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> ***"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)*

Introduction

In May 2021 following the work of the Drug Deaths Task Force (DDTF) the Medication Assisted Treatment (MAT) standards (1) were published. These give 10 standards for addictions services in Scotland to work to:

1. All people accessing services have the option to start MAT from the same day of presentation.
2. All people are supported to make an informed choice on what medication to use for MAT, and the appropriate dose.
3. All people at high risk of drug-related harm are proactively identified and offered support to commence or continue MAT.
4. All people are offered evidence based harm reduction at the point of MAT delivery.
5. All people will receive support to remain in treatment for as long as requested.
6. The system that provides MAT is psychologically informed (tier 1); routinely delivers evidence-based low intensity psychosocial interventions (tier 2); and supports individuals to grow social networks.
7. All people have the option of MAT shared with Primary Care.
8. All people have access to independent advocacy and support for housing, welfare and income needs.
9. All people with co-occurring drug use and mental health difficulties can receive mental health care at the point of MAT delivery.
10. All people receive trauma informed care.

Staff from within the Borders Addiction Service (BAS) were able to be involved with the work of the DDTF and contributed towards these standards. The service had been working towards their implementation prior to their formal publication, with changes to practice to lower barriers to MAT beginning from mid-2019. This guideline aims to reflect this experience and the current practice within the service to meet standards 1-5. MAT is a complex psychosocial intervention, whilst this guideline touches on other areas it is focused on considerations around prescribing of Opioid Substitute Therapy (OST) and does not aim to explore all of the broader psychosocial interventions within MAT, including those covered by standards 6-10. Clinicians should ensure that they are familiar with the full scope of interventions and ongoing service developments. **MAT is not just the prescribing of OST.**

These guidelines should be read alongside the UK Drug misuse and dependence: UK guidelines on clinical management (often called the "Orange Book") (2).

We are grateful to Prof Alexander Baldacchino in NHS Fife for allowing sections of his OST guidelines to be adapted within this document.

Keyworker

Throughout this document reference will be made to the "keyworker" who may be a doctor, nurse, OT, drugs worker, pharmacist or other clinician within the service, who has main responsibility and oversight of a patients care.

Keyworking helps to ensure the delivery and ongoing review of the treatment or care plan and would normally involve a mix of regular appointments, review in drop in settings, video or telephone contacts at which progress against the care plan would be discussed and, if appropriate, the goals revised.

Contents

Framework for Assessment and Management of Opioid Dependence

Phase	Goals	Prescribing	Role of Keyworker	Other Interventions
Assessment phase	Assessment to establish opioid dependence Full psychosocial assessment Initiation of a recovery care plan	Choice of appropriate opioid substitution. Consideration of same day prescribing.	Assessment of current and past drug use and treatment. Harm reduction advice + info Liaise with GP and other services	BBV evaluation, testing and immunisations Child protection assessment Overdose awareness training and Take Home Naloxone
Phase 1 Induction (up to 12 weeks)	Minimise opioid use by optimisation of substitute prescription. Reduced polydrug and alcohol use	Titration on to methadone or buprenorphine Dose adjustment until patient not in withdrawal and opioid use minimised.	Regular review of adequacy of medication dose Address other drug and alcohol use	Support in reduction of intravenous use and illicit use Referral to appropriate service for comorbid conditions.
Phase 2 Maintenance (Duration variable according to patient's progress)	Maintain abstinence from opioid by optimal dose of medication Address other drug and alcohol use	Methadone, oral buprenorphine or Buvidal	Review adequacy of methadone/ buprenorphine dose Assist patient to put in place lifestyle and behaviour changes to support minimal or no drug use.	Vaccination boosters Psychosocial supports Referral to other agencies as required
Phase 3 Reduction and detoxification (2–6 months)	To detoxify from OST	Negotiated methadone reduction regimen or buprenorphine detox	Relapse prevention techniques	Overdose awareness training and Take Home Naloxone
Phase 4 After-care (4 weeks)	To maintain abstinence after detoxification off opioid replacement treatment	Naltrexone for relapse prevention if appropriate	Individual weekly support focussing on relapse prevention	Encourage access to aftercare services

Drug Testing

Drug testing should be carried out at assessment, and at regular, but possibly unannounced times throughout the recovery process. This will confirm that OST is being taken and that illicit drug use is at a minimum to absent.

Urine testing – can show drug use over the past several days and is non-invasive. Urine specimens may be adulterated, substituted, or prone to pre-collection that may produce misleading results.

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, less easy to adulterate.

INITIAL ASSESSMENT / SAME DAY PRESCRIBING DECISON

- A full assessment should be undertaken for all patients who use prescribed and/or illicit opioids.
- The goal of the initial face to face assessment is to establish if it is safe and appropriate to prescribe OST on that day. Initial telephone / video contact can be undertaken in advance to support this assessment.
- The assessment is an ongoing process and can be completed over time, as long as the essential information is taken in the beginning, there is not an expectation that the full psychosocial assessment will be completed at first attendance, or before OST is started. (Use EMIS templates to support documentation where available)

1. DRUG AND ALCOHOL USE over the last 30 days (initial history)

What is being used?

How much is being used?

How often are opioids (& alcohol / other drugs) being used?

Routes of administration

Confirm use with an instant drug screen (urine) and Breath Alcohol Concentration test where appropriate.

IF INITIAL SCREEN IS NEGATIVE FOR OPIATES THEN NOT USUALLY SUITABLE FOR SAME DAY PRESCRIBING

2. ESTABLISH DIAGNOSIS / DEPENDENCE

1. Have you ever taken any of the following: Heroin, methadone, buprenorphine, morphine, oxycodone, tramadol, dihydrocodeine, codeine, and any other opioid analgesic?
2. Do you ever need to use more opioids to get the same high as when you first started using opioids?
3. Does the idea of missing a fix (or dose) ever make you feel anxious or worried?
4. In the morning, do you ever use opioids to keep from having "withdrawals" or do you ever have withdrawals?
5. Do you worry about your use of opioids?
6. Do you find it difficult to stop or not use opioids?
7. Do you ever need to spend a lot of time/energy on finding opioids or recovering from feeling high?
8. Do you ever miss important things like Dr's appointment, family/friends activities, or other things because of opioids?

If answer to Q1 is yes and 3 or more of Q2 - 8 are yes = likely opioid dependent

If answer to Q1 is no or less than 3 answers to Q2 – 8 are yes = likely not opioid dependent.

Rapid Opioid Dependence Screen (Wickersham et al 2015)

Gather further information to support same day prescribing decision and diagnosis of opioid use disorder

- Injection sites
- Past overdose presentations
- Collateral information from WAWY, other services or any contacts prior to assessment
- Previously in treatment with OST?
- **Assessment of physical withdrawal state (COWS)**

3. ADDITIONAL INITIAL INFORMATION

- Identification of physical health problems that may impact immediate prescribing decision e.g. COPD, heart disease
- Other prescribed medications
  - Confirm with GP, EMIS data sharing or ECS
  - Any that prolong QTc?
  - Sedatives?
- Identification of significant mental health problems
- Safe storage of medications / access to children
- Pregnancy test if needed
- Driving status / DVLA / Work at heights or need for concentration

4. DECISION ON SAME DAY PRESCRIBING

1. Can a diagnosis of opioid use disorder, in particular opioid dependence be made today?
2. Would the benefits of starting OST immediately likely outweigh the risks?

There must not be any pressure on a clinician to start OST on the same day where it is not considered safe or clinically appropriate to do so.

5. CHOICE OF OPIOID REPLACEMENT THERAPY

Methadone and Buprenorphine (as oral Espranor, or Buvidal injection) are available within BAS. See section below on comparison between Methadone and Buprenorphine. All prescribers should ensure that they are familiar with SMC guidance and the details of MAT standard 2.

- Patient preference, history in treatment, and risk of overdose should be taken into consideration. **The decision taken on medication used should be collaborative, if a medication is not being offered the rationale should be clearly explained.**
- Risk of precipitant withdrawal must be considered and discussed with patients starting Buprenorphine.
- Consideration must be given to practicalities and availability of staff for further injections if consideration is being given to titration directly onto Buvidal. Buvidal is not currently available outside Galavale without prior planning. For some patients it may be easier to titrate onto a dose of Espranor and convert to Buvidal.

6. START OF OST ON SAME DAY

- Follow titration guidance as per this document.
- Prescriber to ensure ES Team or key worker aware of plan for ongoing titration and review.
- If OST is not started further assessment around need for OST/diagnosis should continue, consider:
  - Additional history / collateral information
  - Further drug tests
  - Requirement to present in a withdrawal state

↓

8. CONTINUE FULL ASSESSMENT

- Continue with full assessment of physical health, mental health and social needs.
- Same day prescribing does not in any way negate the requirement for the traditional comprehensive physical, psychological and social assessment around the patient to be undertaken. This should be continued following the start of OST and remains essential.
- When patients are already engaged in treatment with OST their engagement in and the quality of this assessment would hope to be improved.

Offer Overdose Awareness Training and Take Home Naloxone, clean injection equipment and BBV testing at the point of initial assessment or as soon as possible thereafter.

COMPARISON OF METHADONE AND BUPRENORPHINE

	Methadone	**Buprenorphine**
Requirement for natural withdrawal state when started	No risk of precipitated withdrawals.	Risk of precipitated withdrawals.
Overdose risk	Full agonist, greater risk of overdose (intentional or accidental) when used with other opioids or in polydrug use.	Partial agonist, lower risk of overdose (intentional or accidental) when used with other opioids or in polydrug use. Should be considered as preferable where current risk of overdose is particularly high (e.g. previous overdose, chaotic polysubstance use and high dose groin injecting)
Comorbid alcohol use disorder	Higher risk (more sedative).	Lower risk (less sedative).
QTc prolongation	More likely to prolong QTc.	Less likely to prolong QTc.
Interaction with other medication	Plasma levels may be altered by inducers/inhibitors of CYP3A4. E.g. some SSRI's and erythromycin/clarithromycin.	Less likely to be affected by interactions with other medications.
Retention in treatment	May be more likely to retain patients in treatment than low dose buprenorphine (<7 mg).	Associated with worse retention in treatment if doses <7 mg are used. No difference to methadone for doses >7 mg daily.
Clear headedness / level of sedation from treatment	Does not give clear headedness. Patients with comorbid mental health symptoms (e.g. anxiety or trauma symptoms) may benefit from the greater sedative and anxiolytic effect.	Gives clear headedness and less sedation, useful if undertaking tasks that require concentration or working at heights etc.
Patients desire for a period of stability	Suitable for patients a seeking longer period of stability.	Suitable for patients a seeking longer period of stability. Patients aiming for more rapid detoxification (within 12 months) likely to find this better tolerated.
Withdrawal symptoms when withdrawn	More marked and prolonged compared to buprenorphine.	Less marked and prolonged compared to methadone. May be easier for patients to tolerate detoxification.
Long acting preparations / dosing	No long acting preparation available. Daily oral dosing required.	Long acting preparation available (Buvidal). Less than daily oral dosing possible.
Pregnancy	If pregnant and already on methadone this should be maintained. If not already on OST should be offered methadone.	If pregnant and already on buprenorphine this should be maintained. Should not be started during pregnancy.

INDUCTION

S Safe commencement of opioid replacement therapy,

M measured by a reduction in the use of illicit or prescribed opioids to a minimal level by

A achieving an optimal (therapeutic) dose in line with a

R realistic Recovery Care Plan and

T To an agreed timeframe of no longer than 12 weeks

COMMUNITY TITRATION

- The purpose of **titration** with methadone or buprenorphine is to establish the patient, 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
- The optimal dose achieved by titration is **not** the lowest dose that relieves withdrawal symptoms but the dose required for the patient to feel comfortable and less fixated on acquiring and using illicit drugs.
- **Insufficient dosing may increase the risk of additional illicit drug use, diminish treatment effectiveness, & increase accidental overdose risk.**

At the start of titration:

- At least one drug test should have been performed for new patients.
  - Instant urine drug screens can be used to support same day prescribing.
- The patient must be warned that methadone and buprenorphine interact with other central nervous system depressants, including benzodiazepines, antidepressants, other opioids and alcohol, increasing sedation and hence the risk of overdose. **Other illicit drugs and alcohol should be avoided.**
- Patients on medication known to prolong the QTc interval or with concerns about cardiac status (symptoms of chest complaints, dizzy spells or blackouts) should be considered for an ECG before commencing methadone.
  - However this should not stop methadone being offered within same day prescribing. Risks should be discussed with the patient and ECG arranged as soon as possible +/- changes to other medications if methadone is started.
- Previous practice has been to require BBV status and LFT's before starting Buprenorphine. This would essentially exclude Buprenorphine from same day prescribing. There is now evidence that that Buprenorphine does not selectively cause abnormal liver function compared with methadone (3,4) and that patients with Hep C have tolerated Buprenorphine treatment. All patients should be offered rapid BBV testing when accessing BAS. LFT's should be conducted if there are any clinical concerns.

During titration:

- Regular contacts, phone / video call or face to face, should be planned during titration, at least twice weekly.
- Missed contacts or missed doses should halt titration and the existing dose maintained (provided appropriate presentations to pharmacy) until further contact with and assessment by BAS.

Role of the Pharmacist:

- Supervised self-administration should be available to all patients to support induction.
- The pharmacist should be asked to report **any** missed doses to the prescriber during the titration phase.
- The pharmacist should monitor the clinical state of withdrawal or intoxication, the appearance and the behaviour of the patient.
- **It is important for clinicians to routinely obtain the feedback of the pharmacist when reviewing the patient's progress during titration**

Offer or direct patient to Overdose Awareness Training and Take Home Naloxone

Titration 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,** based on assessment of the person's opioid tolerance, frequency of use, route of administration, use of other drugs and withdrawal's.
- **Increase of dose should be no more than 5mg to 10mg on one day** and this dose should be maintained for at least two, preferably three days, before further increase. Maximum of 30mg increase in any one week.

Example 1

LOW OPIOID USE; TOLERENCE UNCERTAIN	**DAY**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
	Dose	**10**mg	**10**mg	**10**mg	**15**mg	**15**mg	**20**mg	**20**mg
	DAY	**8**	**9**	**10**	**11**	**12**	**13**	**14**
	Dose	**20**mg	**25**mg	**25**mg	**25**mg	**30**mg	**30**mg	**30**mg

Example 2

HIGH OPIOID USE; TOLERENCE LIKELY	**DAY**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
	Dose	**30**mg	**30**mg	**40**mg	**40**mg	**50**mg	**50**mg	**50**mg
	DAY	**8**	**9**	**10**	**11**	**12**	**13**	**14**
	Dose	**60**mg	**60**mg	**70**mg	**70**mg	**70**mg	**80**mg	**80**mg

- 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 the patient has engaged in their treatment.

Patients not presenting in a withdrawal state to start Methadone

- Whilst all patients should be encouraged to present in a withdrawal state to start titration some patients may struggle to tolerate a withdrawal state and may not be able to present in clear objective withdrawal, even when asked to attend on multiple occasions.
- Where clinicians following assessment are satisfied that there is clear evidence of opioid dependence a cautious induction of methadone using the "tolerance uncertain" schedule as detailed above could be considered.
- Alternatively where assessment suggests likely tolerance a starting dose of 20mg could be considered, with increase after at least 2 days to 30mg and titration then continued as per the "tolerance likely" schedule.
- **Starting doses above 20mg should not be used in BAS when patients do not present in a clear withdrawal state.**
- Prescribing in this situation should be done only where experienced clinicians take the judgment that the risks of further delay in starting methadone are greater than prescribing and the patient is not intoxicated and able to understand the risks involved.

- Clinicians should exercise extreme caution if patients present as intoxicated, either with opioids or other substances (especially depressants), these patients would generally not be suitable to be started on that day and should be encouraged return again as soon as possible when not in an intoxicated state.
- Given the nature of methadone as a full agonist and the overdose risks when used alongside other opioids or depressants, "self titration" of initial doses without supervision should not be considered.

Titration with oral Buprenorphine

- NHS Borders uses **Espranor** (Buprenorphine oral lyophilisate) as the preferred preparation of oral Buprenorphine. All doses refer to the use of **Espranor**.
    - Espranor is not dose equivalent to other oral Buprenorphine preparations and prescribers should be aware of dose conversions if moving to or from other preparations.
- Buprenorphine has a high affinity for opioid receptors and can cause **precipitated withdrawal** with first dose of buprenorphine displacing opioids taken previously.
- First dose should be taken when patient is experiencing opioid withdrawal – e.g. 8 to 12 hours after last dose of heroin. Generally patients assessed as scoring 12 or above on COWS are considered low risk to experience precipitated withdrawal.
- **Starting dose should be between 2mg and 6mg daily**.
- **The majority of patients using street heroin should be started on 6mg day 1, increased to 12mg on day 2. There should then be review before further dose increase.**
- Dose increases of 2mg to 4mg a day are usually adequate, although dose increases of up to 8mg daily are safe.
- Patients should be informed that it takes several days to stabilise on their medication and that precipitated withdrawal is unpleasant but not dangerous.
- A therapeutic dose is usually between 8mg and 16mg daily

Buprenorphine with naloxone (Suboxone) may be considered when supervised self-administration is difficult to deliver or where there is a concern about a patient's risk of reverting to injecting and use of Buvidal is not possible.

Patients not presenting in a withdrawal state to start oral Buprenorphine

- It must be accepted that in services offering same day prescribing at a low threshold patients will present seeking treatment with buprenorphine who are not in an adequate withdrawal state to have this started.
- Given its greater relative safety and the risk of precipitating a withdrawal state discouraging its use alongside other full opioid agonists, clinicians can consider dispensing the initial starting dose of buprenorphine without supervised self consumption and allowing the patient to take this home and "self titrate" when they are satisfied that they have entered an adequate withdrawal state.
- Buprenorphine can then be continued the following day and supervised self consumption can begin, with no dose adjustments to the usual titration outlined above.

- Where clinicians consider this as an option care should be taken to ensure that patients clearly understand why precipitated withdrawals may occur and that whilst not "life-threatening" this is an extremely unpleasant experience.
- Clinicians must ensure that patients have an understanding of the level of withdrawal expected before they take an initial dose of buprenorphine.
- To reduce the risk further the initial dose can also be dispensed as 2 mg tablets. With advice given to the patient take an initial 2 mg as a "test dose" and allow at least an hour to see if they experience any withdrawal features, before taking the remainder.
- Consideration could also be given to using a lower total starting dose e.g. 2mg or 4mg for the first day with subsequent titration.

Titration with Buvidal (long acting injectable Buprenorphine)

- It is possible for patients to titrate directly onto Buvidal.
- Patients would be expected to present in a withdrawal state and need to be given a test dose of Espranor 4mg an hour prior to the first injection of Buvidal to establish tolerability and reduce precipitated withdrawal risk.
- Clinicians should refer to the **BAS Buvidal protocol** for full details on the use of Buvidal and the titration process.
- Buvidal is currently stored at Galavale and is not available on other sites without prior planning. Patients wishing to titrate directly onto Buvidal are likely to need to commit to attending Galavale for multiple appointments during the titration period.

Buprenorphine microdosing

- The requirement to enter a withdrawal state prior to commencing Buprenorphine may be intolerable or impractical for some patients due to a variety of reasons. This may lead to lower overall utilization of Buprenorphine even though it has a superior safety profile compared with Methadone.
- Buprenorphine microdosing, also commonly referred to as the "Bernese method" involves an overlapping of low doses of buprenorphine with the continued use of a full opioid agonist by the patient, this is then withdrawn once an adequate dose of Buprenorphine is reached. This effectively means that the patient does not need to reach moderate withdrawal to start Buprenorphine.
- Whilst there is now significant experience across North America, Europe, Australia and the UK it remains an unlicensed method of induction and patients should be clearly consented around the risk and benefits as well as the use of medication in this way.
- Clinical experience locally and in other areas of Scotland has demonstrated microdosing as a valuable and tolerable form of induction for some patients.
- **Microdosing can be used both for initial induction or can be used for patients wishing to transfer from Methadone to Buprenorphine who are not able to reduce to 30mg and tolerate a conventional transfer.**

Example of a Microdosing schedule:

- For doses less than 2mg, 0.4mg sublingual Buprenorphine tablets should be prescribed. For higher doses Espranor should be used.
- Divided doses can be used and generally earlier stages would be dispensed without supervision, single daily dosing with supervision can be considered if there are concerns around possible diversion, or difficulty in understating the instructions.

Day	AM Dose	PM Dose
1	0.4mg sublingual buprenorphine	None
2	0.4mg sublingual buprenorphine	0.4mg sublingual buprenorphine
3	0.4mg sublingual buprenorphine	0.8mg sublingual buprenorphine
4	0.8mg sublingual buprenorphine	0.8mg sublingual buprenorphine
5	0.8mg sublingual buprenorphine	0.8mg sublingual buprenorphine
6	0.8mg sublingual buprenorphine	1.2mg sublingual buprenorphine
7	1.2mg sublingual buprenorphine	1.2mg sublingual buprenorphine
8	1.6mg sublingual buprenorphine	1.6mg sublingual buprenorphine
9	2mg Espranor	2mg Espranor
10	2mg Espranor	4mg Espranor
11	4mg Espranor	4mg Espranor
12	4mg Espranor	4mg Espranor
13	12mg Espranor (supervised daily dosing)	None
14	12mg Espranor	None

- For patients on Methadone dose reduction should begin by at least day 9. Speed of reduction should be negotiated with the patient, but reductions of 10mg daily have been tolerated.
- Microdosing requires planning and careful communication with the dispensing pharmacy, plans should be discussed with the pharmacist and days when dispensing and supervision are expected must be clear. Their feedback should always be sought during the titration.

- Microdosing can be a more complex process for patients; **clinicians must ensure that instructions have been clearly understood.**

- **Titration schedules are available within the service, a copy of their individual titration schedule, allowing them to record doses taken, should be provided to the patient. A copy should also be given to pharmacy prior to commencement. These should be reviewed during the titration.**
- **Written patient information is available within BAS and should be provided to patients prior to starting microdosing.**

- **Schedules such as the above may often need to adjusted based on patients individual circumstances,** this should be agreed with an experienced prescriber.

MAINTENANCE

S Stabilisation of dose and lifestyle

M measured by achieving and then maintaining abstinence from opioid drug use enabling the

A addressing of physical, psychological and social issues according to a

R regularly reviewed Recovery Care Plan and a

T timetable that is agreed but flexible.

Maintenance prescribing for opioid dependence

- Maintenance is suitable for people who want to stop using illicit opioids but are unable to achieve abstinence from all opioids and is more appropriate for adults with a long history of dependence.
- Maintenance can play an important step in a patient's journey towards recovery and does not prevent future abstinence.
- The Treatment and the Recovery Care Plan should be reviewed regularly looking at the following areas where appropriate:
  - Drug and alcohol misuse
  - Physical and mental health
  - Participation in rehabilitation, counselling, relapse and other psychosocial support programmes
  - Progress with family relationships, training and employment.
  - Housing
  - Offending and criminal justice
- Patients may need to have contacts every one or two weeks initially and, if stable, may then have monthly contact.
- Supervised self-administration should be provided for a length of time appropriate to the patient's individual needs and risks. Relaxation of supervised self-administration can act as an incentive if progress is being made but should only be permitted where:
  - A stable dose has been reached
  - Illicit drug and alcohol use has ceased
  - The patient's mental health is stable and there is no risk of self harm
  - Medication is stored safely at home, particularly where children are present.
  - There is no concern of inappropriate use or diversion of medication.
- **Random drug testing may be helpful, and should be done at least twice a year, for all patients.**

If the patient is not benefiting from treatment (i.e. there is continued heroin and other drug use)

- Aim to increase the intensity of pharmacological and psychosocial support
- Ensure medication is at an optimal dose
- Consider changing to a different substitute medication
- Increase keyworking
- Reinstate supervised self-administration
- If a relapse has occurred, try to discover what has triggered it. Help to develop techniques to avoid a breakdown in progress, encouraging participation in relapse prevention and counselling, training and employment etc.

Discharge from treatment due to unacceptable behaviors

Decisions to exclude a patient from MAT should not be taken lightly. It can put them at increased risk of overdose, offending and contracting a BBV. It may also increase the risk to children or vulnerable adults in the home. The decision to discharge any patient due to unacceptable behaviours should only be made following full MDT consideration, including senior clinicians.

Methadone

- Dose induction and stabilisation are carried out first
- Patients should usually be maintained on methadone doses between 60mg and 120mg daily
- Supervised self-administration is needed for a length of time appropriate to the patient's needs and risks.
- Reassessment is required if methadone is missed for three days or more. See Missed Doses
- If dose is missed for five days or more, full assessment of opioid misuse is needed before methadone is inducted again

Buprenorphine

- Dose induction and stabilisation are carried out first.
- Daily doses of Espranor between 8mg and 16mg should usually be used for long-term prescribing.
- Supervised self-administration is needed for a length of time appropriate to the patient's needs and risks.
- Three times weekly oral dosing may suit some patients. Patients requiring a titrated daily dose > 8 mg/day may not find this regimen adequate.
- Reassessment is required if buprenorphine is missed for three days or more. See Missed Doses
- If dose is missed for five days or more, full assessment of opioid misuse is needed before buprenorphine is inducted again. This helps avoid precipitated withdrawal.
- 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.

Other Oral Opioids

Oral opioids other then methadone and buprenorphine, such as dihydrocodeine and slow-release oral morphine preparations are not licensed in the UK for the treatment of opioid dependence. They should not normally be used in the community as OST. Their use in BAS should only be with consultant approval.

Optimal dose

- A key goal is to provide a dose that leads to complete cessation of opioid use, which may well be higher than the dose at which the patient feels "stable". It may take several weeks to reach the desired optimal dose of Methadone.
- To achieve optimisation after induction doses can continue to be increased incrementally. A total target dose of between 60 and 120mg a day of Methadone, and occasionally more, may be required. 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 opioids.
- There is evidence of greater retention in treatment and protection against overdose of doses of Buprenorphine ≥ 8mg
- A patient may come to believe that continuing intermittent lapses are due to lack of willpower when too low a dose is the determining factor. This may need explaining to a patient unwilling to increase the dose beyond that which makes the patient feel comfortable.
- Some patients may be unwilling to increase their dose because they intend to continue to use heroin. This should be addressed, increasing input if needed, but should not stop positive feedback where other important improvements are being achieved
- A small minority of patients may persistently seek higher doses during maintenance in order to seek a drug effect. These patients need to be identified and managed without further dose increases.

Offer or direct patient to Overdose Awareness Training and Take Home Naloxone

DETOXIFICATION

S Safe and effective discontinuation of opioids with minimal withdrawal symptoms,

M measured by becoming drug free and maintaining abstinence,

A attained by negotiating a detoxification **treatment plan** which

R requires commitment and preparation by the patient, regular review & support

T to an agreed timeframe with a defined start and end date.

Opioid detoxification should be offered as part of a package including preparation and post-detoxification support to prevent relapse.

For a patient to give informed 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 keyworking 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

The preparation process for detoxification should address the following points (Appendix 2):

- lessons learnt from previous treatments, detoxifications and rehab programs
- expectations and acknowledgement of positive outcomes
- motivation and readiness for detoxification program
- methods of detoxification, choice of medication
- coping skills to deal with detoxification program and strategies to maintain abstinence
- support network during and after detoxification program
- care plan aimed at relapse prevention
- consider need / suitability for residential rehab following detox

Community based detoxification is suitable for most patients but exceptions may include:

- Those who have not benefited from previous care-planned community detoxifications.
- Those who need medical and nursing care due to significant mental or physical health problems
- Those who require complex polydrug detoxification
- Those who have significant social problems, such as homelessness, that may limit the success of community based detoxification
- **BAS has limited access to resources for inpatient detox and would only offer this where it is clearly needed. This should be approved by a senior clinician and would require coordination with Huntlyburn.**

Supervised self-administration

A return to supervised self-administration may have an advantage in managing dose reduction particularly if the patient is putting extra pressure on themselves by reducing too quickly or having difficulty coping with reductions and may be tempted to take doses too early.

Offer or direct patient to Overdose Awareness Training and Take Home Naloxone

Detoxification with Methadone

- Stabilise the patient on Methadone
- Negotiate a structured rate of reduction with the patient and set an end date.
- Aim to reduce the dose initially by about 5mg every 2 weeks.
- Patients are likely to tolerate a more rapid dose reduction at the beginning until reaching 30mg of methadone.
- Reduction to 0 is likely to be more successful if slowed to 1-2mg fortnightly over the last few weeks
- Prolonged, slow reductions should not be endorsed – longer detoxes are associated with a higher risk of relapse.
- When the patient has reached a dose of 30mg Methadone they may opt for transfer on to Buprenorphine to complete the detox, some patients will find this more tolerable.

Detoxification with oral Buprenorphine

- Stabilise the patient on Espranor
- Negotiate a structured rate of reduction with the patient and set an end date.
- A common regime is reducing by 2 to 4mg every two weeks.
- When the dose is reduced below 2mg, it is necessary to change to sublingual 0.4mg tablets from Espranor to continue the reduction.

For example:

Daily buprenorphine dose	Reduction rate
Above 16mg	4mg every 1 to 2 weeks
8 to 16mg	2 to 4 mg every 1 to 2 weeks
2 to 8mg	2mg every 1 to 2 weeks
Below 2mg	0.4 to 0.8mg every 1 to 2 weeks

Transfer from 30mg or less of Methadone

- The first dose of Buprenorphine should be administered at least 24 to 36 hours after the last use of Methadone and preferably 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 severity of precipitated withdrawal.

  Dose transfer example:

Last Methadone dose	Espranor day 1	Espranor day 2
20 to 30mg	4mg	6 to 8mg
10 to 20mg	4mg	4 to 6mg
<10mg	2mg	2 to 6mg

Transfer from higher doses of Methadone

- It is possible to transfer from a higher dose of Methadone but the risk of experiencing withdrawal symptoms is significantly higher. The first dose of Buprenorphine must be delayed until there are clear signs of withdrawal, this can take several days – even then there is risk of precipitated withdrawal with the first dose of Buprenorphine. High dose inpatient transfer is possible if clearly indicated.
- Withdrawal symptoms may be treated with symptomatic relief.

Detoxification with Buvidal (long acting injectable Buprenorphine)

- There is no current published data to guide detoxification using Buvidal.
- However there is now experience both in the Borders and other parts of Scotland of detox with Buvidal, with patients experienced in detox using other medications having reporting it as more comfortable and very well tolerated.
- It is hypothesised that the "self tapering" effect of the long acting monthly injections when stopped may provide a more tolerable route of opioid detoxification, with a gradual drop in Buprenorphine levels.
- Where Buvidal is used for detox experience is that patients should aim to stabilise on each dosing step for 3 months before reducing. E.g.
    - 128mg monthly for 3 months
    - 96mg monthly for 3 months
    - 64mg monthly for 3 months
    - STOP
- Due to the long acting effects of Buvidal patients should have a longer period of follow up post detox before discharge from the service. It is suggested that contact should be maintained for 3 months following the last injection. This would not be expected to be weekly.
- Practice in this area is likely to continue to evolve in response to additional clinical experience and published data.

Detoxification with an alpha-adrenergic agonist drug

- Lofexidine is a non-opioid, alpha-adrenergic agonist drug licensed to relieve symptoms in patients undergoing opioid detoxification. It is not a controlled drug. Unfortunately Lofexidine has not been available in the UK since 2018 and there is no current expectation that it will re-enter the UK market.
- There are no other alpha-2 adrenoceptor agonists licensed for this use in the UK, however Clonidine is used for this indication in several other countries and there is published experience (5).
- Use of Clonidine to aid opioid detox would be only be considered under specialist supervision where patients have failed using other methods of detox, or there is other clear clinical need.
- Patients would need to be clearly consented as to the off label use of medication.
- Clonidine may induce hypotension to a greater degree than Lofexidine so monitoring of blood pressure prior to and during treatment must be done. This would likely need an inpatient setting.

Detoxification – symptom relief

Detoxification may be undertaken with symptomatic relief only. It is also likely, especially in the last phase of detoxification with Methadone or Buprenorphine, that the patient will experience withdrawal symptoms. The following drugs may be helpful:

Symptom	Drug
Diarrhoea	loperamide 4mg stat, 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	metoclopramide 10mg three times daily when required prochlorperazine 5 to 10mg two or three times daily when required
Agitation and Anxiety	propranolol 40mg once daily increasing to three times daily if required diazepam* 2 to 10mg up to three times daily when required
Muscular pain/headaches	paracetamol 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* 7.5mg at night or trazodone 50mg at night

***These drugs have the potential for abuse and/or dependence – prescribe for no more than 14 days**

AFTER CARE

- Newly detoxified patients, ***remain at increased risk of relapse*.** For this reason they should retain their treatment place (i.e. they are not discharged) for at least 4 weeks while they are in the after-care phase of their opioid replacement therapy.
- Relapse to heroin use during this post medication phase will usually mean automatic re-induction into OST for another period of maintenance prior to another attempt at reduction.
- Keyworkers should continue to provide **weekly support** to the patient **for at least 4 weeks** during this phase.
- 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 and increase the likelihood of staying drug free.
- Patients should be encouraged to access aftercare supports such as We Are With You, group services such as SMART recovery, Narcotics Anonymous and counselling services.
- Information sharing with adult or child and family social work if needed should ensure that parents and children receive support.
- Patients remain at high risk of relapse (often for years) after they have detoxified so the after-care phase of their treatment is an important part of their Recovery Care Plan. Some clients may feel more encouraged to attempt reduction if they know that their treatment 'slot' will still be there and they can rapidly access treatment again should they relapse.

Naltrexone for relapse prevention

- Naltrexone is a long acting opiate antagonist. If taken by an individual continuing to take opioids it will precipitate opiate withdrawal symptoms,
- Taken on a regular basis after detoxification it can assist in relapse prevention by blockade of opioid receptors. Supervision by either a family member or the pharmacy can aid success.
- Naltrexone should be used only as an adjunct to other forms of support and treatment for patients who have recently come off opiates.

Transfer to Naltrexone

- 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.
- An instant negative urine test to confirm the patient's opioid free status should be obtained within 12 hours of initiation of naltrexone 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).
- If no supervision or partnership approach is possible the decision to prescribe rests with the prescriber.
- Naltrexone should be continued for at least 6 – 12 months.

Caution with Naltrexone

- Liver function tests should be carried out before starting, one month post transfer and then six monthly. 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 problematic drinkers.
- Absence of documented evidence means that naltrexone should only be given to pregnant or breastfeeding women when the potential benefits outweigh the possible risks.

Full details of special warnings, precautions and interactions may be found in the Summary of Product Characteristics

Offer or direct patient to Overdose Awareness Training and Take Home Naloxone

TELEMEDICINE within MAT

Four modes of telemedicine have been described,

- **Mode 1.** Hub-home: Clinician connects from clinic to patient at home.
- **Mode 2.** Dyadic hub-spoke: Clinician in specialist hub centre connects to patient in remote spoke, health spoke or care site without additional staff member present (e.g. in an unstaffed kiosk). – *These facilities are not currently available in NHS Borders.*
- **Mode 3.** Triadic hub-spoke: Clinician in specialist 'hub' centre connects to patient in remote 'spoke' healthcare site (for example, a community pharmacy, GP practice) with another healthcare worker present (for example, nurse, pharmacist, healthcare support worker)
- **Mode 4.** Triadic hub-home: Clinician in specialist 'hub' centre connects to patient at home with another healthcare worker present (for example, nurse, healthcare support worker).

Within BAS clinicians should flexibly use telemedicine alongside face to face appointments and drop in settings to reduce barriers to accessing services, support engagement and increase flexibility for patients.

ASSESSMENT PHASE

- Initial phone or video contact can be offered prior to first attendance. This can allow for more rapid contact, collection of initial information and explaining what to expect at first face to face contact, including giving expectations (e.g. need to provide urine specimen, present in withdrawal) **(Mode 1)**
- Where a prescriber is not available physically onsite, a prescriber may consult using phone or video with the patient supported by another member of staff to consider remote prescribing to start OST. Supporting staff must be appropriately trained to interpret “instant” urine drug tests and in assessment of withdrawal states (and use of COWS). This would usually be done in a clinical setting **(Mode 3)**, but could be done at a home visits **(Mode 4)**.
- **The prescriber must be satisfied that adequate assessment has been clearly preformed before starting OST.**
- Arrangements must have been made with a community pharmacy who will accept initial email transmission of the prescription, or other arrangements for delivery of the prescription so that OST can be started on the day of assessment.

TITRATION PHASE

- To allow more rapid titration keyworkers / ES Team should offer a mix of phone, video and face to face contacts during the titration process. There is not a requirement for a patient to be seen face to face before every dose increase, provided feedback has been sought from pharmacy around presentation and regular remote contact is being maintained. **(Mode 1)**
- Further assessment from a prescriber or medical staff can be offered via video or phone, or remotely with the support of other staff. **(Modes 1, 3 and 4)**
- **Clinicians must ensure that patients are still seen face to face frequently enough to allow for assessment of physical state and for drug testing. Concerns should prompt titration to be paused and face to face assessment to be sought.**

MAINTENANCE PHASE

- A mix of face to face and phone / video contact can be offered. **(Mode 1)**
- Senior prescriber, medical or psychiatric review can be offered by phone / video directly, or supported by other staff. **(Modes 1, 3 and 4)**
- Keyworkers should ensure that regular contacts are maintained and that face to face contacts are still available to support drug testing.
- Concerns should prompt face to face review.

DETOXIFICATION AND AFTERCARE PHASE’S

- A mix of face to face and phone / video contact can be offered. **(Mode 1)**
- Consideration should be given to more regular face to face review if there are concerns that the patient is struggling and may be at risk of relapse.

Decisions around the use of telemedicine should be taken jointly with the patient. Some patients will express clear preferences for ongoing face to face contacts and this should be honoured wherever possible.

Hepatitis C treatment

- The Scottish Government has now set the goal of elimination of Hepatitis C in Scotland by 2030 (or earlier).
- All patients within BAS should be offered BBV testing, at the point of assessment, if any high risk exposure is identified and routinely on an annual basis.
- All patients identified as Hep C positive should be referred and supported to engage with hepatology at the BGH.
- Where patients with support do not manage to engage with the BGH they should be discussed with medical staff in BAS and considered for assessment and treatment within addictions.
- BAS clinicians should follow the agreed protocol with hepatology to arrange needed blood tests and assessment within BAS.
- Following review of the assessment by hepatology, counselling for and prescription of direct acting antiviral therapy can now be done within BAS.
- Where direct acting antiviral therapy is prescribed this should be matched to OST dispensing, with supervision by community pharmacy where this is in place for OST also. Some patients have preferred to go back to daily supervision for the period of Hep C treatment to support medication compliance.
- BAS keyworkers should, in consultation with medical staff, support the patient throughout the treatment period and monitor treatment compliance.
- Following treatment further Hep C PCR is required at the end of treatment and at 12 weeks. Keyworkers in BAS should arrange these.
    - Venous blood is preferred, but if not possible DBST can be used.

Assertive Outreach (ES Team)

- The ES Team is embedded within BAS and aims to support patients who are identified as
    - Experiencing barriers in engaging with the core service
    - At risk of disengagement and dropping out of treatment, or who have disengaged
    - Have experienced a near fatal overdose (NFOD), or have been identified as at severe risk of drug-related harms.
- ES Team will respond to notifications from other services (SAS, A&E, Police etc) of NFOD and aim to make contact with the patient and begin assessment within 24 hours (72 hours max) of notification.
- The goal of ES Team is to support patients be able to engage with the core service not to provide long term key working. Patients may have periods of input from ES Team supporting their care depending on their individual need over time.
- Staff keyworking patients who feel they are at risk of disengagement or may benefit from a period of additional input from ES Team should bring them for discussion at the weekly MDT meeting, or discuss with team leaders if more urgent.

Psychosocial components of treatment

- Medication Assisted Treatment (MAT) is a complex psychosocial intervention and more than just the provision of OST.
- In response to the MAT standards services are undergoing significant development work to improve the provision of psychological and social supports available for patients in treatment. This work remains ongoing at the time of writing (September 2021).
- Staff should ensure they remain up to date as to the interventions available within BAS and the broader addictions partnership, as well as being familiar with other services available in the Borders. These are likely to continue to significantly change over the next couple of years.
- One resource that may aid keyworkers is the node-link mapping approach designed by the National Treatment Agency for Substance Misuse illustrated in the publication Routes to Recovery via the Community. This offers a structured and visual set of tools likely to support people with and without cognitive impairment to engage more fully with treatment.
    - This manual provides resources, including worksheets, which keyworkers may find useful as part of creation of care plans and help them to structure ongoing work.

OVERDOSE AWARENESS TRAINING AND TAKE HOME NALOXONE

Being in treatment is, of itself, protective against drug-related death. Clinicians can help to reduce drug-related deaths in their patients by:

- providing or referring to overdose awareness training and Take Home Naloxone (THN) as soon as possible and at any stage of OST.
- providing prompt access to OST with full support for dose optimisation.
- Considering buprenorphine in patients with COPD and/or where current risk of overdose is particularly high (e.g. previous overdose, chaotic polysubstance use and high dose groin injecting)
- Identifying and supporting individuals with an increased risk by virtue of complex medication regimes, multiple diagnoses, social isolation and/or risk of suicide.
- making patients aware of the risks 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 carefully supported exit from OST including a period of aftercare support and planning after cessation of opioid use.
- making patients aware of the dangers of using OST in combination with other drugs, especially benzodiazepines, alcohol, gabapentinoids and other sedating drugs (including prescribed drugs).
- educating patients that the use of their OST by others is extremely dangerous.
- providing education and training or referring families/carers to overdose awareness training and THN

Naloxone

- Naloxone is an opioid/opiate antagonist and is licensed for use in:
  - complete or partial reversal of central nervous system depression and especially 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 across the Borders from We Are With You, Community Pharmacies, BAS and other settings.
- The preferred preparation in the Borders is the intramuscular (IM) naloxone kit; however intranasal naloxone is also available and can be provided where the IM kit is not suitable.
- **All clinicians in BAS must have completed training to allow them to train others in the use of and to dispense naloxone.**
- **All patients in the service as well as their families or close contacts should be offered training and provision of take home naloxone.**
- **Clinicians should be regularly checking that patients do not require a new kit.**

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

SPECIAL GROUPS

Pregnancy and Breastfeeding

- Pregnant women dependent on opioids are at high risk of experiencing complications generally as a result of inadequate antenatal care and lifestyle factors including smoking, poor nutrition, high levels of stress and deprivation.
- Repeated cycles of intoxication and withdrawal which can harm the foetus or precipitate premature labour or miscarriage.
- Opiate dependent women entering treatment due to pregnancy should be offered Methadone as preparation of choice unless special circumstances (e.g. recurrent failure on methadone) apply.
- Methadone carries the potential risk of respiratory depression in the neonate and neonatal withdrawal syndrome. However:
  - **Respiratory depression** is not a significant problem in babies born to mothers on Methadone maintenance treatment
  - Babies may experience **neonatal withdrawal syndrome**. Occurrence is unpredictable with no relationship between the maternal Methadone dose and severity of the neonatal withdrawal syndrome.
- The benefits of Methadone maintenance treatment for both the mother and baby outweigh any risks from neonatal withdrawal syndrome.
- Those who are already stable on Buprenorphine should be maintained on it.
- Buprenorphine provokes a similar incidence, compared to methadone, of neonatal abstinence syndrome, but this tends to be less severe, needing less and shorter treatment.

Management in pregnancy:

- Attending regular antenatal care is of high priority and liaison between OST prescriber and the maternity service is very important.
- Pregnant women should be maintained on adequate doses of Methadone to achieve stability and to prevent relapse or continued illicit opioid drug use.
- Women already in Methadone treatment who become pregnant can be safely maintained on their current dose.
- Pregnant women should be considered as priority cases and titrated as soon as possible.
- **It may be necessary to divide the daily dose and/or possibly to increase the dose in the third trimester of pregnancy to avoid withdrawal symptoms** due to reduced bio-availability of Methadone in the later stages of pregnancy. This is due to increased plasma volume, an increase in plasma proteins which bind methadone and placental metabolism of methadone.

Dose reductions or detoxification during pregnancy:

- Opioid withdrawal in the first trimester of pregnancy is thought to be associated with an increased risk of miscarriage while in the third trimester it may be associated with foetal distress and death. Therefore it is important that pregnant women are not exposed to withdrawal during these two trimesters.
- Dose reductions should only occur in the second trimester and if the pregnancy is stable and should be flexible.
- Withdrawal symptoms should be avoided as much as possible as they cause considerable distress to the foetus.
- Careful monitoring of the pregnancy and foetus should be undertaken during dose reduction.
- In most instances, dose reductions of 2 -3 mg of Methadone every 3 – 5 days or less frequently, for example, are considered safe.

Breastfeeding

- Breast milk contains only small amounts of Methadone and mothers can be encouraged to breastfeed regardless of Methadone dose provided they are not using other drugs.
- Breastfeeding may reduce the severity of the neonatal withdrawal syndrome.
- **Women on high doses of Methadone should be advised to wean their babies slowly to avoid withdrawal in the infant.**

Co-morbid Mental Health Problems

Co-occurring mental health problems are common in drug users. For some patients dual-focussed treatment will be appropriate, where an approach such as cognitive-behavioural therapy and/or motivational interviewing may be adapted to address both the mental health issue and the drug dependency. For other patients, where the mental health disorder is the primary diagnosis and clinical priority, the patient should receive specialist treatment from the appropriate community mental health team (CMHT).

At the time of writing (September 2021) services locally are continuing to respond to the MAT standards. The availability of different treatment options and pathways through services for patients are under review and likely to undergo significant change. The Addiction Psychological Therapies Team (APTT) will accept referrals for patients open either to the BAS core team or We Are With You and Consultant Psychiatrist review is available for patients open to BAS or APTT. Comments below offer general guidance.

Depression

Patients may present with depressed mood following recent substance use, intoxication or withdrawal. However, primary mild or moderate depressive disorder is also very common. For less severe and less complex problems (often described as “mild or moderate”) online therapy, therapeutic group work and 1-2-1 guided self help can be beneficial. Development is undergoing to offer more low level psychological interventions in BAS and APTT is able to provide higher level interventions. Antidepressant therapy may be started within primary care or may be recommended following assessment in BAS. Caution should be exercised around QTc prolonging agents and Methadone. Severe depression, with or without psychotic features, would generally require input from CMHT.

Bipolar affective disorder

Major mental illness would be expected to have joint input from BAS and CMHT, with CMHT taking a lead role in management of psychotropic medication and monitoring of the patients mental health. Randomised control trials have indicated that dual focused treatments based on cognitive behavioural principles have a better impact on depressive, manic and substance use symptoms relative to comparison treatments. Dual focused treatment if considered should be discussed with the Addiction Psychological Therapies Team (APTT).

Post-traumatic stress disorder (PTSD)

Very high rates of PTSD have been reported in those attending substance misuse treatment services. Stabilisation of drug misuse and treatments focused on reducing risky behaviours and emotional regulation will help prepare a patient for trauma-focused treatment and minimise drop-out. Service development is taking place around the range of interventions and supports available within BAS for those with trauma symptoms. APTT offer a range of theraputic approaches and psychiatric review is available to consider medical treatments.

Anxiety disorders

Diagnosis of a comorbid anxiety disorder is common in those with substance misuse problems. Often, confirmation of diagnosis and treatment planning needs to await stabilisation of substance use although advice on anxiety management can often be given at assessment. Some patients after long periods of substance use report a range of chronic anxiety symptoms and will often have been tried on various psychotropics in primary care with little effect. Staff must be careful to manage expectations, especially around prescribing solutions and should aim to promote development of non-medication based coping skills.

Personality disorder

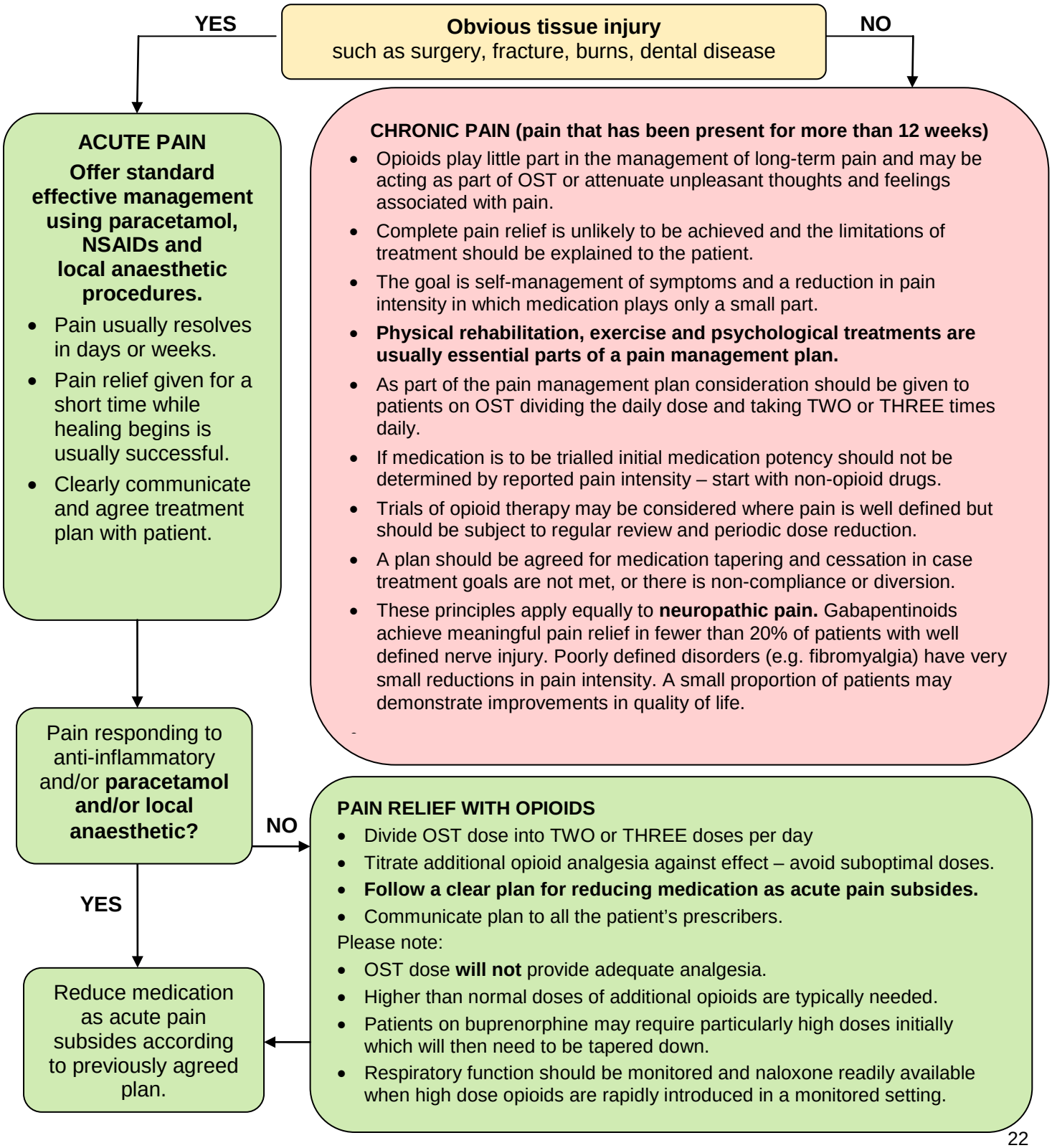
Patients with Emotionally Unstable Personality Disorder (EUPD) and drug/alcohol dependence will be assessed on a case by case basis to determine how best to meet their needs. Patients may remain under the care of mental health service for treatment of EUPD and with Addiction Services for assessment and management of their drug dependence. However some patient’s may be able to be managed within BAS with input as needed from APTT. Patients being open to BAS should not stop them accessing other areas of the mental health service where this is clinically indicated.

Psychosis

Major mental illness would be expected to have joint input from BAS and CMHT, with CMHT taking a lead role in management of psychotropic medication and monitoring of the patients mental health. At present, there is not sufficient evidence to recommend dual-focused treatment for management of psychosis and substance use disorder.

Treatment of pain in opioid dependent patients

- Drug users experience the same sources of pain as others and will have similar needs for pharmacological and other interventions to address pain.
- Drug users may have previously self-medicated to relieve pain and psychological distress and may have a poor acceptance of non-pharmacological interventions for pain control.
- Detailed assessment of the pain, of the dependence and of any co-morbid mental health problems is essential particularly for chronic pain.
- Patients dependent on drugs require empathic communication and reassurance that their pain will be taken seriously and managed.
- Patients abstinent in recovery risk relapse from re-exposure to opioids or under treatment of pain. Discuss treatment options with patient and respect patient's decisions. Effective non-opioid acute pain regimens should be used where possible.



Cardiovascular disease and ECG monitoring for patients on Methadone

- Patients receiving Methadone should be assessed for the risk of QTc prolongation. Risk factors include:
  - Prescribed ≥100mg methadone and has not had an ECG in the past year.
  - Prescribed < 100mg methadone daily and taking any other medication that prolongs the QTc interval (e.g. antidepressants, antipsychotics. See www.crediblemeds.org for searchable database)
  - Prescribed <100mg methadone and taking any other medication which inhibits metabolism by Cytochrome p450 pathway
  - Family history of cardiac conditions and/or sudden death
  - Patient history of syncope, palpitations, shortness of breath, seizures and/or cardiac conditions
  - Symptomatic presentation at an appointment – pallor, sweatiness, cyanosis.
  - Patient using stimulants
  - Patient with other conditions such as:
    - Hypothyroidism
    - Liver disease
    - Malnourishment
    - HIV infection
    - Anorexia nervosa
    - Alcohol dependence

All patients with identified risk factors should be offered ECG monitoring at least annually, more frequently if any abnormality identified.

- If an ECG is reported as showing QTc abnormalities the following actions should be taken:
  - QTc >469 for females, >439 for males should be offered repeat ECG. QTc risk factors should be reviewed.
  - QTc>499 should be referred for specialist opinion. Consideration should be given to reducing Methadone or switching to Buprenorphine.
  - QTc>550 should result in urgent referral to specialist services and Methadone should be stopped.

6 lead (6L) and 12 lead (12L) ECG monitoring

12L ECG's are the gold standard and patients should be encouraged to attend the BGH or their GP for these. However it is recognised that many patients within BAS even with support struggle to do this. Within BAS a 6L ECG can be performed within the service using the KardiaMobile 6L device. This is a small, portable ECG recorder that can be used outside a healthcare setting. This is placed on the patient's knee or ankle and within 30 seconds remotely records the ECG via Bluetooth onto the professional's NHS smartphone. The reading can then be emailed to the patient's team as a PDF and then requires interpretation and manual QTc calculation by an appropriately trained clinician.

The KardiaMobile 6L does not replace the 12L ECG. However for the purpose of QTc screening this device is approved by FDA & CE. This device has also been used by other NHS organisations for atrial fibrillation screening and QTc monitoring in other areas of the UK.

Where patients are not engaging with 12L ECG monitoring BAS staff should use the KardiaMobile 6L as this offers the best available estimation of their QTc. Where abnormalities are identified patients should be strongly encouraged to attend for a 12L ECG.

Respiratory disease

Smoking and respiratory function

- Most patients in drug treatment smoke tobacco. Some will also have been smoking other drugs that can damage their lungs (such as crack cocaine, heroin and cannabis).
- Smoking by people who use drugs causes extensive morbidity and leads to large numbers of premature deaths. This is mainly through the effects of tobacco smoking on the development of cardiovascular diseases and respiratory diseases (chronic obstructive pulmonary disease (COPD), lung cancer and poorly controlled asthma). The effects of lung disease on depression of lung function may also contribute to some deaths from opioid overdose.
- During ongoing assessment patients should be asked about:
  - Recent and previous levels of smoking and current quit status for all substances.
  - Current or recent history of cough, shortness of breath, wheeze or other signs of respiratory disease and any consequent impairment in activity such as walking.
  - Previous respiratory diagnoses and any treatment for existing lung disease.
  - The desire, now or in the future, to quit tobacco smoking and experience of previous quit attempts.
- Where symptoms suggest potential respiratory disease the patient should be referred and supported to attend GP for investigation and treatment.
- The patient should be supported to continue treatment for respiratory problems by GP and/or specialist respiratory health services
- If diagnosed with respiratory disease (or other qualifying conditions) the patient should be encouraged to receive annual vaccinations for influenza, COVID-19 and pneumococcus when invited, especially as they get older.

Smoking Cessation

- Whilst smoking cessation might not seem a priority, engagement with smoking cessation support has been associated with improved drug treatment outcomes for patients in treatment.
- There is no reason to delay a discussion around smoking cessation as evidence suggest a majority of patients express the desire to quit.
- Given that different patients may wish to engage in help with smoking at different stages of their treatment journey repeated brief advice for smoking cessation should be offered as treatment progresses
- The best outcomes for smoking cessation are seen from a combination of behavioural support and pharmacological interventions such as nicotine replacement therapies, and other drugs such as bupropion and varenicline (Champix). Evidence for the wider population supports the use of Varenicline as a first-line intervention if clinically appropriate. 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.
- Patients should be encouraged to access smoking cessation services available at their pharmacy or by contacting NHS Borders Quit4Good on 01835 825971.

Harm reduction for tobacco smoking

- 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 cigarettes with other sources of nicotine. This could be in the form of patches or gum for some of the day or use of other replacements such as e-cigarettes*.

*While there is no evidence to show there are likely to be additional long-term harms caused by e-cigarettes (and from the chemical agents used alongside the nicotine), there are no long-term studies to assure the safety of this.

Multiple dependencies

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. Common drug misuse scenarios leading to failure to benefit from treatment are outlined in **table 1**, together with their risks and some proposed responses.

Heavy drinking on top of OST

- The risks of prescribing (and supplying) opioids for heroin dependence alongside high levels of alcohol use need to be balanced against the benefits of retaining the patient in and on treatment. It could be riskier for patients if they are not provided with a continued, stable dose of OST.
- Because of the protective effect of tolerance to opioids as a protection against respiratory depression, there is unlikely to be any advantage to keeping doses of OST low because of alcohol misuse.
- The more that the drinking behaviour is intertwined with drug misuse or dependence, the more the two are likely to need dealing with together, and they may require a more intensive intervention.
- If heavily-drinking patients are attending the pharmacy, it is important to communicate relevant aspects of the treatment plan to the pharmacist in advance. There is no contraindication to providing OST to a patient who has simply been drinking. Strategies to deal with situations of gross intoxication and significant impairment should be agreed in advance and the patient informed that in these circumstances supervised or take-home doses will not be dispensed. Good communication with the dispensing pharmacist is essential

Using a breathalyser

- Regular use of breathalyser readings may be useful in monitoring the amount of alcohol recently consumed and in assisting patients to reduce their use.
- Because of widely varying tolerance levels between individuals, careful interpretation and use of breathalyser readings is needed. No single breathalyser level has been identified that reflects definite severe impairment or substantial acute risk from alcohol intoxication.
- A risk assessment should be completed, an individualised care plan drawn up and target breath alcohol levels set.

Multiple assisted withdrawals from alcohol and from other drugs.

- Polypharmacy for patients with alcohol and other drug dependence should be minimised and consideration given to the order in which to address withdrawal from multiple substances.
- The dose of substitute opioids on which the patient has already stabilised should be maintained until detoxification from alcohol (and any sedative-hypnotic) has been completed. Only then should opioid detoxification start.
- It is recommended to carry out detoxification from one substance at a time. When a patient plans to become abstinent from all substances including opioids, it is normally recommended first to focus on detoxification from alcohol and then from sedative-hypnotics (such as benzodiazepines) if they are also a problem.
- However, if after suitable discussion, a patient opts to detoxify from opioids first, this should be supported, while monitoring for and managing the risk of deterioration in alcohol or other drug use.

Continued drug use

- Patients continuing to use illicit opioids “on top” of their OST need to be assessed on a case by case basis. A risk assessment is key and if the patient’s safety is not at risk of ongoing drug use it will generally be in the patient’s best interest to persist with treatment.
- Adequate doses of replacement opioid required for a positive outcome are usually higher than those that eliminate withdrawal signs.
- Random drug testing as part of an individualised care plan provides an opportunity to reflect back to the patient real evidence of good or continuing poor progress and to share information about the risks and about the concerns of use on top of the prescribing, whether that relates to heroin or other drugs and alcohol. This can be combined with regular injecting site examination, observation for intoxication and assessment of wellbeing and progress.

- ❖ Persistent failure to benefit from treatment should trigger a full review and the patient informed of the risks and consequences of continued chaotic drug use whilst established on OST. The patient must be actively engaged in the process to identify and address their difficulties and risks and the continuation of OST be subject to agreed strategies and goals

Table 1, Responses to drug and alcohol misuse on top of an opioid prescription

Scenario	Risk	Possible response
Alcohol or benzodiazepine misuse on top of an opioid prescription	Overdose or 'near misses' Drug interactions Alteration of methadone metabolism Deterioration of hepatic functioning in those with hepatitis C Street drinking Intoxicated presentations	• Review evidence of alcohol/benzodiazepine dependence and the need for alcohol-focused keyworking support and/or assisted withdrawal • Increase frequency of keyworking and psychosocial interventions and medical review • Reintroduce daily supervised consumption, carefully titrating up the proportion supervised as appropriate, and agree the progress needed before relaxing the arrangements • Do not reduce opioid dose simply because of alcohol/benzodiazepine use but review opioid tolerance and any evidence of opioid intoxication • Consider whether breathalyser testing can be useful in monitoring progress (e.g. to confirm no evidence of recent alcohol use).
Opioid misuse on top of an opioid prescription.	Overdose Blood-borne viruses and other infections if injecting Continued offending and involvement in drug misusing lifestyle Impaired engagement	• Increase dose, if inadequate • Divide dose, in addition, if fast metaboliser • Offer to change OST medication • If patient on reducing regimen, re-stabilise patient on higher dose and review support and patient goals • Reintroduce daily supervised consumption, carefully titrating up the proportion supervised if appropriate, and monitor successful progress before relaxing this arrangement • Consider increase in other psychosocial interventions (e.g. increase frequency of keyworking and motivational support or medical review and/or provide more formal contingency management) • Ensure access to safer injecting advice and supplies • Reinforce advice and support for overdose prevention • Confirm suitability of medication collection and review arrangements.
Crack cocaine and cocaine misuse on top of an opioid prescription	Blood-borne viruses and other infections if injecting More chaotic drug misuse Increased crime Psychological problems Overdose	• Confirm adequate stability on current dose of OST • Increase frequency of keyworking or other psychosocial interventions • Ensure access to safer injecting advice and supplies • Review understanding of overdose risk and reinforce advice on reducing risk • Review for any comorbid mental health problems • Review level of instability and possible need for daily supervised consumption of OST.

Drug misuse and dependence: UK guidelines on clinical management. Update 2017. Chapter 4, p109

Prescribing Protocols

Missed Doses

- When medication doses are missed for **three or more consecutive days** tolerance to opioids may be reduced, placing patients at increased risk of overdose when recommencing medication.

- The dose should be withheld or reduced until the patient has been assessed or telephone advice sought from the prescriber.

- The patient should be assessed for signs of withdrawal or intoxication before medication is recommenced.

- In general the following schedule can be presumed to be safe:

No. of days missed	Action
One or Two days	**No change in dose.** Normal dose may be taken if no evidence of intoxication.
Three or Four days	**Telephone advice must be obtained from prescriber.** Cancel existing prescription and commence new prescription. Recommended dose will usually be half current dose and retitration.
Five days or more	**Regard as new induction. Existing script must be stopped.** Bring situation back to weekly MDT meeting or, if requiring more urgent response, discuss with medical staff or nurse team leader.

Reinstatement of supervision

- If the situation occurs where supervised self-administration requires reinstatement the prescriber should have a frank discussion with the patient about whether they have been taking their prescribed dose.
- There must be clear documentation of this discussion and that the risk of overdose, were they not taking the full dose of prescribed OST, has been explained to the patient.
- If the prescriber still has concerns, the patient should be considered for retitration
    - Consideration can be given to split supervision, where a part of the dose is initially supervised with the rest taken away. The proportion of the dose being supervised gradually increased until the full dose is being supervised.
    - Example: patient has been prescribed 60mg of Methadone daily, unsupervised.
        - Supervision is reintroduced for 20mg, with the remainder dispensed. The amount supervised is increased by 10mg every 3 days until the whole dose is supervised.

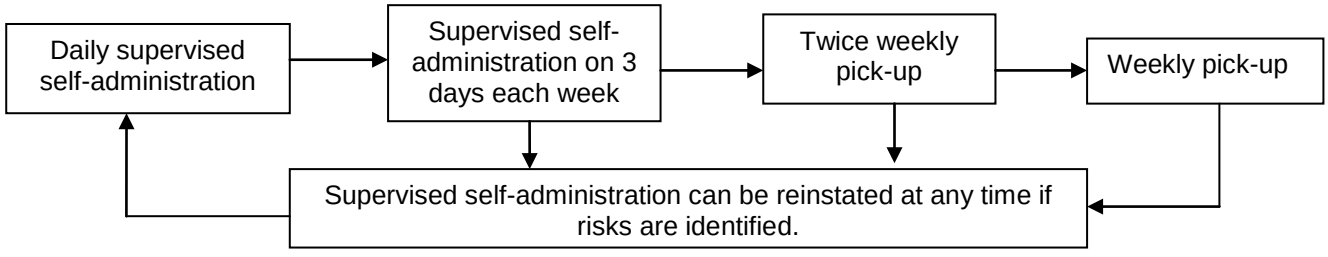
Supervised Self-Administration

- Supervised self-administration by an appropriate professional provides the best guarantee that a medicine is being taken as directed.
- Supervised self-administration is recommended initially and should continue for a length of time appropriate to the patient's individual needs and risks.
- It is also important that once the patient has stabilised he/she is trusted to accept some responsibility by the introduction of 'take-away' doses.
- Supervised self-administration enhances compliance, reduces the potential for sharing or selling medication, increases prescriber confidence in prescribing higher doses, ensures regular contact with healthcare professional and introduces routine as a result of daily attendance.
- There are also disadvantages such as inconvenience, difficulties for people in employment, difficulties for patients with child care issues, stigmatising patients receiving OST and reduced personal responsibility.
- Assessment of suitability for take-away doses should include consideration of the following criteria:

Indicators for supervised self-administration	**Indicators for take-away doses***
Recurrent failure to attend appointments and frequently missed doses	Regular attendance at appointments and pharmacy
Continued or return to unstable pattern of illicit substance, alcohol, benzodiazepine or other drug misuse	Negative drugs tests for illicit drugs (2-3 negative tests would generally be sufficient)
Relevant child protection concerns	No child protection concerns (e.g. **safe storage of medication available**)
Patient has not reached a stable dose	Patient prescribed adequate daily dose
Patient has significant, unstable psychiatric and/or physical morbidity or is threatening self-harm	No significant or destabilising psychiatric and/or physical morbidity.
Continued or returned concern that prescribed medication is being, or may be, diverted or used inappropriately.	Positive drugs tests for prescribed OST.
Homelessness and/or severe social instability	Evidence of stable home and social environment
Patient recommencing methadone or buprenorphine prescription or a significant increase in daily dose (>4mg/day for buprenorphine or >10mg/day for methadone).	

*If any of the indicators are not met the prescriber must justify a take-away dose decision.

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



There is often little value in supervision less than 3 times weekly.

Stopping Prescriptions and Attendance Protocol.

- It is occasionally necessary to suspend, cancel or initiate a phased reduction in a patient's prescription.
- A **suspension** is a temporary inactivation of the prescription so that the pharmacist cannot dispense the prescription without further advice from the prescriber. Indications for suspending prescription include:
    - Patient has missed three or more consecutive days at the pharmacy.
    - Missed appointment(s) with keyworker or prescriber without contact from patient.
    - Acute admission to hospital.
    - Patient on remand and no prison liberation date given.
    - Patient significantly intoxicated at appointment.
- Suspending a prescription is designed to encourage the patient to make contact with the prescriber in order to continue treatment. Failure to make contact within a reasonable period of time will usually result in cancellation of the prescription. Every effort should be made to track down the patient and appropriate services contacted. (Consider seeking ES Team support)
- Indications for considering cancellation of a prescription would include:
    - Unacceptable level of verbal or physical violence
    - Dealing drugs on the premises of any BAS clinic / drop in or community pharmacy
    - Defrauding (i.e. defacing or faking) opiate prescription
    - Recurrent failure to attend keyworking or medical appointments (after risk assessment and discussion with senior staff).
    - Convincing evidence of adulterating drug screens.
    - Obtaining prescriptions elsewhere for other opioid or sedative medications e.g. dihydrocodeine or benzodiazepines, without prior consultation and agreement of keyworker.
- There may also be cases where a patient's presentation, e.g. marked intoxication, requires an immediate cancellation or suspension of a prescription. It may be appropriate to continue to work with the patient to address issues such as alcohol dependence; this should be discussed with senior staff.
- If the patient continues to fail to benefit in any way from even minimum treatment goals they must be forewarned of the potential actions, such as a phased reduction of the prescription.
- The patient should be offered the opportunity to set new goals or identify contingencies that might influence progress from this point.
- A risk assessment must be carried out as permanent exclusion can put the patient at an increased risk of overdose death.
- If there are no pressing safety concerns, a rapid phased reduction could be initiated, reducing the dose usually by 10% each day. Though slower reductions can be considered if felt safe to do so, this can give opportunity for reengagement with the service.

Missed Appointments

- Regular attendance at appointments is a sign of engagement and progress. Failure to attend appointments should always be carefully assessed. Risk assessment must be completed to determine appropriate action.

Dose Administration Errors

- A patient who is dispensed an OST dose in excess of that prescribed is at risk of overdose.
- The critical issues which determine how clinicians should respond are the patient's level of tolerance, and the amount of OST given in error. **Methadone is greater risk than Buprenorphine.**

Overdose up to 50% of the normal dose:

- The pharmacist must advise the prescriber of the dosing error and record the event
- Advise the patient of the mistake and carefully explain the possible consequences
- Inform the patients about signs and symptoms of overdose and advise him/her to go to a hospital emergency department if any symptoms develop

Overdose greater than 50% of the normal dose:

- The pharmacist must contact the prescriber immediately
- Advise the patient of the mistake and carefully explain the possible seriousness of the consequences
- If it is decided by the prescriber that the patient requires hospitalisation, the reasons should be explained to the patient and they should be accompanied to the hospital to ensure admitting staff receive clear information on the circumstances.
- If the patient has left before the mistake is realised, every attempt must be made to contact the patient.

Patients in the first two weeks of methadone treatment:

- Patients in the first 2 weeks of treatment who receive an overdose of any magnitude require observation for 4 hours. If signs of intoxication continue more prolonged observation is required e.g. transfer to a hospital emergency department.

Patients on a dose greater than 40 mg a day for more than 2 months:

- This patient group will generally tolerate a dose double their usual amount without significant symptoms. For an overdose greater than this margin of error, the patient will require observation for at least 4 hours. If signs of intoxication are observed, more prolonged observation must be maintained.

Patients receiving regular takeaway doses, or irregular attenders:

- This patient group cannot be safely assumed to have been taking their daily dose and therefore their known level of tolerance is uncertain. Such patients require observation in the event of overdose of greater than 50% of their usual dose.

Caution regarding induced vomiting:

- Induced vomiting may be dangerous and is contraindicated if the patient has any signs of CNS depression.
- Even if the patient is able to induce vomiting this should not alter a decision to seek further medical intervention or observation, as it is not possible to ascertain how much of the dose has been eliminated.

Holiday prescriptions

- OST is designed to help patients move away from substance misusing lifestyles and should aim to facilitate people going on holiday.
- However, for patients at an early stage in their treatment and/or with continued drug misuse a take-away prescription would add to the risks associated with treatment.
- Each case should be considered on an individual basis, but a general pattern of drug tests appropriate to the prescription and good attendance at appointments will be expected prior to going on holiday.
- If the holiday is in the UK it is the patient's responsibility to identify a pharmacy near the holiday destination which will agree to continue with the usual dispensing requirements (e.g. supervision).
- For holidays abroad patients should provide proof of flights* and accommodation when requesting a holiday script.
- A personal export licence for controlled drugs is not required for persons travelling for less than 3 months.
- The Home Office advises that the patient should carry a letter from the prescribing doctor or drug worker confirming the patient's name, travel itinerary, names of prescribed controlled drugs, dosages, total amounts being carried and signature of prescriber. See: https://www.gov.uk/travelling-controlled-drugs
- It is also advisable to carry a letter for any other medication.
- Other countries may have their own regulations for controlled drugs and prescription medicines. International rules vary and the patient should contact the embassy for each country being visited. See: https://www.gov.uk/government/publications/foreign-embassies-in-the-uk
- Key workers must ensure the safe storage of medication whilst away; particularly in respect to child protection.
- **Usually 28 days notice is required to organise prescriptions.**
- **The service will not agree to holiday prescriptions where this is not considered to be clinically appropriate and is judged to potentially increase risk.**
- If a holiday is cancelled the patient should inform the service, dispensed drugs should be returned to the pharmacy and pre-existing dispensing resumed.

* The restrictions on the quantity of liquid allowed into the cabins of commercial aircraft mean a patient on Methadone may be unable to travel safely with sufficient Methadone solution for more than a day. Methadone tablets may need to be provided, off licence, for longer trips if checked baggage is not available.

Drug Testing

Urine testing – can show drug use over the past several days and is non-invasive. Urine specimens may be adulterated, substituted, or prone to pre-collection that may produce misleading results

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, less easy to adulterate.

Drug testing is used for

- Initial assessment and confirmation of drug use.
- Confirming compliance with opioid replacement therapy
- Monitoring illicit drug use and providing an opportunity to reflect back to the patient real evidence of progress, or lack of progress, during treatment.

The following guidance is offered:

- Self reported use should be considered with equal status as drug test results, and recorded as such.
- Self reported use should be confirmed, on occasion, with drug testing.
- Patients in the maintenance phase should have at least 2 drug tests per year.
- When patients present intoxicated a full drug screen should be requested, either urine or oral fluid sent to the lab.
- "Instant" urine drug test kits are neither as accurate, nor test for as wide a range of substances as lab samples.
    - "Instant" tests should be used when a result on the day will alter a clinical decision that needs to be made.
    - **Lab samples are preferred** for monitoring and should be used where a result is not required on the day.
    - An "instant" urine test, with the same sample also sent on to the lab should only be done where there is a clear clinical reason, for example requiring a result to start OST, but also wishing to screen for illicit benzodiazepines or gabapentinoids, that may not be detected by the "instant" test. **This should not be routine practice.**

References:

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2. Drug misuse and dependence: UK guidelines on clinical management [Internet]. GOV.UK. [cited 2021 Jun 21]. Available from: https://www.gov.uk/government/publications/drug-misuse-and-dependence-uk-guidelines-on-clinical-management
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4. Bruce RD, Altice FL. Case Series on the Safe Use of Buprenorphine/Naloxone in Individuals with Acute Hepatitis C Infection and Abnormal Hepatic Liver Transaminases. Am J Drug Alcohol Abuse. 2007 Jan 1;33(6):869–74.
5. Gowing L, Farrell MF, Ali R, White JM. Alpha2-adrenergic agonists for the management of opioid withdrawal. Cochrane Database Syst Rev. 2014 Mar 31;(3):CD002024.

Appendix 1 **Preparation for detoxification**

The following is aimed at helping the patient and keyworker draw up a comprehensive care plan during the preparatory process for detoxification and for aftercare:

Patient Name	Keyworker	Date
1. What lessons have you learnt from previous treatment, detoxification and relapse prevention programmes?		
2. What are your expectations at the end of detoxification		
3. List the high risk situations/triggers for craving which could lead to relapse into drug taking?		
As you reduce the dose of opioid you will lose your tolerance to drugs and any relapse into drug taking will put you at risk of an overdose.		
4. List the skills you have developed and activities you have engaged in to manage cravings and other painful emotions without using drugs.		
5. What is your plan to recognise, challenge and avoid unhelpful thoughts and high risk situations that might lead to a relapse?		
6. What services or individuals are supporting you during and after detoxification?		
7. What are you looking forward to achieving after detoxification?		

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.

<table>
<tr><td colspan="2">Patient's Name:_____ Date and Time ____/_____/____:_____

Reason for this assessment:_____</td></tr>
<tr><td>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</td><td>GI Upset: over last ½ hour
0 no GI symptoms
1 stomach cramps
2 nausea or loose stool
3 vomiting or diarrhea
5 Multiple episodes of diarrhea or vomiting</td></tr>
<tr><td>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</td><td>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</td></tr>
<tr><td>Restlessness Observation during assessment
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</td><td>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</td></tr>
<tr><td>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</td><td>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</td></tr>
<tr><td>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</td><td>Gooseflesh skin
0 skin is smooth
3 piloerrection of skin can be felt or hairs standing up on arms
5 prominent piloerrection</td></tr>
<tr><td>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</td><td>Total Score _____
The total score is the sum of all 11 items

Initials of person
completing Assessment: _____</td></tr>
</table>

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