NHS Grampian

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Date: 3rd April 2025
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Dear Colleagues

This guidance is currently under review by the author.

Grampian Guidance for Prescribing Medication Assisted Treatment (MAT) in Community Settings for Patients Experiencing Problematic Substance Use, Version 1

This document has been risk assessed by the author and deemed appropriate to be used during this review period. A copy of the risk assessment can be provided on request.

If you have any queries regarding this, please do not hesitate to contact the Medicines Guidelines and Policy Group (MGPG) email at gram.mgpg@nhs.scot

Yours sincerely

Lesley Coyle
Chair of Medicines Guidelines and Policy Group (MGPG), NHSG

NHS Grampian

Grampian Guidance for Prescribing Medication Assisted Treatment (MAT) in Community Settings for Patients Experiencing Problematic Substance Use

Co-ordinators:	Consultation Group:	Approver:
Substance Use and Medicines Management Pharmacists	See page 29	Medicine Guidelines and Policies Group

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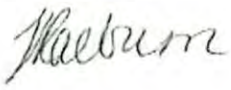
		

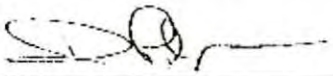
Identifier:	Review Date:	Date Approved:
NHSG/Guid/MAT_CS/ MGPG1359	March 2025	March 2023

Uncontrolled when printed

Version 1

Executive Sign-Off

This document has been endorsed by the Director of Pharmacy and Medicines Management

Signature: 

Title:	Grampian Guidance for Prescribing Medication Assisted Treatment (MAT) in Community Settings for Patients Experiencing Problematic Substance Use
Unique Identifier:	NHSG/Guid/MAT_CS/MGPG1359
Replaces:	N/A new document
Lead Author/Co-ordinator:	Substance Use and Medicines Management Pharmacists
Subject (as per document registration categories):	Clinical Guidance
Key word(s):	MAT; medication; assisted; treatment; methadone; same; day; prescribing; OST; ORT; opioid; substitution; substitute; replacement; treatment; substance; use
Process Document: Policy, Protocol, Procedure or Guideline	Guidance
Document application:	NHS Grampian
Purpose/description:	Consistency of prescribing practice for people who use substances in community settings across Grampian
Group/Individual responsible for this document:	Grampian MAT Standards Clinical Guidance SLWG chaired by a senior pharmacist in substance use and medicines management
Policy statement:	It is the responsibility of all staff to ensure that they are working to the most up to date and relevant policies, protocols procedures.

Responsibilities for ensuring registration of this document on the NHS Grampian Information/ Document Silo:

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Job/group title of those who have control over this document:	Clinical Lead, Grampian Alcohol and Drug Services and Substance Use and Medicines Management Pharmacists

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Organisational:	Operational Management Team and Chief Executive
Sector	General Managers, Medical Leads and Nursing Leads
Departmental:	Clinical Leads
Area:	Line Manager

Review frequency and date of next review:	This policy will be reviewed in three years or sooner if current treatment recommendations change

Responsibilities for review of this document:

Lead Author/Co-ordinator:	Substance Use and Medicines Management Pharmacists

Revision History:

Revision Date	Previous Revision Date	Summary of Changes (Descriptive summary of the changes made)	Changes Marked* (Identify page numbers and section heading)
N/A			

* Changes marked should detail the section(s) of the document that have been amended, i.e. page number and section heading.

Grampian Guidance for Prescribing Medication Assisted Treatment (MAT) in Community Settings for Patients Experiencing Problematic Substance Use

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1. Introduction

This document is a guide to the delivery of medication assisted treatment (MAT) for people in Grampian who experience problematic drug use. It takes into account local and national guidance including Drug misuse and dependence: UK guidelines on clinical management[1] and the Medication Assisted Treatment (MAT) Standards for Scotland[2]. The MAT standards are evidence based standards designed to facilitate the consistent delivery of safe, accessible, high-quality drug treatment across Scotland.

Treatment options outlined in this document should be initiated and prescribed by clinicians with sufficient knowledge in their use or in collaboration with a specialist clinician in substance use. Particular care is required in planning transitions of care between different services or settings whether this be geographic, community drug and alcohol services, custodial, acute or primary care. Release or discharge from custodial or hospital settings are identified as times of higher risk for drug related death. A collaborative approach to care is recommended.

We are grateful to NHS Borders and NHS Fife for allowing us to adapt their existing documents.

> "Optimising the use of Medication Assisted Treatment (MAT) will ensure that people have immediate access to the treatment they need with a range of options and the right to make informed choices. If an individual chooses this option within a robust Recovery Oriented System of Care (ROSC) they should expect to receive good quality, person centred care, immediately (if required) with supports into other services and opportunities for challenge and growth."
>
> *[Scottish Government - Medication Assisted Treatment (MAT) Standards: Access, Choice, Support (2021)]*

2. Overview of Assessment and Management of People with Problematic Drug Use in Grampian

All phases of prescribing should be underpinned by psychological and trauma informed principles of care where assessment and prescribing should be based on a holistic assessment, taking into account a person's biological, psychological and social needs. Establishing a trusting and collaborative therapeutic relationship that creates a safe space where a person can openly discuss their substance use is the foundation upon which all care is delivered and is critical to enhance engagement and retention in treatment.

Prescribing interventions should not occur in isolation; there are a range of evidence based psychosocial/logical interventions and resources to support a person in achieving their substance use goals. A full description of the matched care model is out with the remit of this guidance but a full description, including links to resources are outlined in the 2018 Scottish Government LPASS report[3].

Holistic assessment will inform a comprehensive, person centered care plan based on shared decision making that incorporates goals specific to the person. If a person wishes, a family member or other named person should also be included in discussions so they can understand rationale for care and treatment decisions in order to support the person in their recovery.

Opioid dependence is one of the few areas of drug use with a clear evidence base for prescribing substitution treatment as part of the wider care plan and is therefore the main focus of the document. The document also contains a link to NHS Grampian's guidance on prescribing for benzodiazepine dependence.

Table 1 provides a summary of opioid substitution treatment (OST) assessment and treatment phases. It is important to remember a person's recovery is often not linear and care needs to be matched to where the person is at any time informed by regular review.

Table 1: Summary of Assessment and Treatment Phases

PHASE	GOALS	PRESCRIBING	ROLES OF CLINICAL TEAM	ROLES OF INTEGRATED TEAM
Phase 1 **Initial Assessment and Induction** This phase will last up to 16 weeks for most people	• Establish extent of and function of problematic drug use • Identify shared initial goals • Agree initial care plan • Initiate and optimise opioid substitution treatment (OST) where indicated. • Reduce or stop use of other opioids, poly drug and alcohol use • Reduce associated harms • Confirm current blood borne virus (BBV) and immunisation status • Complete initial assessment	• Confirm diagnosis of dependence • Agree initial prescribing plan • Discuss and agree type of OST where indicated • Provide information in a format suitable to the patient • If indicated, determine if same day prescribing of OST is clinically appropriate and safe • Initiate and titrate OST • Adjust dose until patient not in withdrawal and cravings / on top opioid use minimised or stopped.	• Assess current and past drug use and treatments tried • Liaise with patient's GP practice, and other services • Contact patient's preferred pharmacy to agree initiation • Regularly review efficacy of OST including dose, ongoing substance use and adverse effects • Review physical health including wound care	• Child protection assessment • Overdose awareness and naloxone supply • Initial assessment of injecting risk, equipment supply and harm reduction support • Continue tailored harm reduction support, including injecting equipment throughout Phase 1 • Complete Blood Borne Virus (BBV) test • Support access to vaccination • Refer to appropriate services for comorbid conditions • Assess need for social support

PHASE	GOALS	PRESCRIBING	ROLES OF CLINICAL TEAM	ROLES OF INTEGRATED TEAM
Phase 2 **Maintenance** Duration according to patient's progress	• Work to maintain abstinence from "on top" opioid use and (or) other goals agreed in Phase 1 by optimal dosing of medication • Address other drug and alcohol use	• Maintain and adjust OST dose according to patient needs, assessing for signs of toxicity / symptoms of withdrawal etc. • Regular review of OST choice for efficacy and suitability • Monitor for interactions and adverse effects	• Review efficacy of OST dose • Assist patient to put in place lifestyle and behavior changes to support goals of treatment	• Tailored harm reduction support • Psychosocial support • Regular review of vaccine and BBV status • Link with other agencies as indicated
Phase 3 **Stopping OST** In agreement with patient	• Reduce and stop OST when this becomes the goal agreed by clinician and patient	• Agree plan for reducing OST • Monitor progress • Assess for signs of opioid withdrawal or lapse and adjust treatment as appropriate	• Regular review of progress • Adjust and tailor plan according to progress • Liaise with key partners including community pharmacy	• Relapse prevention techniques • Psychosocial support • Ensure overdose awareness and naloxone up to date
Phase 4: **Aftercare:** 4 - 12 weeks for most	• To maintain abstinence after stopping OST	Implement relapse prevention if appropriate – medication or practical	• Individual support focused on relapse prevention	Encourage access to aftercare services

Urine or Oral Fluid Testing for Drugs. Key times and reasons for testing:

• initial assessment and confirmation of drug use. NB: testing alone does not confirm dependence and should be used alongside other methods of assessment.

• confirming prescribed medication is being taken

• monitoring drug use / progress towards patient's treatment goals.

Drug Misuse and Dependence[1] states that value in the longer term depends on the current status of the patient but they should be carried out at least twice a year and support objective assessment of stability and progress.

3. Overview of Considerations for Same Day Prescribing of Opioid Substitution Therapy

Initial assessment and decision on OST same day prescribing	• Undertake initial assessment including: drug history, medical history, examination, and drug screen • For people using opioids, the key goal of the first assessment is to establish if it is safe and appropriate to start OST on that day (if indicated). Advance telephone or video contact may support the initial assessment • Assessment is an ongoing process that can be completed over time. There is not an expectation that the full psychosocial assessment will be completed at first attendance, or before OST is started.
1. The last 30 days (initial history taking)	• Which substances are being used? o What is the duration, amount and frequency of each substance used, including alcohol? o Routes of drug administration used (check health of injecting sites if this route is used) o Urine or oral fluid drug screening. Near patient testing is recommended to support diagnosis of dependence required for same day prescribing of OST • Check medicines prescribed by other services (GP, Trakcare) and OTC medications.
2. Establishing Diagnosis of Dependence	• Follow International Classification of Diseases 11th Revision (ICD-11) criteria for diagnostic requirements to confirm dependence. A prescription for opioid substitute medication should normally only be considered if: o opioid use is regular – usually every day o there is convincing evidence of current opioid dependence o the assessment – including history, examination and toxicology – clearly supports the diagnosis and treatment need. Objective signs can be particularly useful e.g. evidence of injecting sites (regularly check health of these), opioid withdrawal etc. Consider use of the Clinical Opiate Withdrawal Scale (COWS) o the clinician is satisfied that the patient is likely to manage the proposed prescribing regimen o it can be confirmed that the patient is not receiving an OST prescription from another source • Consider risks and benefits of initiating prescribing at the end of the week, particularly where support from pharmacies and drug services may not be easy to access.
3. Additional Information	• Gather further information to support diagnosis of dependence and same day prescribing decision. Check: o for physical and mental health problems that may impact immediate prescribing decision o that it is safe to prescribe with other medications taken o check available sources e.g. GP, Trakcare, patient o speak to pharmacist/request medication review if there is any doubt medication can be stored safely and children cannot access. NB: OST is usually supervised for initiation / titration o pregnancy status if appropriate o driving status / DVLA / Does the person work at heights or have a need for concentration.

4. Decision on OST same day prescribing	• Can a diagnosis of opioid dependence be made today? • Would the benefits of starting OST immediately likely outweigh the risks? • Clinicians should not be pressured to start OST on the same day if there is insufficient information to safely initiate prescribing. The rationale to prescribe or not should be clearly documented either way.
5. Choice of opioid substitute (OST)	• Methadone and buprenorphine are both available in Grampian (in various formats). Table 2 compares them • Clinical staff involved in managing patients should ensure that they are competent and familiar with prescribing guidance and can effectively discuss options with patients to allow choice in treatment • If a medication is not offered, the rationale should be clearly explained to the patient and documented • Consider patient preference, treatment history, other medical conditions & medication (Trakcare), risk of overdose etc • Discuss risk of precipitated withdrawal (and ways to avoid this) with patients starting buprenorphine • Consider practicalities of administering Buvidal injection if this is the agreed treatment option - if patients are new to buprenorphine, oral administration is recommended first to ensure suitability.
6. Starting OST	• Follow titration guidance for each product • Contact patient's preferred community pharmacy, check stock is available, provide overview of prescribing plan • If different from the prescriber, ensure the key worker is aware of the plan for ongoing titration and review • If starting OST on the same day is assessed as being inappropriate or unsafe, further assessment around need for OST and/or diagnosis of dependence should occur. Consider: o other support, harm reduction and treatment options that could benefit the patient o additional history, information or drug tests which might help treatment planning o further assessment when the patient is in the early stages of withdrawal if acceptable to them.
Continue full assessment	• Continue with full assessment of physical health, mental health and social needs • Same day prescribing does not do away with the need for a comprehensive physical, psychological and social assessment to be undertaken. This is essential and should be continued following the initiation of OST when patients are more comfortable and in a better position to engage in meaningful discussion.

PROVIDE OVERDOSE AWARENESS, NALOXONE, INJECTING EQUPIMENT AND BBV TESTING AT INITIAL ASSESSMENT OR AS SOON AS POSSIBLE THEREAFTER

4. Comparison of Methadone and Buprenorphine as OST (Table 2)

	METHADONE	BUPRENORPHINE / BUPRENORPHINE PLUS NALOXONE
Can it precipitate withdrawal when you start it?	No risk of causing (precipitating) sudden symptoms of withdrawal when you start it although some people will experience symptoms of withdrawal (or continue to use other substances) until titrated to the correct dose	Risk of precipitating withdrawal if full opioid agonists such as heroin, morphine or methadone are still in the body. Leave enough time after taking these to avoid it. Provide advice on how to manage it if it does occur
Overdose risk	Full opioid agonist. Greater risk of overdose (intentional or accidental) if higher than normal dose is taken or if used with other opioids or in poly drug use (including alcohol). Caution needed with starting dose, speed of titration and rate of dose increase.	Partial agonist. Lower but not zero risk of overdose (intentional or accidental) with other opioids or in poly drug use. May be an option if risk of overdose is particularly high (e.g. previous overdoses, significant polysubstance use, high risk injecting activity)
Rate of titration	May take a few weeks to reach the appropriate dose	Can be quickly titrated to the appropriate dose
Comorbid alcohol or poly drug use	More sedative, potentially higher risk	Less sedative, potentially lower risk
QTc prolongation	More likely to prolong QTc. Consider risks and need for ECG e.g. co-morbidities, impact of other medicines and substances, family history etc (section 5.1.1.)	Less likely to prolong QTc
Liver Function	Low risk of liver injury	Rare incidence of liver injury. Risk increases with hepatitis B or C diagnosis and in those who inject buprenorphine tablets. Consider monitoring liver function in these patients
Respiratory conditions	May cause more respiratory depression than buprenorphine	May cause less respiratory depression than methadone

	METHADONE	BUPRENORPHINE / BUPRENORPHINE PLUS NALOXONE
Interaction with other medication	More affected by interactions. Plasma levels may be altered by inducers/ inhibitors of CYP3A4 e.g. some anti-epileptics, some SSRIs, erythromycin/ clarithromycin. Check BNF for full list	Less affected by interactions. Risk of precipitating withdrawal (see above). May reduce efficacy of other prescribed opioids. Check BNF for full list
Retention in treatment	Some evidence suggests better retention in treatment than with low dose buprenorphine (<8 mg)	Retention in treatment may be worse than with methadone at daily doses <8 mg. No difference for doses >8 mg daily
Clear headed feeling / level of sedation from treatment	Not associated with clear headedness. Patients with mental health symptoms (e.g. anxiety or trauma symptoms) may benefit from the greater sedative effects	Gives clear headed feeling and less sedation. Patients with co-morbid mental health diagnoses can report feeling more connected to and aware of thoughts and emotions which may influence the risk of lapse/relapse
Opioid detoxification and stopping OST	Less suitable for rapid detoxification if indicated. Some people report it being less well tolerated in the final stages of OST dose reduction	May be useful in more rapid opioid detoxification if indicated. May be better tolerated in the final stages of OST dose reduction
Stopping OST	Symptoms of withdrawal may be more marked and prolonged compared to buprenorphine	Symptoms of withdrawal may be less marked and prolonged compared to methadone
Long acting preparations dosing	No long acting preparation available. Daily oral dosing required	Long acting options available. Less than daily oral doses possible
Pregnancy: Check BUMPS – Best Use of Medicine in Pregnancy	If pregnant and already on methadone this should be maintained. If not already on OST methadone should be considered first line	If pregnant and already on buprenorphine this can be maintained. Weigh up risks of initiation during pregnancy. (Risk of precipitating withdrawal in mother and baby)

4.1 Resources to Support Discussion on Choice of OST with Patients

Discussions regarding choice of OST should follow the principles of Realistic Medicine where shared decision making and informed consent are central to prescribing decisions to inform person centred care. Where the person wishes, a family member or named person can be involved in discussions. It is important to understand a person's existing knowledge and understanding of the different OST options prior to offering information. There are a range of leaflets available, tailored to different languages and levels of literacy. They can be found in the Choice and Medication website which is part of NHS Inform. NB: Leaflets for all mental health diagnoses can be searched for in the Handy Charts, Handy Fact Sheets and Patient Information Leaflet sections.

- Home page: www.choiceandmedication.org/nhs24/
- Chart to compare all prescribing options for opioid dependence: www.choiceandmedication.org/nhs24/generate/handychartopiatedependenceuk.pdf
- Comparing methadone versus buprenorphine: www.choiceandmedication.org/nhs24/generate/handyfactsheetmethadonevsbuprenorphineuk.pdf
- Buprenorphine leaflets (injectable, orally administered, different languages): www.choiceandmedication.org/nhs24/printable-leaflets/patient-information-leaflets/20/ALL/
- Methadone leaflets (oral, different languages): www.choiceandmedication.org/nhs24/printable-leaflets/patient-information-leaflets/90/ALL/

5. Induction onto Opioid Substitution Treatment in Community Settings

The primary aim to initiate OST in Community settings is to establish the person, as safely and quickly as possible, on a dose of OST that:

- Eliminates withdrawal symptoms
- Reduces/alleviates cravings for and the need to take other opioids (not prescribed to the person)
- Keeps adverse effects to a minimum
- Avoids toxicity.

At least one positive result for opioids (urine or oral fluid test) should be obtained during assessment. Near patient drug screens can support the assessment and diagnosis of dependence and enable same day prescribing where indicated and clinically appropriate.

The optimal dose of OST is not necessarily the lowest dose that relieves symptoms of withdrawal. It is a dose where the patient feels comfortable but not over-sedated, where cravings are managed and the focus on finding and using substances is reduced. Insufficient dosing may increase the risk of additional substance use, reduce treatment effectiveness and increase risk of accidental overdose. Establishing the person's understanding of increased risks of overdose when initiating methadone and buprenorphine should form part of the holistic assessment. Where the assessment has identified polysubstance use, particularly central nervous

system depressants, such as benzodiazepines, antidepressants, other opioids and alcohol; discuss and offer advice to reduce risks. Where avoiding all other substance use is unrealistic, offer harm reduction advice such as splitting and reducing doses to assess combination effects (Crew, 2020).

Overdose awareness and responding to overdose should be discussed with everyone prescribed OST. They should be regularly offered a supply of naloxone (Prenoxad® or Nyxoid®), shown how to use it and encouraged to carry it so it can be used if needed.

5.1 Physical Health Checks

People who use drugs are at increased risk of other physical or mental health conditions[4]. This should not delay treatment initiation where presentation, assessment and history taking support this. Patients should be encouraged and supported to access assessment and care for their physical health as indicated. Where provided by the service, tests should be undertaken at the earliest opportunity and as needed to support prescribing decisions.

5.1.1 Methadone and Electrocardiograms (ECGs)[15]

Methadone has potential to prolong the QTc interval which in rare cases can lead to the potentially fatal Torsades de Pointes. Acknowledging there may be slight gender related variations in QTc, in terms of risk, intervals of 500ms and above can be considered high-risk. Risk is considered to increase with dose increases. Debate remains over the value and efficacy of ECG screening however factors which may indicate a need should be considered for an ECG before commencing methadone. These include:

- Patients who are prescribed medication or take other substances which can prolong the QTc interval e.g. cocaine, many antipsychotics and antidepressants. The American website www.crediblemeds.org/ (registration required) has regularly updated lists of medicines which cause prolongation of the QT interval. Information can also be found in the British National Formulary (BNF, available via www.evidence.nhs.uk/), Summaries of Product Characteristics (SPCs, www.medicines.org.uk) and Stockley's Drug Interactions (Medicines Complete)
- Concerns about cardiac status (significant family history, cardiomyopathy, recent myocardial infarction, sinus bradycardia, symptoms of cardiac complaints, dizzy spells or blackouts)
- Titrating to daily doses above 100mg methadone
- Other known risk factors including; electrolyte disturbances, diabetes mellitus, thyroid or pituitary insufficiency, female gender, older age (>65 years in the general population), subarachnoid haemorrhage, starvation, obesity, alcoholism, cirrhosis

This should not stop methadone being offered within same day prescribing. Risks should be discussed with the patient, recorded in notes and ECG arranged at the earliest opportunity. Clinicians should consider impact of other medications which affect QTc and liaise with the prescriber overseeing these to ensure optimal care is delivered.

Management of Risk

- For QTc intervals between 450ms and 500ms, the risks of initiating or prescribing methadone should be discussed with the patient and where agreed the most appropriate choice, accompanied by frequent monitoring
- For QTc intervals of or above 500ms, strong consideration should be given to adopting a risk minimisation strategy, such as reducing the methadone dose, eliminating other contributing factors, transitioning the patient to an alternative treatment such as buprenorphine, or discontinuing methadone treatment
- The following British Medical Journal review provides a broader overview of the principles of QT prolongation and management.

5.1.2 Buprenorphine and Liver Function Tests (LFTs)

- There are rare case reports of liver injury in patients prescribed buprenorphine. This led drug companies to recommend routine LFTs. Available evidence suggests the majority of reports occurred in patients with a diagnosis of hepatitis B or C or following injection of buprenorphine SL tablets. It suggests the risk is no greater for buprenorphine than for methadone[9-12].
- Liver function tests (LFTs) are therefore not routinely recommended prior to initiating OST. Laboratory results, Trakcare and GP records (if accessible) should be checked.
- Clinicians should highlight the rare risk to hepatic function with buprenorphine to patients to support an informed, shared decision on prescribing and necessity of LFTs.
- Regular review of BBV status and BBV testing is recommended for all patients and will help identify those who may be at higher risk. LFTs should therefore be considered for patients with a diagnosis of hepatitis or evidence of hepatic dysfunction.

All patients should be offered BBV testing and discuss vaccination status in the early stages of treatment. Details on how to access vaccination in each HSCP area can be found here. www.grampianvax.com/professional-referrals/

5.2 During Titration

- Regular contacts, face to face, video call or by phone, should be planned during titration, at least twice weekly.
- This should inform the decision on whether dose increase is required.
- Titration should pause if missed contacts or doses occur. The current dose should be maintained until review with the clinician occurs. If pharmacy attendance is erratic, it may be necessary to reduce or withhold further doses for safety until review can occur.

5.3 Role of the Community Pharmacy

- Pharmacy teams are in frequent face to face contact with patients. They are a crucial source of support for patients and information to support prescribing decisions.
- Supervised self-administration should be available to all patients who require this.
- The pharmacy team should be asked to report all missed doses to the prescriber during the titration phase. Let the pharmacy know when this need changes.
- Pharmacy staff should observe patients for symptoms of withdrawal, over-sedation and general presentation. Concerns should be fed back to the person and with the prescribing service. The pharmacy should also discuss the rationale for feeding back to the service with the patient.
- It is important for clinicians to routinely obtain the feedback of the pharmacist when reviewing the patient's progress during titration.

5.4 Initiating OST at the End of the Week

Prescribing services are not routinely available at weekends and many pharmacies close on Sundays. This provides less opportunity for support. Initiation at the end of the week requires careful consideration, assessment and collaborative planning with the patient. The decision to initiate should be discussed and agreed with colleagues within the drug and alcohol service e.g. during multi-disciplinary team meetings or with experienced clinical staff following analysis of risks versus benefits of prescribing or not. Rationale should be clearly documented either way.

Potential risks include but are not limited to:

- Lack of support available from services if initiation does not go to plan
- Risk of overdose if "take away" doses are taken earlier than prescribed
- Lack of support for pharmacies in decision making if patients miss doses or attend intoxicated
- Risks associated with engagement and ongoing drug use if OST is not prescribed.

Considerations to support decision making include but are not limited to:

- Patient's previous history with OST and the prescribing service
- Availability of service staff over the weekend to support patients (or longer if there are public holidays)
- Time of presentation at the prescribing service – it may be easier to assess the effects of dose 1 if the patient can be seen earlier in the day
- Ability to confirm dependence – uncertainty should delay initiation of OST until this can be confirmed
- Following discussion of pros and cons, patient's preference and likelihood of continued engagement if prescribing starts the following week
- Patient's understanding of the risks associated with double dosing and clinician's assessment of likely risk

- Consideration of buprenorphine if clinically appropriate (may be safer in overdose). Consider the potential impact of poor experience/disengagement with treatment if precipitated withdrawal occurs or the patient does not tolerate the medication
- Risks versus benefits of prescribing a lower dose of methadone e.g. 10-20mg daily
- Clinician's availability to assess progress at the earliest possible time, post weekend
- Patient's home circumstances, will they have support. Is there consent to involve them
- Patient's willingness to take a supply of naloxone
- Availability of a 7 day pharmacy*. This offers support and reduces risk associated with take home doses. Clearly discuss with the pharmacy what to do if patient presents intoxicated, misses a dose or where there are any other concerns.

*NB: 7 day pharmacies are not available in all parts of Grampian and are not a mandatory requirement to initiating or restarting medication. Review and risk assessment with the patient should give an indication of the level of support required and help in agreeing a plan which is proportionate to the assessed level of risk.

Prescribers should not be pressured to prescribe where there is any uncertainty around initiation of OST. Multi-disciplinary discussion should be used to support the decision making process which should be clearly documented either way.

5.5 Initiation and Titration with Methadone (See also Appendix 1)

- Methadone should be prescribed as 1mg/ml oral solution. This reduces risk of error during dispensing and administration.
- It is available as sugar containing and sugar free solutions. Some brands of sugar-free methadone can produce unacceptable side effects due to adverse effects associated with artificial sweeteners with high sorbitol content. These include nausea, stomach cramps and diarrhoea.
- An association between sugar containing methadone and dental problems has not been demonstrated however all opioid medicines can cause dry mouth which can cause dental issues. Poor dental hygiene may also be an issue. Patients should be given information on oral hygiene, including ways to minimise negative effects of their medication on oral health.
- Methadone has a variable half-life of 13 – 55 hours. Inappropriate dosing can result in overdose due to cumulative toxicity.
- As a rule of thumb, advice is to **start low and go slow:** After the first few doses it takes 4–5 days for plasma levels to stabilise and up to 10 days to reach steady state. Repeated dosing leads to accumulation, and therefore methadone initiation should be done cautiously and gradually. This should be balanced against reports of ongoing symptoms of withdrawal. Titrating too slowly may cause unnecessary discomfort and reliance on other substances increasing risk of overdose.

5.5.1 Starting Dose

- Most patients will require an initial dose of up to 30mg daily. This should be based on assessment of the person's opioid tolerance, frequency of use, route of administration, use of other drugs and withdrawal symptoms.
- For patients assessed as having high levels of dependence and tolerance, starting doses of 40mg can be prescribed by experienced prescribers with close monitoring.
- A starting dose of 10-20mg daily may be indicated in low or uncertain tolerance
- Lower doses should also be considered for the following patients:
  - Elderly patients
  - Use or co-prescription of other CNS depressant medication, drugs or alcohol
  - Drug interactions or co-morbidities. Including but not limited to:
    - Respiratory disease
    - History of cardiac abnormalities
    - Advanced heart disease
    - Ischaemic heart disease
    - Cardiac conduction issues
    - Long QT syndrome or taking drugs that prolong QT
    - Hepatic impairment
- Clinicians should exercise extreme caution if patients present for assessment when intoxicated. Same day prescribing would generally not be suitable.
- Given the nature of methadone as a full agonist and the overdose risks when used alongside other opioids or depressants, supervision during titration is recommended.

5.5.2 Dose increases[1,6,7]

Patients should be assessed before each dose increase.

During the first 7 days:

- More frequent in person assessment will allow for observation of withdrawal, toxicity and changing risk
- Where in person assessment is not possible, a minimum of 3 days between each dose increase is recommended
- If the patient assessed is over-sedated, further dose increases should be delayed, or the dose reduced or withheld as appropriate
- The daily dose can be titrated in steps of 5-10mg in response to continued presence of symptoms of withdrawal and/or cravings
- The maximum increase in daily dose in the first 7 days is 30mg.

From week 2 on:

- A minimum of 3 full days before each subsequent dose increase is recommended due to accumulation. The Orange book[1] and BNF[7] recommend "a few days".
- Continue to titrate the daily dose in steps of 5-10mg in response to continued presence of symptoms of withdrawal and/or cravings.

Usual therapeutic dose:

- For most this will fall between 60mg and 120mg daily
- It is important to ensure patients (and any significant others present) can recognise and respond to symptoms of methadone toxicity. Naloxone should be available.

5.6 Initiation and Titration with Buprenorphine

Please refer to following NHS Grampian Guidance when prescribing buprenorphine:

- Sublingual and supralingual products: Guidance for the Use of Buprenorphine Products for the Treatment of Opioid Dependence in NHS Grampian
- Long Acting Injection: Guidance For Prescribing And Administration Of Buprenorphine Subcutaneous Injection (Buvidal) For Treatment Of Opioid Dependence In NHSG

5.7 Use of Other Opioids as OST

- Oral opioids other than methadone and buprenorphine are not licensed in the UK for the treatment of opioid dependence. This includes dihydrocodeine and slow-release oral morphine preparations. They are not currently recommended, or on the Grampian Area Formulary, for use in Grampian. Treatment using prescribed diamorphine is not currently available.

6. Maintenance on Opioid Substitution Treatment

- Following titration, most patients will have a period of maintenance. The duration will vary according to each patient's needs.
- Each patient's MAT goals should be regularly reviewed to ensure that treatment remains tailored to their needs. Areas of review can include but are not limited to:
  - Progress towards goals
  - Ongoing efficacy and suitability of treatment
  - Current drug and alcohol use
  - Status of physical and mental health
  - Review of participation in, or support to engage with appropriate, rehabilitation, counselling, relapse prevention and/or psychological support
  - Progress with family relationships, training and employment
  - Any ongoing challenges with social factors such as housing and finance
  - Any ongoing challenges associated with offending and criminal justice
- Prescribers should link patients with the team members or partner organisations most qualified to provide additional support in each area
- Patients may require more regular reviews initially. This is especially important for people with co-occurring mental health presentations or other significant harms such as repeated non-fatal overdose. Frequency of review should be regularly discussed and agreed between the patient and clinician.
- Supervised self-administration should be provided for a length of time appropriate to the patient's individual needs and risks. Considerations to relax supervised self-administration include but are not limited to:
  - The optimal daily dose of OST has been reached
  - Drug and alcohol use has stopped or significantly reduced

- Consideration of risks associated with poor mental health e.g. self-harm through overdose
- Medication can be stored safely at home, particularly where children are present
- There are no concerns of diversion of medication (through pressure or choice)
- The barriers caused by supervised self-administration e.g. struggling with employment and education outweigh assessed risk of take home doses

- Clinicians should consider the positive features of supervision e.g. where daily structure and support of pharmacy staff could be beneficial

6.1 Drug Testing During Maintenance

- Guidance[1] states that random intermittent drug screening is a practical and cost-effective option for providing reliable information about a patient's recent drug use
- Staff should be competent in interpreting the results and know which drugs can be checked (or not) with each type of test
- Positive results for drugs which are not prescribed are not a reason to exclude patients from treatment. They are an opportunity to discuss and reduce harm and review the patient's treatment plan and goals and should be tailored to each individual patient.
- The patient's presentation and reporting of drug use will influence the need to test however guidance[1] recommends testing a minimum of twice a year
- Testing is likely to be most useful where differences between reported use of substances and presentation are raising concerns regarding the risk of harm to the patient or those in their care
- Routine drug screens are not sufficiently robust for use in child protection cases and not intended or recommended for this purpose

6.2 Responding to Patient Goals

Regular review of a person's goals is important to support engagement and motivation as these may change over time. Where a person is struggling to achieve their goal it can be helpful to review whether the goal is still relevant, their strengths and resources, what steps they have already taken and any barriers. Where there has been a lapse or relapse time should be taken to explore with the person the circumstances leading up to this and offer relapse prevention where appropriate. Re-visiting the assessment and goals with the person will inform an appropriate response. This may include a review of current OST medication including dose, increased support from clinical team or other agencies (including peer support).

Any decision to withdraw MAT should be based on a comprehensive assessment of need including risks. Evidence tells us that retention in treatment is a protective factor and can provide positive outcomes that extend beyond the individual, including families and communities. Every effort should be made to maintain engagement in treatment.

6.3 Principles of Maintenance for OST

- Range for maintenance doses. NB: Doses above and below the range many be effective for some patients. Patient response should determine action
  - o Methadone. For most patients this will fall between **60mg and 120mg daily**
  - o Buprenorphine. For most patients this will fall between **12 and 16mg daily** for sublingual and supralingual formulations. There is evidence of greater retention in treatment and protection against overdose of doses of Buprenorphine ≥ 8mg. Equivalence of buprenorphine long acting injection is as follows:

Daily dose of buprenorphine oral lyophilisate	Daily dose of Sublingual buprenorphine product	WEEKLY dose of Buvidal®	MONTHLY dose of Buvidal®
2-4mg	2-6mg	8 mg	-
6mg-8mg	8mg-10mg	16mg	64mg
10-12mg	12mg-16mg	24mg	96mg
14mg -18mg	18mg-24mg	32mg	128mg

- Continued craving or use of other substances may mean the dose of OST is too low. This may require more focused work if patients are not keen to increase the dose above one that they perceive feeling comfortable on
- The dose, frequency of dispensing and patient's goals should be reviewed regularly to ensure prescribing remains appropriate
- Supervised self-administration is needed for a length of time appropriate to the patient's needs and risks. (see section 8)

7. Responding to Missed Doses of OST

Missing doses of OST- particularly methadone - can lead to reduced opioid tolerance, increasing the risk of overdose. The reason(s) for missed doses and actions taken by the patient in the interim should inform decision making. Information provided should support clinical decision making. Community pharmacies are generally encouraged to contact prescribers if a patient has missed 3 or more days of OST (earlier if there are other concerns) and are a source of information on current progress. They are encouraged to report all missed doses during the titration period. Response should be tailored to each patient's needs. Best practice is to review patients, ideally face-to-face, before restarting. Risk assessment should focus on the individual patient's presentation and unique circumstances. Where there are safety concerns, a 7-day pharmacy may be helpful if available.

Points to consider:

- Reasons for missing doses
- History of missed doses. Multiple missed doses may meant that tolerance is low
- Progress in treatment. Multiple missed doses during titration may require a more cautious approach
- The impact of other medication or substances if the patient reports taking any
- Presentation, physical health, mental health, signs of withdrawal or intoxication

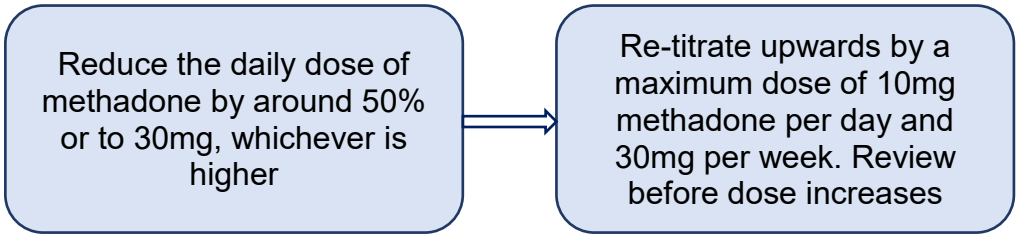
- If the current choice of OST is still preferred and appropriate
- If the full dose of OST has been taken regularly as prescribed prior to missing doses
- If there are concerns the patient is struggling, one option is to increase the frequency of pick up allowing the pharmacy to assess presentation before providing further doses.

7.1 Missed Doses of Methadone

The following is provided as a guide but should not replace clinical judgement. In most cases daily methadone doses of 30mg and below can be continued at the current dose. If missed doses occur at the end of the week, consideration should be given to the possible risks associated with reduced service support.

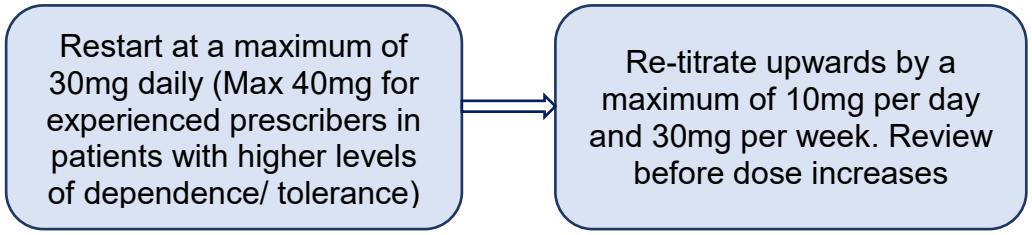
7.1.1 3 or 4 consecutive days missed methadone

Tolerance to opioids will begin to reduce. Assessment, duration on treatment and dose should inform decision making.



7.1.2 5 or more consecutive days missed methadone

Tolerance will have reduced after 5 days without taking methadone.



7.2 Missed Doses of Buprenorphine:

See Section 11 of the buprenorphine guidance document.

7.3 Lost, Spilled or Regurgitated Doses/Instalments

- Consider risks and benefits of replacing lost, spilled or regurgitated doses (by the patient). If the decision is made to replace a dose that has already been dispensed, a new prescription is required by the pharmacy to cover the additional dose(s) provided

- Regular occurrence should prompt review of prescribing to ensure it remains appropriate to patient circumstances and risk. This can be an indication that the prescribing regimen or medication is no longer effective or appropriate
- It may be tricky to safely replace a regurgitated dose. There are limited ways to assess how much has been absorbed and how much regurgitated. Toxicity may be a risk.
- If regurgitation occurs following administration in the pharmacy and is witnessed, there may be enough information to support decision making. NICE Clinical Knowledge Summaries provides advice for regurgitation of methadone in pregnancy[12] which may help inform other situations. If a decision is made to replace the dose - consider replacing 50–75% of the full dose. If the dose is more than 120 mg, a maximum of 50% of the full dose should be replaced. Doses should not be replaced if regurgitation takes place more than 30 mins after administration. If there is any doubt it may be safer to withhold the dose that day. A new prescription is required to cover the quantity of any replaced doses.

8. Supervised Self Administration and Dispensing Of OST

There is a delicate balance between offsetting risks of unsupervised dispensing versus creating a barrier to engagement with educational, occupational, social and vocational opportunities that are also important to a person's recovery. The reason for supervised dispensing should be clearly explained to the person (and any family/named persons present) and regularly reviewed. Primary care colleagues can contact drug and alcohol service for advice where needed. Any changes to dispensing arrangements and the reasons should be discussed with the person in advance wherever possible.

The rationale for supervised self-administration of OST dispensing includes:

- To support clinicians' assess engagement and response to the prescribed dose in a bid to reduce risk of toxicity and overdose
- To support initiation and titration
- To support monitoring of presentation during periods of instability or increased risk where supervision is assessed as having potential to provide a protective factor
- Risk factors that may indicate a need for supervised administration include but are not limited to:

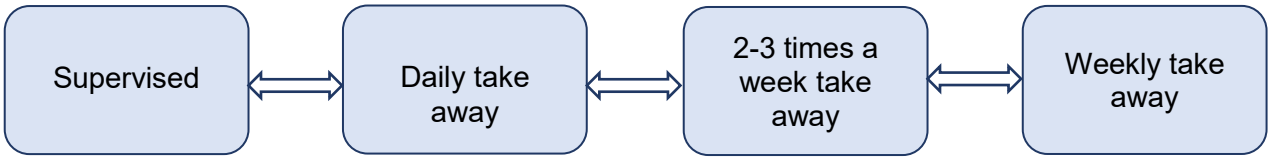
The patient has not reached a stable dose of OST	Continued and unstable pattern of drug or alcohol use including non-fatal overdose	Concerns regarding a deterioration in mental health presentation
Concern that prescribed medication is being used inappropriately, diverted (self or under pressure from others) or lost	Concerns about the safety of medicines stored in the home and possible risk to children or others	Regular missed "take home" collections – a period of supervision may improve stability

8.1 Changes to Dispensing Arrangements

There are a number of reasons why changes are made to dispensing. This may include a relaxation of dispensing or a return to supervised self-administration of OST. Ideally any changes to dispensing should be discussed with the person in advance but in some cases this is not always practically possible. Community pharmacies have regular contact with people and may have information which can support decision making.

8.1.1 Relaxation of Dispensing

The decision to relax dispensing arrangements is one example of an evidenced based psychological intervention (Contingency Management) and should always follow a collaborative review with the patient. Dispensing should be relaxed in a stepwise fashion and reviewed before each step.



Prior to relaxation of dispensing thought needs to be given to:

- Secure storage - how are medications being stored at home, particularly if children are present
- Whether the instalment instruction "If an instalment's collection day has been missed, please still dispense the amount for any remaining days of that instalment" is appropriate for this patient. Pharmacists may not alert prescribers to variable attendance as quickly as they may otherwise do. Adding "contact prescriber if 3 or more days missed" or similar to prescriptions can help
- Relaxation of dispensing should stay at the level that meets the patient's needs and level of risk. It can be stepped up again if risk emerges
- Weekly instalments are the lowest instalment frequency recommended for most. If less frequent instalments are prescribed the rationale should be documented and reviewed

8.1.2 Return to Supervised Self-Administration of OST

As mentioned in Section 2, a person's recovery journey is not always linear and people may move across different phases of treatment at different times. Where there are increased concerns about risk, and where a return to supervised dispensing is being considered, a review with the person to discuss dispensing arrangements should be offered. The therapeutic relationship in supporting discussions is key. Providing a non-judgmental, validating and compassionate response to the person's views and/or concerns will limit damage to the therapeutic relationship. A move to more frequent dispensing or supervision is generally recommended unless there are clear indications the impact on patient care, outcomes or engagement outweighs the identified risks.

A return to supervision risks overdose if the full dose is not being taken. The following options are available. They order is not one of preference, rather options for consideration. If there is any uncertainty, seek advice of colleagues within the drug and alcohol service. E.g. during hub/cluster meetings or medical or experienced clinical staff.

Table 3: Considerations for return to supervision versus continued take home doses

Option	Potential Benefits	Potential Risks
Maintain daily dose. Split into supervised and take home dose. Titrate by increasing supervised and decreasing take home portions as per example below*	Reduces risk of withdrawal if the patient is taking the full dose, whilst reducing risk of toxicity	May cause confusion in dosing if patient (and professionals) not clear on the plan
Continue on take home dispense but increase collection frequency	Lower volume of OST may reduce risk of toxicity if full dose taken in one day. May aid engagement of patient albeit with increased risks	Does not help the clinician assess if the dose prescribed is the dose taken. Potential to divert
Reduce dose and re-titrate supervised dose	Less risk of toxicity and overdose from medication	Risk of withdrawal, return to drug use associated harms, including overdose
Discuss risks of overdose with the patient. Ask them to confirm they are taking the full dose and confirm they wish to remain on it. Return full dose to supervision	Continuity of OST prescribing is maintained [assuming it is the appropriate dose]	Toxicity and overdose if not taking the full dose as prescribed
Continue current prescription as is. Discuss continued risks with patients. Offer harm reduction advice. Agree future review	May maintain engagement of patient and continuity of OST albeit with increased risks	Lack of clarity on dose taken and effective OST dose. Risk to patient from drug use remains, and to the wider community if diverted

*Table 4: Example of split supervised/take home re-titration for a patient currently prescribed 100mg as a take home dose. Included for illustration only and requires agreement between patient, pharmacy and prescriber around plan and dosing frequency.

	Supervised dose	Take Home Dose
Previous daily dose	-	100mg
New daily dose	30mg	70mg
Keep on previous dose for a minimum of 3 days. Stop titration and review if patient exhibits signs of toxicity	40mg	60mg
	50mg	50mg
	60mg	40mg
	70mg	30mg
	80mg	20mg
	90mg	10mg
	100mg	-

Pharmacy staff can support process by assessing for signs of toxicity or over-sedation before further increases to the supervised component occur. On days when the pharmacy is closed e.g. Sundays, it may be necessary to give the full dose away.

9. Supported Reduction and Stopping of OST in Community Settings

Where the agreed goal is to stop OST, a supported plan should be developed which includes both preparation and post-treatment support to minimise risk of relapse or harm. Where the patient continues to use substances, discussion of the benefits of OST and risks of stopping should be discussed and documented. Wherever possible, patients should be encouraged to continue OST where this is the case.

Points of discussion with the patient prior to beginning dose reduction of OST include but are not limited to:

- The possible physical and psychological aspects of dose reduction, including duration and intensity of symptoms of withdrawal and options for managing these. The goal is to reduce at a rate which avoids these
- Ensure the patient is aware of symptoms of withdrawal and encourage them to contact the service if these emerge. Use of COWS scale can support this. Dose reduction can be slowed down or stopped at any step until ready to continue
- The importance and format of non-pharmacological support and availability of these during periods of reduction
- The importance of continued engagement and support in achieving goals and reducing the risk of adverse outcomes
- The benefits that continued participation in psychosocial interventions and key working can have on successful outcomes
- 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
- For this reason it is important that overdose prevention work and naloxone supply is covered at this point. NB significant others can also receive a supply
- Updating other healthcare providers such as the community pharmacy and GP of the plan to reduce OST will allow them to provide support and feedback during their contacts

Dose reduction in community-based settings is suitable for most patients but exceptions may include those who:

- Have experienced significant difficulties with previous community dose reductions
- Need medical and nursing care due to significant mental or physical health problems
- Require complex poly drug detoxification
- Have significant social problems, such as homelessness, that may limit the success of community-based dose reduction
- State a preference and are assessed as eligible for residential detoxification

9.1 Reducing and Stopping Methadone

- Discuss the patient's views and agree the plan at each stage during the reduction. Tailor and adapt the plan to their needs and response

- An initial reduction in daily dose of around 5mg is comfortable for most
- Review before each further dose reduction and continue at a dose and rate agreed with the patient – generally no more frequently than every 2 weeks
- As the dose reduces it may be necessary to undertake reductions by 1-2mg daily
- On reaching a daily dose of around 30mg methadone or lower, a switch to buprenorphine can be discussed. Some patients report this is more tolerable.

9.2 Reducing and Stopping Buprenorphine

The principles are the same as for methadone however specific guidance can be accessed here.

- Sublingual and supralingual products: Guidance for the Use of Buprenorphine Products for the Treatment of Opioid Dependence in NHS Grampian.
- Long Acting Injection: Guidance for Prescribing And Administration Of Buprenorphine Subcutaneous Injection (Buvidal) For Treatment Of Opioid Dependence In NHS Grampian.

9.3 Managing Symptoms of Withdrawal

It is possible to undertake detoxification from opioids such as heroin with medicines which provide symptomatic relief however OST should be encouraged as it is more likely to result in effective outcomes. Lofexidine is not currently available in the UK.

It is also possible, especially in the last stages of reducing and stopping OST, that the patient will experience some withdrawal symptoms. If they do occur, the rate and amount of dose reduction should be reviewed however the following medication may be helpful. As with all medicines the clinical record should be checked to ensure they are compatible with other medication and medical conditions.

Table 5: Symptomatic relief

Symptom	Medication
Diarrhoea	Loperamide tablets 4mg initially, then 2mg after each loose stool (max.16mg/day)
Stomach cramps	Hyoscine butylbromide* tablets 10 to 20mg four times daily, as required or mebeverine tablets 135mg three times daily, 20 mins before meals
Nausea and/or vomiting	Metoclopramide tablets 10mg up to three times daily as required. prochlorperazine tablets 5 to 10mg two or three times daily as required
Agitation and anxiety	Diazepam* tablets 5 to 10mg up to three times daily when required. Max 7-14 days duration
Muscular aches and pains	Paracetamol tablets 1g four times daily if over 50kg, reduce dose if 40-49 kg to 1g three times daily, or if <=40kg 500mg four times daily or ibuprofen 400mg three times daily
Insomnia	Zopiclone* tablets 7.5mg at night. Max 7-14 days duration
* Maximum treatment duration of 14 days to minimise risk of dependence	

10. After Care

- Newly abstinent patients are at increased risk of overdose. Support focused on relapse prevention should be offered weekly and continued for at least 4 weeks after stopping OST. For those prescribed long-acting preparations of buprenorphine, this may be longer. Patients should not be discharged during this time
- Relapse to opioid use will usually require restarting of OST. Clinicians should ensure patients know how to access this quickly if it is needed and know how important it is in reducing risk and minimising any periods of relapse
- Access to interventions focused on engagement in work-related activity and education or activities to replace lifestyles linked to drug use increases the likelihood of achieving abstinence. They should be offered and encouraged at all stages of treatment
- Access to groups such as SMART recovery, Narcotics Anonymous and counselling services should also be highlighted
- Integrated working with adult or child and family social work if needed should ensure that parents and children continue to receive necessary support
- Patients remain at risk of relapse on becoming opioid free. The aftercare phase is therefore a critical part of any abstinence focused care plan. Updating other care givers e.g. GPs may provide additional support

11. Relapse Prevention Medication – Naltrexone

- Naltrexone is a long-acting opioid antagonist
- Taken on a regular basis after stopping opioids, it can assist in relapse prevention by blocking opioid receptors
- Motivation is key but supervision of administration can aid successful outcomes. Community pharmacies do not currently offer this service in Grampian however it may be that a family member or significant other can support the patient
- Naltrexone should be used only in combination with other forms of support for patients who have recently stopped taking opioids (OST or other)

11.1 Transfer to Naltrexone

- Naltrexone will precipitate opioid withdrawal symptoms if given to someone who is taking, or has recently taken, an opioid
- Wait for at least 72 hours after last dose of oral buprenorphine or 7 days after the last dose of methadone to initiate naltrexone treatment
- There is less value in prescribing naltrexone following cessation of monthly injections of long-acting buprenorphine which can be present in the body for 3-5 months after the last injection. For weekly injections this would be 3-5 weeks. Prescribing naltrexone during this time would result in symptoms of withdrawal
- A near patient urine test can be used to support the patient's opioid free status if there is any doubt
- The initial dose of naltrexone is 25mg followed by 50mg daily. 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.

- Naltrexone should be continued for at least 6 – 12 months. Assessment should focus on the patient's ongoing abstinence and perceived ability to maintain this. There is no requirement to taper the dose when stopping treatment.
- Gastrointestinal adverse effects are relatively common. A Choice and Medication leaflet is available and provides some advice on how to manage these www.choiceandmedication.org/nhs24/generate/pillnaltrexoneuk.pdf

11.2 Caution with Naltrexone

- Liver function tests are recommended before starting, one month post transfer and then six monthly. They are essential if patients have any signs of liver disease e.g. diagnosis of hepatitis
- Naltrexone should be discontinued if there is evidence of progressive hepatic impairment
- Naltrexone does not prevent the use of other classes of drugs, though there is evidence for reduced alcohol consumption for people with problematic alcohol use
- Absence of documented evidence means that naltrexone should only be given to pregnant or breastfeeding women when potential benefits outweigh the possible risks

Full details of special warnings, precautions and interactions may be found in the BNF and Summary of Product Characteristics:
BNF: https://bnf.nice.org.uk/drugs/naltrexone-hydrochloride/
SmPC: www.medicines.org.uk/emc/product/6073/smpc

12. Benzodiazepine Dependence

Guidance for the management of patients with benzodiazepine dependence can be accessed here:
http://foi.nhsgrampian.org/globalassets/foidocument/foi-public-documents1---all-documents/NHSG_BenzoZnovls.pdf

The harms associated with benzodiazepine use are widely acknowledged, particularly the contribution of street benzodiazepines to drug related deaths in the context of polysubstance use. Research is underway (2022) to support review of prescribing guidance in Scotland. This document will be updated on its completion. In the meantime, the Drug Death Taskforce in Scotland has produce the following interim recommendations for consideration (DDTF). This guidance states that professionals involved in patient care "…have a responsibility to listen to, assess and understand a person's unique story of benzodiazepine use to identify appropriate treatment and care." We all have a responsibility to have to listen and respond to benzodiazepine related concerns.

https://drugdeathstaskforce.scot/news-information/publications/reports/interim-guidance-on-benzodiazepine-prescribing/

13. Overdose Awareness and Naloxone

Being in treatment is, of itself, a factor which can reduce the risk of drug-related death. Clinicians can help to reduce drug-related deaths in their patients by:

- Discussing harm reduction strategies to reduce risk of overdose and supply naloxone as soon as possible, and reissue at regular intervals during OST treatment.
- Providing prompt access to OST with full support to achieve an optimal dose
- Consider suitability of buprenorphine as a treatment option in patients with chronic respiratory diseases such as COPD or asthma and/or where current risk of overdose is particularly high e.g. frequent overdose, significant polysubstance use
- Making patients aware of the higher risk of overdose during induction onto opioid treatment and after periods of loss of tolerance (including missing prescribed doses for a few days or more)
- Providing a carefully supported exit from OST including a period of aftercare support and planning after stopping OST
- Making patients aware of the dangers of using OST in combination with other drugs, especially benzodiazepines, alcohol, gabapentinoids and other sedating drugs (prescribed or non-prescribed). Consider these risks when making prescribing decisions
- Educating patients that the use of their OST by others is extremely dangerous.
- Providing education and training or referring families/carers/significant others to overdose awareness training and naloxone supply
- Identifying and supporting individuals with an increased risk associated with complex medication regimes, multiple diagnoses, social isolation and/or risk of suicide.

13.1 Naloxone

- Naloxone is an opioid antagonist and is licensed for use in community settings to reverse the effects of suspected opioid overdose whilst the ambulance arrives
- Systematic reviews conclude that provision of naloxone to people who use drugs can be effective. There is also evidence for the effectiveness of training those likely to witness an overdose in the use of naloxone
- Naloxone should be proactively recommended to all patients attending services and is available from all drug treatment services including clinical teams, Alcohol and Drugs Action, Arrows and most community pharmacies. It should be proactively offered alongside training on how to identify and respond to overdose and how to administer naloxone
- It is available in two formats, Prenoxad® intramuscular injection and Nyxoid® nasal spray. It can be prescribed for dispensing by community pharmacy and planned discharge from hospital or supplied using Grampian Guidance or PGD
  - Guidance for Drug Treatment Services and those services covered by the Lord Advocate's statement of prosecution: https://foi.nhsgrampian.org/globalassets/foidocument/foi-public-documents1---all-documents/Guide_NaloxoneS.pdf

- Other clinical services: https://www.nhsgrampian.org//globalassets/foidocument/foi-public-documents1---all-documents/PGD_Naloxone_Supply.pdf
- All resources for naloxone can be found on Hinet www.hi-netgrampian.scot.nhs.uk/people-networks/alcohol-and-drugs-in-grampian/naloxone/

14. Rapid Response and Assertive Outreach Teams

Each service should have a documented procedure to identify and follow-up people at high risk of severe drug-related harm, including death. This includes those who may have left residential, justice and inpatient settings, as well as those who have stopped attending treatment services and people who have just experienced a near-fatal overdose. The multiagency response should:

- ensure that engagement with a person is timely, respectful, age-appropriate and recognises the persons needs and choices;
- in most cases to take place within 24 hours (maximum 72 hours) of notification. Contact should take place in community settings, this could include at the person's own home, to maximise accessibility and address barriers presented by stigma;
- include a comprehensive assessment of risk based on the available information and including the person and their family member or nominated person.

Care provided should be tailored to the individual, documented and actioned as appropriate. Action may include rapid initiation of MAT where appropriate.

Contacts for each area's rapid response service are as follows: -

Drug Related Death Prevention Service, Aberdeen City

Email: gram.assertiveoutreach@nhs.scot
Answer phone: 01224 557780.

Referrals can be left on the answer phone and will be picked up daily. Name, date of birth and information about the reason for referral.

ARIES – Aberdeenshire

Email: aries@aberdeenshire.gov.uk with person's name, address, date of birth (CHI if known) and overview of reason for referral.

Arrows and MIDAS – Moray

Arrows and Moray Integrated Drug and Alcohol Service (MIDAS) work collaboratively to provide care for people with problematic drug or alcohol use in Moray. They meet daily to assess the status of all people requiring support and agree a plan of action for each person. This includes outreach where needed.

Arrows are the main point of contact and can be accessed by any of the following means. If referral is made by a professional rather than the person directly an

overview of the person's name, date of birth, address and contact details and reason for referral is helpful.

Walk-in: 23 High Street, Elgin IV30 1EE
Telephone: 01343 610500
Text: 07812 228547
Email: arrows@quarriers.org.uk

15. References

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16. Consultation

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17. Appendix 1 – Flow Chart For Initiating Methadone