individual clinicians have responsibility for their own prescribing and ensuring this is safe and reasonable in the circumstances. No clinician is obliged to prescribe benzodiazepines if they feel this is unsafe.

Nurse NMPs will not initiate benzodiazepine prescribing but will monitor and review benzodiazepine prescribing for their caseload under a Clinical Management Plan.

NMP pharmacists will not initiate benzodiazepine prescribing but will monitor and review benzodiazepine prescribing for their caseload.

Patient referral criteria:

1. Patient must already be open to ART, CAReS or CPS
2. Patient must already be prescribed or in the process of being prescribed OAT
3. Initial assessment and attempts at supported self-reduction should already have been sufficiently attempted before referral
4. Patients must be referred to the appropriate GPwSI within the patient's geographic locality.
5. An email containing appropriate clinical information should be sent to the appropriate GPwSI before patients are entered into the clinics.
6. Patients must have had a positive Urine Drug Screen (UDS) for benzodiazepines from analysis.
7. Appropriate Harm Reduction advice provided to patients with a drug diary to assess/ monitor substance use.

Possible indications for benzodiazepine prescribing

- To facilitate detoxification were supported self-reduction with optimisation of other treatments (OAT dose, antidepressants, or social issues) has failed and significant risk or harm is apparent due to benzodiazepine use.
- To stabilise chaotic high dose benzodiazepine, use that is causing risk or harm and is continuing despite optimisation of other treatments (as above) or is precluding delivery of appropriate treatments. The ultimate aim would remain detoxification and abstinence. Severity of benzodiazepine dependence, past prescribing and comorbidity would be factors considered in determining aims, doses, and duration of prescribing. This strategy should only be considered in cases where significant harm or risk is

apparent and in the view of GPwSI, short term detoxification would not be suitable or previous attempt(s) have failed.

- Continuation of an existing long-term prescription prescribed by another substance use service (i.e., prison, hospital or transfer from another health board area, not primary care GP services) that has been interrupted. It would not be good practice and potentially very dangerous to abruptly stop a long-term or high dose benzodiazepine prescription so if necessary, when taking on a new case the service should facilitate a continuation of supply but immediately institute assessment and management according to principles below.

Principles of benzodiazepine prescribing with concomitant opioid dependence

- The patient should have had a face-to-face appointment with their keyworker before the appointment with GPwSI. This should be an assessment of benzodiazepine use, dependence and patient needs including a patient diary of illicit use to be brought to the appointment with GPwSI.
- Patients should already be prescribed OAT and this treatment optimised.
- Patients should already be open to ART, CAReS or CPS and will require joint working.
- Patients should be referred for psychological or psychiatry support whilst undergoing detoxification. Although not currently available in NHS Lanarkshire this requires development.
- The ultimate goal in all cases should be reduction and cessation of benzodiazepine use.
- In all cases where prescription is considered, a careful analysis of aims of prescription and risks and benefits should be recorded and discussed with patient.
- Progress in terms of aims, risks and benefits should be monitored regularly, and prescription altered accordingly. Prescribing should not continue in the absence of clear evidence of benefit to patient the patient.
- Repeated attempts to benzodiazepine detoxification are not recommended but attempts are dependent on a full clinical assessment (including motivation and commitment) and should be limited to as few as possible.

Practicalities

- Extended assessment should evidence longstanding and/or severe benzodiazepine dependence prior to any prescribing taking place.
- Initial benzodiazepine prescription should be 30mg daily or less. Daily doses greater than 30mg **WILL NOT BE PRESCRIBED**.
- If street benzodiazepine use continues (proven with drug screens), treatment should be discontinued.
- Reduction frequencies should be stipulated to the patient at initiation and should be 2-4 weekly. This discussion requires to be documented clearly. Any reduction is best to occur in line with appointments.
- Benzodiazepines should only be prescribed in exceptional circumstances where there is **NO OPIOID AGONIST TREATMENT** prescribed.
- There should be consideration to reviewing and synchronising the benzodiazepine and OAT dispensing.

- Diazepam 2mg tablets are the only drug and formulation prescribed in treatment of benzodiazepine dependence.
- Benefits of treatment with benzodiazepines should outweigh the risks
- The decision to prescribe must be taken with the patient who must accept the increased risk.
- Treatment must be individualised and reviewed regularly
- Reasons for prescribing and the discussion must be clearly documented in patient record systems – Vision and MORSE.

Benzodiazepine dependence and pregnancy

- Benzodiazepines cross the placenta and have potential to damage the foetus and should be avoided in pregnancy.
- If a patient using benzodiazepines becomes pregnant, graded self-reduction or a planned detoxification should be undertaken using lowest doses for as short a duration as possible.
- If detoxification cannot be completed the individual should be prescribed the smallest dose possible.
- With cases of established benzodiazepine dependence, the aim of detoxification or withdrawal needs to be balanced against the risks associated with withdrawal from treatment or continued illicit use.
- In early pregnancy risks of benzodiazepine use are linked to potential teratogenesis, particularly concern re cleft palate and associated abnormality.
- In later pregnancy risks predominately concern neonatal toxicity and withdrawal syndromes so continuing to reduce doses may be worthwhile.

MISSED DOSES OF OAT

Regular or serial missed doses may lead to a reduction in opioid tolerance.

Regular missed doses or non-attendance at the community pharmacy should be explored by the key worker. Issues relating to poor compliance should be identified and addressed, where possible, to reduce barriers to treatment, whilst managing the risk to both the patient and the wider public. Issues to explore may include childcare issues, frequency of collection, work patterns, sub-optimal dose, issues with pharmacy etc.

Community pharmacies are requested to inform the service when a patient has **missed 3 or more doses** and in this instance the patient should be reviewed by the key worker/suitably qualified healthcare practitioner and advice sought from a prescriber on how to proceed where necessary. Undue delay to a patient accessing treatment should be minimised as far as possible as being out of treatment may expose the patient to increased risk of harm.

If there are concerns regarding loss of tolerance or this cannot be established the below table should be as a guide on reduction of dose dependent on the number of days missed. This dose should then be titrated as per titration guidance.

Table 4: OAT dose to be prescribed after missed days

Days Missed (not counting today)	OAT dose
1 or 2 days	No reduction
3 days	Remain in Treatment – reduce dose by 25% and re-titrate
4 days	Remain in Treatment – reduce dose by 50% and re-titrate
5 or more days	Treat as induction (This will not need a medical review, to be discussed with prescriber if significant risks are present)

Patients are at highest risk of death and/or overdose in the period just after stopping treatment and immediately prior to starting treatment. All reasonable efforts should be made to retain patients in treatment and avoid unnecessary delays in re-starting treatment

Missed doses of LAIB

- To avoid missed doses, weekly formulations may be administered up to 2 days before or after the weekly time point and monthly formulations may be administered up to 7-days before or after the monthly time point.

- If a dose is missed, the next dose should be administered as soon as practically possible, seeking guidance where appropriate

ONGOING MONITORING OF PATIENTS PRESCRIBED OAT

Prescribers need to be satisfied that an adequate regular assessment is being provided for each patient and that treatment is safe, appropriate and takes into consideration the patient's needs, opinions and aspirations.

Strategic reviews of Recovery Care Plan

Where treatment includes OAT, a strategic review of the recovery care plan should be performed within three months of treatment entry (and no later than six months). This **should** be repeated annually at a minimum, although this frequency may be increased or reduced based on an individual's need.

A strategic review of the recovery care plan should include input from the keyworker, a CPS prescriber, the patient, and any other relevant parties, as appropriate. It provides an opportunity to review the current pharmacological, psychological, and social interventions. It is intended as an important opportunity for all parties to reflect on overall progress in treatment and recovery and to enable broader consideration of possible alternative goals or direction of treatment.

Monitoring of co-morbid health issues

People who use drugs are susceptible to an increased range of health issues. Addiction services do not replace the responsibility of primary care and other secondary care health services for providing such assessment and care for patients. They can however highlight and identify health problems and liaise with primary care and other services to complete required assessment and/or refer/signpost for further review or treatment as required.

Suitable, private, and confidential facilities, which respect the dignity of service users are essential in all services involved in prescribing or that offer physical examination.

The following general health assessments or examinations may be carried out, especially before prescribing and at minimum at each recovery plan review. They may be done by suitably trained and qualified addiction staff, but elements may be carried out by another suitable clinician, such as the patients' GP. They should include, where relevant:

- assessment of injection sites on all limbs and inguinal areas, particularly if injecting (or injected in the past).
- a general assessment of mental health and referral to GP / Psychiatry / Psychology where appropriate.
- a general assessment of respiratory, vascular, and other body systems.

- measurement of weight and blood pressure – whilst not routinely required prior to initiating substitute prescribing, baseline measurements can be useful in monitoring progress and may be needed in cases where there are concerns.
- assessment of current prescribed/over the counter and illicit drug use to reduce the risk of identifiable drug/drug or drug/condition interactions or safety issues.

Special examinations and testing that may be required

Access to the following specific investigations and physical examinations may be needed in some patients. Whether these are provided within Addiction services, by primary care or by others will depend on local arrangements, expertise and clinical competence of staff, and referral pathways available.

Based on the presence of history, risks, symptoms or findings of previous general physical examination, further physical examinations and testing that may be required include:

- detailed examination of cardiovascular and respiratory systems, including ECG, chest X-rays and pulmonary function tests such as peak flow, pulse oximetry and spirometry.
- detailed examination of gastrointestinal system including dentition and liver.
- pregnancy testing/sexual health.
- testing for the presence of HIV, hepatitis C, and hepatitis B infection.
- blood tests to assess liver function, thyroid function, renal function, and haematological indices.
- neurological examination (indications include loss of sensation, organic causes of confusion, forgetfulness, convulsions, blackouts).

Records and Communication

Details of all examinations, tests and referrals made should be recorded in the patient's clinical notes. If a patient chooses to decline any intervention, this should also be recorded, alongside any appropriate actions taken to ensure patient safety.

Patients' GPs must be kept informed of the outcomes, where appropriate, of RPRs, test results or treatment offered when there is a significant finding. Communication should also occur at any other time where it is felt appropriate to update the GP on a patient's progress or health.

Monitoring poly-drug and/or alcohol use

The use of more than one drug, including alcohol, is common. Concurrent use of alcohol, benzodiazepines and other sedating drugs substantially increases the risk of death from methadone overdose. Patients must be made aware of these risks and offered additional support if required. Access to OAT, however, should not be dependent on stopping illicit drug or alcohol use.

Monitoring continued drug use

- Patients continuing to use non-prescribed opioids or other substances e.g., “street valium,” gabapentin, “on top” of their prescribed OAT need to be risk assessed. In most cases it is in the patient’s best interest to persist with treatment, unless significant risks are identified.
- Adequate doses of OAT are generally higher than those that eliminate withdrawal signs.
- Random drug testing may be used; however, this should be combined with self-reporting, regular injecting site examination, observation for intoxication and assessment of wellbeing and progress.
- Persistent failure to benefit from treatment should trigger a RPR and the patient should be informed of the risks and consequences of continued chaotic drug use. It is important to continue OAT and ensure patient engagement, whilst waiting for review.

Monitoring problem alcohol use on top of OAT

- Patients continuing to use excessive alcohol “on top” of their prescribed OAT and/or additional substances need to be risk assessed. In most cases it is in the patient’s best interest to persist with treatment, unless significant risks are identified.
- Those with problematic alcohol **and** substance use may require more intensive intervention.
- Strategies to deal with situations of gross intoxication and significant impairment should be agreed on in advance and the patient informed that in these circumstances supervised or take-home doses of OAT will not be dispensed.

Multiple assisted withdrawals from alcohol and from other drugs.

- Polypharmacy and alcohol excess should be minimised, where possible. Where multiple substances are used, agreement should be sought in which order each substance should be reduced.
- The dose of OAT which the patient has already stabilised on should normally be maintained until detoxification from alcohol (and/or any sedative-hypnotic) has been completed.
- It is best practice to detoxify from one substance at a time.

HARM REDUCTION INTERVENTIONS

Harm Reduction Team

NHS Lanarkshire's Harm Reduction (HRT) team aims to reduce drug-related deaths and share injecting equipment. This should result in reducing levels of blood borne virus infection, an improvement in the personal health of drug users and improved public health across North and South Lanarkshire.

The Harm Reduction Team supports patients with a range of services either through the locality teams/Keyworkers or directly to individuals and their families. These services include:

- Blood Borne Virus testing
- Hepatitis A&B immunisation
- Injecting Equipment Provision
- Training including safer injecting techniques and consideration of alternative delivery routes
- Provision and supply of Take-Home Naloxone

Testing for Blood Borne Viruses (BBV)

- All patients attending Addiction Services should be offered BBV testing on entry to the service and at least annually, or more often if increased risk has been established. This should be normalised as part of routine practice during reviews.
- All addiction teams should have access to dry blood spot testing (DBST) kits and testing equipment.
- Patients consent should be sought prior to testing.
- Patients should be advised of results face-to-face unless exceptional circumstances.
- If a positive result is found for either Hepatitis C, Hepatitis B or HIV this should be discussed with the patient and after receiving consent, there should be prompt referral to infectious disease services.
- Discuss with patients if they wish to receive support from Positive Support and make referral, if applicable. They can help support the patient with appointments etc.
- Consideration should be given for the importance of harm reduction advice when giving negative tests results in the context of ongoing risk taking behaviour.

Hepatitis A&B Vaccination

- Patients should also be offered the opportunity to receive 3 x Hepatitis A&B vaccinations and the required booster. Administration information should be recorded in the patient's notes and copied to the patient's GP.
- NHS Lanarkshire have a Patient Group Direction (PGD) in place to support this. Please see current local guidance for further information.

Injecting Equipment Provision (IEP)

IEP can be provided through various channels including the Harm Reduction Team, selected community pharmacies, and local addiction teams.

It should be clearly understood that any supply of IEP should be seen as an evidence-based harm reduction intervention and continuation of OAT should not be contingent on abstinence from ongoing substance use.

Overdose awareness and take-home naloxone

All patients should be **regularly** offered overdose awareness training. This should be offered even if the supply of naloxone is declined. This should be recorded in the patient's notes and documented when a patient declines supply/training.

Take-Home Naloxone

Naloxone is an opioid antagonist and is licensed for use in:

- Complete or partial reversal of central nervous system depression and respiratory depression, caused by natural or synthetic opioids
- Treatment of suspected acute opioid overdose or intoxication

Systematic reviews conclude that provision of naloxone to patients can be effective in reversing opioid overdoses, and there is also evidence for the effectiveness of training family members or peers in how to administer the drug.

Naloxone is available through various sources including Harm Reduction Team, Local Addiction Teams, and 3rd sector organisations. From Winter 2023, all community pharmacies should have a supply of naloxone for use in emergency situations.

Anyone can administer naloxone for the purpose of saving a life.

SPECIAL GROUPS

Pregnancy

Pregnant women dependent on opioids are at high risk of experiencing complications because of inadequate antenatal care and lifestyle factors including, smoking, poor nutrition, high levels of stress and deprivation. Attending regular antenatal care is of high priority and liaison between OAT prescriber and maternity service is very important.

Prescribing in pregnancy:

- Substitute prescribing can occur at any time in pregnancy and carries a lower risk than illicit use.
- Achieving an appropriate maintenance dose that stops or reduces illicit use is best for ensuring continuity of management during pregnancy.
- Research demonstrates no difference in adverse effects between methadone and buprenorphine during pregnancy or in neonatal outcomes, however there is some research suggesting buprenorphine causes reduced severity of neonatal abstinence syndrome.
- Women already in OAT treatment who become pregnant should be safely maintained on their current dose.
- Detoxification should not normally be considered in the first trimester due to risk of spontaneous abortion or the third trimester due to risk of foetal distress and even stillbirth.
- During the second trimester, small frequent reductions can be considered, if there is no illicit use.
- Transfer to buprenorphine during pregnancy is not advised due to risk of precipitated withdrawal and risk of inducing withdrawal in the foetus.
- It may be necessary to divide the daily dose and/or to increase the dose of methadone in the third trimester of pregnancy due to increased metabolism.
- Withdrawal symptoms should be avoided as much as possible as they cause considerable distress to the foetus.

Patients should be referred into specialist maternity/perinatal services who can support pregnancies by improving engagement for antenatal care, providing support for their holistic needs, and preparing them to care for their new-born effectively and safely through multi-agency, collaborative working.

Breastfeeding

Breast milk contains only small amounts of methadone / buprenorphine and mothers can be encouraged to breastfeed regardless of OAT dose provided they are not using other drugs.

Breastfeeding may reduce the severity of the neonatal withdrawal syndrome.

Children and families

Addiction staff should be aware of the importance of early assessment of parents and sharing relevant information with appropriate services.

Addiction staff must identify where children are cared for by adults with substance use problems or are present in households frequented by adults with them.

Where such children have been identified, it becomes a professional and legal obligation to ensure they are not at risk of harm.

Child Protection concerns should be addressed through immediate information sharing, assessment, and intervention. This will normally require liaison with the local Social Work Children and Families Team, ensuring relevant policies are adhered to. If the young person is in immediate danger Police Scotland should be contacted.

Addiction staff should be equipped to provide information to parents about the impacts on children of their alcohol and/or drug use, including unborn babies.

All services should be alert to any recent changes or concerns in a family's circumstances and consider any detrimental impacts on their ability to look after children.

Smoking and respiratory function

Many patients in drug treatment services smoke tobacco. Some will smoke other drugs such as crack cocaine, heroin and cannabis that can cause significant damage to their lungs. High morbidity and mortality are seen in this patient group, mainly through the effects of tobacco smoking on development of cardiovascular and respiratory diseases.

The effects of lung disease on depression of lung function may also contribute to some deaths from opioid overdose.

Whilst smoking cessation might not seem a priority, engagement with support has been associated with improved drug treatment outcomes:

- There is no reason to delay a discussion around smoking cessation, as many have a desire to quit.
- Repeated brief advice for smoking cessation should be offered regularly.
- The best outcomes are seen from a combination of behavioural support and pharmacological intervention.
- People who use drugs can respond to these same treatments as the general population although they may need more intensive or extensive options to achieve the same results.

Given the high rates of smoking and the low quit rates in people who use drugs, it may be reasonable to consider harm reduction approaches to smoking, such as replacing some tobacco with other sources of nicotine.

Patients should be encouraged to access smoking cessation services available at their community pharmacy or by contacting Quit Your Way, who offer support in NHS Lanarkshire.

Cardiovascular disease and ECG monitoring

ECG at initiation

There is a limited role for routine ECG screening of all patients seeking to commence methadone treatment, due to the potential delays in initiating effective treatment. All patients should be risk assessed for potential QTc prolongation using factors below:

- Previous history of QTc prolongation (for any reason)
- Clinical manifestations of QTc prolongation or cardiac arrhythmias (syncope, palpitations, dizziness)
- Significant other risk factors for QTc prolongation (consider drug interactions)

Those at high risk should be informed of the potential of QTc prolongation with methadone, and the benefits of ECG assessment prior to commencing treatment. Delays to starting methadone treatment may place the patient at greater risk due to remaining out of treatment. Buprenorphine seems to be associated with less QTc prolongation and may be a safer alternative.

Ongoing ECG Monitoring

Patients on high doses of methadone or with other risk factors should, if possible, have regular (annual) ECGs, although consideration should be taken of the risks and benefits if a patient refuse to attend.

The Medicines and Healthcare Product Regulatory Agency (MHRA) recommended that patients with the following risk factors for QT interval prolongation are carefully monitored whilst taking methadone:

- History of syncope, palpitations, shortness of breath, seizures, and/or cardiac conditions
- Any patient requiring more than 100mg daily as the risk of QTc prolongation is dose related
- Electrolyte/metabolic abnormalities
- Concomitant treatment with CYP3A4 inhibitors or medicines with the potential to cause QT interval prolongation
- Patients who also take cocaine/stimulants
- Co-morbid eating disorder
- History of heart disease or stroke
- Liver disease including alcohol dependence and/or chronic hepatitis infection
- HIV-positive status (irrespective of medications)

Managing ECG results

The table below highlights the appropriate actions to be taken dependent on the results of ECG

Borderline prolonged QTc	Action	Prolonged ECG	Action	Very Prolonged EGC	Action
Females ≥470ms **Males ≥440ms**	• Repeat ECG • Check electrolytes • Modify risk factors e.g., cocaine use, psychotropic medication, methadone dose • Regular ECG until normal	≥500ms	• Repeat ECG • Check electrolytes • Modify risk factors e.g., cocaine use, psychotropic medication, • Reduce methadone dose • If persistent QTc despite reduction, consider switch to buprenorphine • Regular ECG until normal	≥550 ms	• Urgent cardiology and addiction specialist advice • Repeat ECG • Electrolytes • Try to modify QT risk factors • Reduce methadone and reevaluate within a week • Plan urgent switch to buprenorphine where appropriate

Adapted from The Maudsley® Prescribing Guidelines in Psychiatry 2022

Hepatic Impairment

Both methadone and buprenorphine can accumulate in patients with hepatic impairment and may need a dose adjustment. Clinicians should weigh up the risk of continued illicit drug use versus the risks associated with the prescribed drug and monitor accordingly. With its ceiling effect, buprenorphine may present less of a risk of over sedation and overdose.

Patients treated with buprenorphine who have an active viral hepatitis infection, misuse alcohol, or take other drugs that can impact on the liver or have existing liver impairment are at risk of accelerated liver injury. Regular monitoring of liver function is recommended in these patients. Buprenorphine manufacturers advise avoiding this medication in severe hepatic impairment.

Renal Impairment

Caution and dose reduction may be needed with both methadone and buprenorphine due to the risk of accumulation.

Palliative and End of Life Care

Patients who have a palliative diagnosis and current or past substance use disorder require appropriate support and interventions to ensure their complex needs are managed. It is

important to refer/ensure the referral of the patient to the specialist palliative care team at the earliest opportunity to allow the patient to access empathetic, joined-up, non-judgmental care.

The national palliative care guidelines can be accessed via: https://www.palliativecareguidelines.scot.nhs.uk/guidelines/pain/individuals-with-substance-use-disorder.aspx

SUPERVISED SELF-ADMINISTRATION & COLLECTION FROM PHARMACY

Supervised self-administration and/or frequent collection from the community pharmacy, where appropriate:

- Can enhance compliance
- Reduces potential for sharing or selling medication
- Ensures regular contact with a healthcare professional
- May provide stability and routine for those starting out in treatment

It should continue for a length of time appropriate to the patient's individual needs and risks. Supervision should not be a barrier to treatment and may not need to be imposed in all cases. It can cause difficulties for people in employment and those with childcare issues. It is often felt to be stigmatising and takes away personal responsibility and can be inconvenient and increase contact with individuals who may be selling drugs.

Supervision should not be seen as a punitive measure.

Factors that may be considered for suitability for increased take-home medications or relaxation of supervision include:

- Attendance at appointments or contact with worker
- Patient preference
- Ongoing risky substance and/or drug use
- Child/Adult welfare and public protection concerns
- Availability of safe keeping and storage of medication & stable accommodation
- Significant mental and/or physical health concerns (including co-prescribing)
- Risk of diversion of medication

Any changes to supervision or frequency of collection should be well documented within the patients' notes showing the rationale behind the decision.

Suggested pathway from supervised self-administration to weekly pick-up:

- Supervised self-administration 5 days each week then,
- Supervised self-administration 3 days each week then,
- Unsupervised self-administration, twice weekly then
- Unsupervised self-administration weekly

Supervised self-administration can be reinstated/increased at any time if risks are identified.

Reinstatement of supervision after a period of receiving take-home medication

The return to supervised dosing needs to be carefully considered and re-introduced. It is suggested that for patients who are on doses of 40mg or less of methadone or 8mg of less of buprenorphine, supervision can be reinstated with no need to phase the reintroduction, as these doses are at a level that would be considered appropriate starting doses.

For patients on daily doses of methadone greater than 40mg or buprenorphine greater than 8mg, it is suggested that the supervised doses are gradually re-introduced.

For methadone, the process should be gradual. A suggested reintroduction would be:

- 40mg to be supervised with remainder of the daily dose to take home, increasing supervised dose by 10mg at weekly intervals until all dose is supervised in the community pharmacy. This may take several weeks to achieve but it can be accelerated, if necessary, i.e., a twice weekly increase of supervised dose by 10mg.

For buprenorphine, the process is more rapid and can be achieved within 3 days. A suggested reintroduction would be:

- 8mg supervised with remainder take-home, increasing the supervised dose by up to 8mg at each subsequent collection (with take-home of remainder) until the full dose is supervised in the community pharmacy.

Community pharmacies will be encouraged to communicate with teams, either by direct contact or via the NEO communication tool if they notice any issues relating to intoxication from patients, as they have their supervised doses increased.

MISSED APPOINTMENTS

Missed appointments or a repeated inability to contact a patient by phone must be carefully considered and an appropriate response should be formulated and agreed with those involved in the patient's care. The response plan and all attempts at contact / information gained must be clearly documented in the patient's notes.

If a face-to-face appointment is missed:

- Attempts should be made to contact the patient by telephone
- The pharmacy should be contacted to check the last dose collection, recent compliance, and any concerns
- Clinical portal should be checked for admission or contact with emergency department.
- Known relatives/ friends could be contacted (if consent to share information documented)
- Criminal justice colleagues can advise if in custody

An assessment of risk should be undertaken and documented in notes. Factors to consider should include:

- Current drug and alcohol use
- Mental and physical health
- Dependent children or adults
- Vulnerability
- Social situation
- Previous appointment attendance

A clinical decision about the patient's prescription must be made. This will be a balance of risks between the benefit of retaining someone in treatment, with the risk of continuing treatment in somebody not seen by Addiction Services. MAT standards highlight the importance of keeping someone in treatment therefore in most cases the continuation of a prescription is the most appropriate option. Options to continue prescriptions include delivery of the prescription to their usual pharmacy or leaving a prescription at the local addiction team for the patient to collect. The clinical decision to discontinue/provide a prescription and where it is left should be documented within the patient's notes.

If there are significant concerns about a patient a discussion with the relevant team/service manager/senior member of staff should be undertaken and assertive outreach should be considered or other appropriate actions. Any actions and outcomes should be clearly documented.

If there is still no contact, consideration should be made to reporting to the police as a missing person.

LOST, MISPLACE OR STOLEN OAT OR PRESCRIPTION

If someone reports that they have lost, misplaced, or have had their OAT or prescription stolen then the following steps should be taken:

- Confirm with the pharmacy when the patient has last collected the OAT and how much was supplied.
- If there is a lost prescription, check that the patient has not handed it in already.
- Check with the pharmacy if any OAT or prescription has been handed in by the public.
- Advise the patient to contact the police to report the incident and request the incident number.
- Report lost OAT medication or prescription to the relevant prescriber.
- Lost supplies should not be replaced generally to reduce the risk of diversion or double dosing; however, this may be considered in exceptional circumstances, e.g., where there is no risk of double dosing.

As the patient's pharmacy is usually printed on the prescription, it is normally fine to reprint a lost prescription, as another pharmacy would not be expected to dispense the medicine if the patient was trying to get duplicate. If a new prescription is issued, the community pharmacy should be contacted to make them aware of this.

The patient's notes should be updated with all details of the incident, adding police incident code, where applicable. An incident report (InPhase) should also be completed, where applicable.

The keyworker should discuss the importance of safe storage and transport of OAT and prescriptions with the patient. A review of dispensing arrangements may be considered necessary depending on circumstances.

INCORRECT OAT DOSE ADMINISTERED

OAT has the potential to cause serious harm if more than the prescribed dose is consumed.

Where excess methadone is consumed

In the case of an accidental methadone overdose, issues that determine how to respond includes, the patient's level of tolerance and the amount of methadone given in error:

- In the first 2 weeks of treatment, patients who receive an overdose of any magnitude require observation for 4 hours. If signs of intoxication continue, more prolonged observation is required. This may involve sending the patient to the emergency department.
- Patients in whom the level of tolerance is uncertain, dose <40 mg/day, or in treatment for <2 months) require observation for at least 4 hours if they are given a dose more than 50% higher than their usual dose.
- Patients who have been on a dose greater than 40 mg/day consistently for two months will tolerate a dose double their usual dose without significant symptoms. For an overdose with greater than double the usual daily dose, the patient will require observation for at least 4 hours. If signs of intoxication are observed, more prolonged observation must be maintained.
- If patients are receiving regular takeaway doses, or if they do not attend daily, it cannot safely be assumed that they have been taking their daily dose and have a known level of tolerance. Therefore, such patients require observation in the event of an overdose of more than 50% of their usual dose.

Where excess oral buprenorphine is consumed

The risks associated with an incorrect dose of buprenorphine are not as severe as with full opioid agonist medicines. If an incorrect dose is administered:

- The pharmacy should immediately notify the patient and the key worker/prescriber.
- The patient should be warned of the likely consequences (increased sedation or drowsiness may occur for several hours afterwards), and warned against any additional drug use, and driving or operating machinery, for the rest of the day.

If a higher than intended dose has been taken and any of the following circumstances apply, the patient should be monitored for at least 6 hours:

- The patient is sedated following the dose (for any reason)
- The patient is new to opioid agonist treatment (within first 2 weeks)
- A buprenorphine dose of ≥64 mg was incorrectly administered (regardless of routine daily dose).

The patient should be reviewed by Addiction Services before the next dose of buprenorphine. It may be that a lower dose, or no dose, is required the following day (in effect, a two-day dose has been administered)

General Advice where incorrect OAT dose administered

If the pharmacy discovers the error after the patient has left the premises all reasonable steps should be taken to ensure patient safety. If there are significant concerns, then it may be appropriate to contact the police for assistance and support where it is believed there is a significant risk of patient harm.

Pharmacies have an obligation to report this error to the prescriber and controlled drug governance team.

In all cases, it is important to provide patient overdose awareness advice (include warnings on the consumption of other medication/drugs, particularly benzodiazepines and alcohol, that may depress respiration) and ensure patents are aware overdose symptoms can be prolonged AND delayed.

Patients should present at Hospital Emergency Departments if becoming very sedated or breathing slows.

If the patient is not rousable or starts snoring heavily, seek urgent medical assistance. Administration of naloxone, if available, may be appropriate in cases of severe overdose

Consider altering the dose for the next day depending on the dose administered.

A review of the level of supervised self-administration or frequency of collection may be justified depending on risks and if a patient has tried to obtain extra supplies of medication through deception.

GUIDANCE FOR THE ISSUE OF MEDICATION IN EXCESS OF NORMAL DISPENSING ARRANGEMENTS (HOLIDAY PRESCRIPTION)

NHS Lanarkshire Addiction Services have a role to play in supporting patients in going away from time to time and this should be seen as part of the therapeutic recovery process. In particular, spending time with other family members can often be beneficial in helping patients move away from a drug-based lifestyle. For this guideline's purposes, all extended period prescriptions, including those needed for patients working away from home, are termed holiday prescriptions.

Timescales and Evidence of Travel

Generally, to issue a holiday prescription, evidence of travel should be provided by the patient 1-2 weeks prior to issuing the holiday prescription and letter, if required. This can be travel tickets or booking confirmation. It is appreciated that this is not always possible for travel within the UK, however, is essential for all foreign travel. Evidence of travel can be useful as it will enable the keyworker to have an insight into who is going and accommodation type to assist with the risk assessment.

In exceptional circumstances, shorter notice may be accommodated, but the patient's keyworker/local team must coordinate with an appropriate prescriber to issue the prescriptions and, if required, holiday letter.

Rarely circumstances could mean that holiday prescriptions more than two weeks may be issued, but in no situations should a prescription more than four weeks ever be issued unless patient monitoring can be arranged through another appropriate agency at the holiday destination and the prescription is collected from the pharmacy in acceptable amounts.

Risk assessment for holiday prescription

A detailed and adequate risk assessment is required prior to a holiday prescription being issued. Risk factors may include:

- dispensing unsupervised take-home medication in quantities far greater than would normally be supplied. This is particularly relevant for people who are travelling overseas where utilising a local pharmacy will not be possible.
- an increase in risk taking behaviours may well occur during this time, particularly in relation to the use of alcohol and illicit substances.
- establishing that the patient can maintain safe storage of all medication throughout the travel period.
- who the patient is travelling with and if there are any Child/Adult protection concerns. You may wish to discuss this further with the case social work before the agreement is made to prescribe.

Guidance for issuing holiday prescription

After risk assessment is carried out, the options available depend on whether travel is within or outside the UK.

- Travel within UK
    - Low risk- Arrangements made for patient to collect medication prior to time away
    - High risk- Pharmacy located near destination and usual or relaxed dispensing arrangements put into place dependent on assessment
- Travel out with the UK
    - Low risk- -Patients should have prescription generated to cover duration of holiday and letter issued for customs purposes. See Appendix 3 and (https://www.gov.uk/guidance/controlled-drugs-licences-fees-and-returns)

  High risk- Discuss with prescriber & team if prescription can be facilitated based on clinical assessment and document outcome in patient's notes. If prescribing is agreed follow low risk guidance.

Variation of prescribed medication and form.

The use of methadone tablets for treatment of addiction is out with its product licence, but they may be considered for foreign travel for a patient after a suitable risk assessment and discussion with the patient. Any use of unlicensed medication must be documented clearly in the Vision/MORSE notes.

Rarely, changes to the medicine prescribed may need to be made. For instance, a change from methadone to buprenorphine is required so that the patient can take their medication into a country where methadone is not permitted or available. In these situations, the patient will need to be stabilised on the alternative prescription prior to the period of travel.

Home Office advice for foreign travel

Advice from the Home Office states that if a patient is travelling for less than 3 months and is carrying less than 3 months' supply of prescribed controlled drugs, they will not need a personal import or export licence to enter or leave the United Kingdom. The Home Office does advise that the patient obtain a letter from the prescribing doctor or drug worker, which should confirm your name, travel itinerary, names of prescribed controlled drugs, dosages, and total amounts of each drug to be carried. (https://www.gov.uk/guidance/controlled-drugs-licences-fees-and-returns)

It must be remembered that a Home Office licence or a letter of clarification only permits exportation and importation of controlled drugs from the UK. The patient should establish what the regional regulations are as it is **not** the responsibility of any member of the NHS Lanarkshire Addiction Services to check other nations' entry requirements.

DRUG TESTING

Orange guidelines recommend drug testing to be carried out randomly twice per year, however several factors may influence this such as clinic sites/facilities, clinical risk, self-reported use of illicit substances & other prescribed medication.

Drug testing may be used for:

- initial assessment and confirmation of drug use where appropriate
- confirming compliance with opioid replacement therapy
- monitoring illicit drug use and providing an opportunity to reflect to the patient objective evidence of progress, or lack of progress, during treatment.
- when patients present intoxicated a full drug screen may be requested if clinically appropriate.

Drug testing when a patient in treatment has already admitted to using, is not worthwhile except when the testing is being used to assess non-compliance with prescribed medication or to comply with the conditions of a Drug Treatment and Testing Order (DTTO). This should be documented in patient notes.

Types of testing

Urine testing (Point of care and Laboratory) – can show drug use over the past several days and is non-invasive. Urine specimens may be adulterated or substituted prior to collection that may produce misleading results. There is a rate of laboratory or testing error which must be borne in mind. Results of these tests should be used to assess response to treatment and should not be used for any other reason e.g., child protection issues, medico-legal issues.

Oral fluid testing – oral fluid is easier to collect but drugs are present in lower concentrations and only recent use (previous 24 to 48 hours) is captured. It is, however, more difficult to adulterate.

DRIVING AND DVLA

People who have used illegal drugs, misused prescription drugs and/or have an alcohol problem who have a driving licence should be told that they have a legal obligation to inform the DVLA as this may affect their ability to drive. They must be warned that failure to report this may lead to a fine and if they are involved in an accident as a result, they may face criminal prosecution. This discussion and/or warnings about driving should be recorded in the patient's notes and reiterated regularly.

https://www.gov.uk/drug-use-and-driving

Patients should also be made aware of the legalisation regarding drug driving and the use of roadside/blood testing for drug driving.

The General Medical Council has issued guidance for doctors reporting concerns to the DVLA and a link to the current guidance is documented below and should be followed by all Lanarkshire Addictions staff. Any decision to breach confidentiality should be made by the CPS Lead GP and/or Addiction Service Manager unless there is an immediate risk to patient or public safety.
https://www.gmc-uk.org/-/media/documents/gmc-guidance-for-doctors---confidentiality---patients-fitness-to-drive-and-reporting-concer-70063275.pdf

ADMISSION TO HOSPITAL/DISCHARGES

The three NHS Lanarkshire University hospitals have dedicated Substance Misuse Liaison Nurses (SMLN) in place, and they should be contacted on admission to support the smooth transition of care between primary and secondary care and to support with any substance use issues during an in-patient admission.

In the event of a patient admission, hospital staff should contact the community pharmacist and CPS prescriber/key worker to make them aware of the admission, establish current dose and preparation and ask them to put a hold on further dispensing instalment prescriptions until otherwise informed.

The information on ECS regarding OAT should not be relied on as a reliable up to date source of information as prescribing via Addiction Services is not automatically uploaded to Emergency Care Summary (ECS).

SMLN will advise addictions service staff when patients have been admitted via Scottish Ambulance Service after overdose (either opioids or benzodiazepines). The patients should also be offered a follow-up appointment to offer support and harm reduction advice.

Discharges should be planned to ensure that a patient has/will have a prescription in place for OAT to ensure a continuity of supply and reduce the risk of a patient missing doses. Relevant clinical information should be shared with the Keyworker to alter care plans or therapeutic regimens if needed.

Please check for any Acute Policies in each hospital site.

Buprenorphine in those who are admitted to hospital

Patients prescribed buprenorphine may need special consideration as the high affinity of buprenorphine for opioid receptors may impact on the management of acute pain during hospital admissions.
There are several strategies which can be used to manage pain which include, but are not limited to:

- Prescribing non-opioid analgesia and/or use of anaesthesia
- Using higher doses of full opioid agonists
- Splitting the dose of buprenorphine across the day.

Patients on Long-Acting Injectable Buprenorphine (LAIB)

Patients on LAIB should be discussed with members of the pain team who have completed additional training around how best to treat this group of patients. Additional advice can be obtained from an experienced CPS prescriber.

PRISONS/CUSTODY

Entering Prison

It is important that there is continuity of provision of OAT when a patient enters prison. Prison healthcare services will contact locality addiction teams to confirm OAT and current dosage. It is imperative that this information is passed on as quickly as possible to ensure that a patient does not face undue delay in accessing treatment.

Community pharmacies will also be contacted to ascertain the last day of collection of OAT. They should also be asked to withhold any further instalments until the patient is released, this is especially important for those whose prescription is not supervised.

Leaving Prison

It is well understood that the period immediately after prison release is high risk for opioid users and continuity of care is required to ensure positive outcomes, therefore it is recommended that:

- prison healthcare services should contact the local addiction team to provide liberation date and confirm the OAT prescribed whilst in prison.
- addiction teams should ensure a prescription for OAT is available for the patient on liberation and an appointment with key worker is arranged as soon as practically possible on release.
- harm reduction advice should be offered, and naloxone supplied, if this was not issued prior to liberation.
- if a patient fails to attend the local addiction team on liberation, every effort should be made to contact the patient to encourage them to attend.
- in the event of a Friday liberation, the addiction team may take the decision to leave a prescription with the community pharmacy if they fail to attend before closing time. This should be assessed on a case-by-case basis.
- dispensing arrangement should be reviewed on liberation, considering patient risk.

OUT OF HOURS PRESENTATION OF SUBSTANCE USE PATIENTS

Opioid Agonist Therapy (OAT) Patients

Patients who present to Out of Hours Services should not be prescribed additional OAT under any circumstances.

If a patient reports that they have missed the collection of their medication at a community pharmacy, and the community pharmacy is closed, there is no reliable method to confirm if a patient has collected their medication and, as a result, the risk of overdose and/or diversion is too great should further supply be provided. Consulting ECS or Vision will only confirm the medication is prescribed, not if it has been collected/consumed. It is solely the community pharmacy that can confirm when/if the medication has been collected or supplied.

Due to the long half-life of OAT, significant clinical signs of withdrawal from stable patients typically will take 24-48 hours to manifest. There is little evidence of serious physical harm coming from opioid withdrawal and the risks associated with supply of additional OAT are far greater.

If clinically necessary and appropriate, symptomatic relief may be prescribed/advised as described in the section – Detoxification – Symptomatic relief.

Alcohol and/or benzodiazepines patients

Patients who present in acute withdrawal for alcohol and/or benzodiazepines should be assessed carefully as there is a possibility of life-threatening seizures and/or withdrawal syndromes (e.g., Delirium Tremens) and this may necessitate close monitoring or hospital admission dependent on clinical presentation.

REFERENCES

1. Clinical Guidelines on Drug Misuse and Dependence Update 2017 Independent Expert Working Group (2017) Drug misuse and dependence: UK guidelines on clinical management. London: Department of Health https://www.gov.uk/government/publications/drug-misuse-and-dependence-uk-guidelines-on-clinical-management
2. "The delivery of psychological interventions in substance misuse services in Scotland" (Scottish Government, June 2018)
3. "Guidance for the use of substitute prescribing in the treatment of opioid dependence in primary care" (RCGP, SMMGP & The Alliance, 2011)
4. NHS Fife Guidance for the Assessment and Management of Opioid Dependence (2018)
5. Rights Respect Recovery: alcohol and drug treatment strategy. (Scottish Government, November 2018) https://www.gov.scot/publications/rights-respect-recovery/
6. NICE Pathway for opioid detoxification for drug misuse in people over 16. (NICE, March 2019) online https://pathways.nice.org.uk/pathways/drug-misuse-management-in-over-16s#content=view-help&path=view%3A/pathways/drug-misuse-management-in-over-16s/drug-misuse-management-in-over-16s-overview.xml
7. Taylor, D.M., Barnes, T.R.E. and Young, A.H. (2022). Addictions and Substance Misuse. In The Maudsley Prescribing Guidelines in Psychiatry (eds D.M. Taylor, T.R.E. Barnes, and A.H. Young)
8. Scottish Drug Death Task Force & Public Health Scotland (2021) Medication Assisted Treatment (MAT) Standards for Scotland Access, Choice, Support. Available from https://www.gov.scot/binaries/content/documents/govscot/publications/independent-report/2021/05/medication-assisted-treatment-mat-standards-scotland-access-choice-support/documents/medication-assisted-treatment-mat-standards-scotland-access-choice-support/medication-assisted-treatment-mat-standards-scotland-access-choice-support/govscot%3Adocument/medication-assisted-treatment-mat-standards-scotland-access-choice-support.pdf Scottish Government, Edinburgh
9. David M. Taylor, Thomas R. E. Barnes, Allan H. Young The Maudsley Prescribing Guidelines in Psychiatry (2021), 14th Edition. John Wiley & Sons Ltd
10. New South Wales prescribing guidelines.
11. National guidelines for medication-assisted treatment of opioid dependence | Australian Government Department of Health and Aged Care

Acknowledgement:

The authors would like to acknowledge the prior work of NHS Fife and their document "NHS Fife Guidance for the Assessment and Management of Opioid Dependence" written by Prof. A Baldacchino & Liz Hutchings which was used as a template for parts of the guideline published here.

Appendix 1: Example GP update letter

«MEDICAL_HISTORY»

Your Ref: «PATIENT_CHI_Number»

Contact: Community Prescribing Service

Tel No: 01698 753839

Date: «SYSTEM_Date»

Dear Practice,

«PATIENT_Forename1» «PATIENT_Surname» CHI: «PATIENT_CHI_Number»
«PATIENT_House» «PATIENT_Road» «PATIENT_Town» «PATIENT_Postcode»

We are writing to update you on your patient's treatment; they are in receipt of Opiate Agonist Therapy via NHS Lanarkshire Addiction Services. Please find attached a report of recently prescribed medication from our service for your information.

We would like to request that you add their current therapy to your records as an outside practice repeat medication. This will ensure our prescribing is listed on the patient's Emergency Care Summary (ECS) and will also enable the practice to monitor for potential drug interactions with other prescribed medication. *The current dose should not be annotated on the prescription as the practice will not be informed of dose changes, and this has the potential for error if a patient is admitted to hospital and the dose has not been updated.*

NHS Lanarkshire Addiction Services would also ask your practice to take the opportunity to review the prescribing of potential medication of misuse in your patient. Drugs such as benzodiazepines, opiates, and Gabapentinoids have been increasingly implicated in Drug-Related Deaths. Such medication, if clinically appropriate, should be prescribed at the lowest dose possible and reviewed regularly. If there is no longer a clinical need for the medication, then please consider tapering and then stopping this. Where any risk of misuse is identified, consideration should be made to supplying these prescriptions in instalments.

We will endeavour to keep you updated on the progress made by your patient, however please contact the patient's key worker within the local CAReS/ART team in the first instance if you have any questions regarding your patients care or to update them on any significant changes to their prescribed medication.

Yours sincerely,

Appendix 2: Clinical Opiate Withdrawal Scale (COWS)

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

Patient's Name: _____ Date and Time ____/_____/____:_____ Reason for this assessment: _____	
Resting Pulse Rate:_____beats/minute *Measured after patient is sitting or lying for one minute* 0 pulse rate 80 or below 1 pulse rate 81-100 2 pulse rate 101-120 4 pulse rate greater than 120	**GI Upset**: *over last ½ hour* 0 no GI symptoms 1 stomach cramps 2 nausea or loose stool 3 vomiting or diarrhoea 5 Multiple episodes of diarrhoea or vomiting
Sweating: *over past ½ hour not accounted for by room temperature or patient activity.* 0 no report of chills or flushing 1 subjective report of chills or flushing 2 flushed or observable moistness on face 3 beads of sweat on brow or face 4 sweat streaming off face	**Tremor** *observation of outstretched hands* 0 No tremor 1 tremor can be felt, but not observed 2 slight tremor observable 4 gross tremor or muscle twitching
Restlessness *Observation during assessmen*t 0 able to sit still 1 reports difficulty sitting still, but is able to do so 3 frequent shifting or extraneous movements of legs/arms 5 Unable to sit still for more than a few seconds	**Yawning** *Observation during assessment* 0 no yawning 1 yawning once or twice during assessment 2 yawning three or more times during assessment 4 yawning several times/minute
Pupil size 0 pupils pinned or normal size for room light 1 pupils possibly larger than normal for room light 2 pupils moderately dilated 5 pupils so dilated that only the rim of the iris is visible	**Anxiety or Irritability** 0 none 1 patient reports increasing irritability or anxiousness 2 patient obviously irritable anxious 4 patient so irritable or anxious that participation in the assessment is difficult
Bone or Joint Aches *If patient was having pain previously, only the additional component attributed to opiates withdrawal is scored* 0 not present 1 mild diffuse discomfort 2 patient reports severe diffuse aching of joints/ muscles 4 patient is rubbing joints or muscles and is unable to sit still because of discomfort	**Gooseflesh skin** 0 skin is smooth 3 piloerrection of skin can be felt or hairs standing up on arms 5 prominent piloerrection
Runny nose or tearing *Not accounted for by cold symptoms or allergies* 0 not present 1 nasal stuffiness or unusually moist eyes 2 nose running or tearing 4 nose constantly running or tears streaming down cheeks	Total Score _____ The total score is the sum of all 11 items Initials of person completing Assessment: _____

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

https://www.drugabuse.gov/sites/default/files/files/ClinicalOpiateWithdrawalScale.pdf

Appendix 3: Holiday Letter to be placed on appropriate headed letter and issued by keyworker

Our Ref :
Your Ref:
Contact:
Tel:
Email:
Date:

To Whom It May Concern

Re: Patient Name, Address and Date of Birth.

The above named patient is currently in treatment with SERVICE NAME

They are going on holiday to DESTINATION, COUNTRY from DEPARTURE DATE to RETURN DATE (inclusive).

They are currently prescribed DRUG, DAILY DOSE by our service and as such will have a total quantity of TOTAL QUANTITY OF MEDICATION.

Trusting this meets with your approval.

Yours sincerely

NAME
DESIGNATION
SERVICE

Please Note: This letter is provided to comply with foreign travel recommendations from the UK Home Office. This patient will have been advised that it is their responsibility to check with the appropriate embassy the entry requirements of any country that they are visiting to ensure that they comply with local laws and customs rules.

References/Evidence

Included as a section in the guidelines

Appendices

1. Governance information for Guidance document

Lead Author(s):	D Hill, L Foot, E Marr, C Smith
Endorsing Body:	ADTC
Version Number:	1.2
Approval date	**October 2025**
Review Date:	October 2027
Responsible Person (if different from lead author)	Duncan Hill, Specialist Pharmacist in Substance use Management

CONSULTATION AND DISTRIBUTION RECORD	
Contributing Author / Authors	D Hill, L Foot, E Marr, C Smith, M Hughes*, Dr E Stewart*, N Cassells* *Version1.0
Consultation Process / Stakeholders:	Community Prescribing Service NHS Lanarkshire Addiction Service. Addiction Recovery Teams (North Lanarkshire) and Community Addiction Recovery Service (South Lanarkshire) Addiction Psychiatry
Distribution	Community Prescribing Service NHS Lanarkshire Addiction Service. Addiction Recovery Teams (North Lanarkshire) and Community Addiction Recovery Service (South Lanarkshire) Addiction Psychiatry Other Primary Care services and other NHS Board addiction services

CHANGE RECORD			
Date	**Lead Author**	**Change**	**Version No.**
October 2023	D Hill	Rewritten guideline to update and meet Scottish Government MAT standards	1.0
October 2024	D Hill	Review and update. Inclusion of other guidelines	1.1
October 2025	D Hill	Review and update.	1.2
		.	

2.You can include additional appendices with complimentary information that doesn't fit into the main text of your guideline, but is crucial and supports its understanding.

Everything is encompassed in the guideline.