

# **FIRST STAGE REPORT**

## **SUBSTITUTE PRESCRIBING IN AYRSHIRE AND ARRAN**

**A REPORT ON THE SUBSTITUTE PRESCRIBING  
SERVICE PROVIDED TO RESIDENTS OF EAST,  
NORTH AND SOUTH AYRSHIRE**

**BY**

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AYRSHIRE AND ARRAN  
ALCOHOL AND DRUG ACTION TEAM**

**September 2003**

**EXECUTIVE SUMMARY AND RECOMMENDATIONS**

A rapid review of the substitute prescribing service in Ayrshire and Arran shows that the programme has expanded rapidly with a disproportionate increase in pharmacy dispensings and supervisions. The programme as currently designed is stretching capacity of all services. Methadone maintenance and detoxification models which are more clinically and cost-effective are available, with greater engagement of general practitioners forming a cornerstone of these.

The review makes the following recommendations:

- A more robust study of the totality of addiction services should be undertaken in a realistic timescale and drawing on the work from existing reviews, particularly noting the views of service users (5.2)
- The substitute prescribing programme should encompass methadone maintenance and detoxification (5.2)
- The programme should include progression to throughcare and after care services (5.3)
- The capacity of community pharmacies to dispense and supervise methadone treatment should be increased (5.5)
- The requirement for supervision should be evidence based (5.5)
- Alternative methods of supervision and testing should be assessed (5.5, 5.12)
- The substitute prescribing protocol should be re-written in line with current best practice (5.12)
- The range of available psychosocial services including throughcare and aftercare should be reviewed and appropriate arrangements made (5.13)
- Integrated care pathways based on the principles of shared care should be developed (5.14)
- The revised programme will offer methadone maintenance as a mainstay of treatment for a standard minimum period (5.16)
- The planned programme will be linked to psychosocial services, urine testing and daily dispensing (5.17)

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## INTRODUCTION

1.1 In June 2003, as a result of increasing expenditure, a move was made to limit access to the substitute prescribing programme run in Ayrshire and Arran to three prioritised categories. This move was not universally favoured or accepted and the Ayrshire and Arran Alcohol and Drug Action Team (ADAT) determined to review the substitute prescribing service. It commissioned a sub-group to undertake this work.

1.2 The task remitted, as set out in the minutes of the ADAT meeting of 25<sup>th</sup> June, was:

To conduct a cross-agency option appraisal with the aim of re-designing the service to reduce costs and increase the number of clients to be treated by 10% per year.

This will include an examination of:

- Current problems
- Differentiate demand and associated costs between new and maintenance clients
- Audit of all cross agency costs, including comparison with other Board areas
- Effectiveness and efficiency of cross agency services
- Current adherence to agreed protocols
- Changes to protocols required
- Basis for projection of increased demand and capacity required for future
- Recommendations to achieve 10% increase in clients being treated within current budget allocations
- Timescales for the implementation plan

1.3 The sub-group met on three occasions and consisted of:

Dr Maggie Watts, Department of Public Health, Ayrshire and Arran NHS Board (Chairman)

Ruth Shepherd, Co-ordinator, ADAT

Sharon Hackney, Drug Development Officer, ADAT Support Team

Jo Murray, East Ayrshire Community Addiction Concerns / Bridge Project

Fiona McKinnon, Social Services, East Ayrshire Council

Frances Rodger, Scottish Drugs Forum

Fiona Neilson, Finance Dept, Ayrshire and Arran NHS Board

Iain MacLeod, Finance Dept, Ayrshire and Arran Primary Care Trust

Liz Sneddon, Social Work, North Ayrshire Council

Marnie Hodge, HMP Kilmarnock

Pat Lerpiniere, Addiction Services, Ayrshire and Arran Primary Care Trust

Dr Charles Lind, Associate Medical Director, Ayrshire and Arran Primary Care Trust

Allan Thomas, Pharmacy and Prescribing Team, Ayrshire and Arran Primary Care Trust

Dr Niall Mackie, GP prescriber, Cumnock

Diane Page, Social Work Department, South Ayrshire Council

- 1.4 It established principles of working, recognising that the review needed to be service user-focussed, address the substitute prescribing service and seek to incorporate the views of service users and carers.
- 1.5 The review is intended to be:
- inclusive
  - open and transparent
  - evidence based
  - underpinned by NHS Ayrshire and Arran's core values including making best use of resources, reducing inequalities and working well with others.
- 1.6 Based on the remit, the sub-group established its key aims as:
- conducting an evaluation of the community substitute prescribing service in Ayrshire and Arran, encompassing clinical and cost-effectiveness
  - making recommendations for the future provision of the services to enable an increase in clients of 10% per annum
  - planning for future services derived from these recommendations.

## 2. BACKGROUND

2.1 Historically, moral and political judgements about drug dependence have influenced treatment systems. Treatment options available cover withdrawal, harm reduction including stabilisation, abstinence, and relapse prevention approaches. The aim of treatment services is to enable people with drug problems to overcome them and live healthy and crime-free lives<sup>1</sup>. The current Scottish objectives are to:

- reduce the health risks to individuals and communities from drug misuse, and related infectious diseases
- increase the number of drug misusers becoming, and remaining, drug free, and promote their inclusion in society
- reduce the incidence of injecting, sharing and polydrug misuse among drug misusers
- reduce the number of drug related deaths
- increase the proportion of drug misusers in contact with services, including those in prison, through the development of good, accessible, responsive and effective services
- reduce the number of drug misusers who have no quick access to appropriate treatment.

### *Substitute prescribing*

2.2 Substitute prescribing can be defined as ‘the use of a drug substitute for a drug of dependence.....The substance will be legal, safer and easier to manage clinically in treatment than the drug of dependence’<sup>2</sup>.

2.3 Substitute prescribing programmes for opiate dependent drug users offer a package of care which includes the prescription of medication designed to replace the illegal street drug(s). They may encompass detoxification, stabilisation and maintenance. Programmes have been in place in Great Britain for around 20 years, and in Ayrshire and Arran since 1989.

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<sup>1</sup> The Scottish Office. Tackling Drugs in Scotland: Action in Partnership. Edinburgh: The Scottish Office, 1999

<sup>2</sup> Effective Interventions Unit. The effectiveness of treatment for opiate dependent drug users. EIU, 2002

- 2.4 Methadone is a synthetic opioid used in the treatment of drug dependence. It relieves craving for opiates, blocks the euphoric effect of additionally used heroin and has a long half-life enabling once-daily dosage. It is the commonest drug used in substitute prescribing programmes. Other drugs used include buprenorphine, naltrexone, naloxone and dihydrocodeine.
- 2.5 In Ayrshire the most frequent drug used in the substitute prescribing programme is methadone, but, as stated above, other drugs are available and used according to the clinical needs of the individual service user.

### *The Scottish perspective*

- 2.6 In Scotland, the aims of treatment for drug misuse and dependence are set out in joint Department of Health guidelines<sup>3</sup> as to:
- assist the patient to remain healthy, until, with appropriate care and support, he or she can achieve a drug-free life
  - reduce the use of illicit or non-prescribed drugs by the individual
  - deal with problems related to drug misuse
  - reduce the dangers associated with drug misuse, particularly the risk of HIV, hepatitis B and C, and other blood-borne infections from injecting and sharing injecting paraphernalia
  - reduce the duration of episodes of drug misuse
  - reduce the chance of future relapse to drug misuse
  - reduce the need for criminal activity to finance drug misuse
  - reduce the risk of prescribed drugs being diverted onto the illegal drug market
  - stabilise the patient where appropriate on a substitute medication to alleviate withdrawal symptoms
  - improve overall personal, social and family functioning.
- 2.7 The guidelines consider the aim of substitute prescribing as the prevention of withdrawal symptoms and the reduction or elimination of non-prescribed drug

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<sup>3</sup> Department of Health. Drug misuse and dependence: guidelines on clinical management. London: HMSO, 1999

use. They recognise that substitute prescribing may have several impacts including:

- reducing or preventing withdrawal symptoms
- offering an opportunity to stabilise drug intake and lifestyle whilst breaking with previous illicit drug use and associated unhealthy behaviours
- promoting a process of change in drug taking and risk behaviour
- helping to maintain contact and offering an opportunity to work with the patient.

2.8 The guidelines also recognise the multi-disciplinary approach to treatment and encourage the development of primary care treatment for drug users. This has led to an expansion of primary care treatments across a range of services including within general practice and shared care schemes.

2.9 This approach is also highlighted in Scotland's Action Priorities<sup>4</sup>. These state the priorities of providing effective shared care arrangements and integrated drug misuse services, including substitute prescribing of oral methadone, with proper project management linking together a comprehensive range of services and taking into account the views of users.

2.10 Established in 2000, the Effective Interventions Unit of the Substance Misuse Division at the Scottish Executive aims to identify and disseminate effective practice to support the implementation of the drug misuse strategy. It has recently produced reports on the effectiveness of treatment for opiate dependent drug users - an international systematic review of the evidence<sup>5</sup>, and a survey of NHS services for opiate dependents in Scotland<sup>6</sup>. This review has drawn on the evidence base of the international review and the current practice and expert opinions given in the survey.

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<sup>4</sup> The Scottish Office. Tackling Drugs in Scotland: Action in Partnership. Edinburgh: The Scottish Office, 1999

<sup>5</sup> Effective Interventions Unit. The effectiveness of treatment for opiate dependent drug users. EIU, 2002

<sup>6</sup> Effective Interventions Unit. A survey of NHS services for opiate dependents in Scotland. EIU, 2002

### 3. METHODOLOGY

- 3.1 The review was conducted using a combination of methods. These included:
- the establishment of a gold standard or benchmark
  - identification of local protocols for benchmarking
  - data collection, analysis and presentation about services covering service, prescribing and financial information.
- 3.2 A literature review was undertaken to:
- a) identify a gold standard for substitute prescribing programmes
  - b) identify expected costs and benefits of treatment
  - c) seek models of good practice and their evaluation.
- This was conducted with support from the librarian at NHS Ayrshire and Arran.
- 3.3 The local protocol in use was identified and used to derive a pro-forma for local interviews. Sites of substitute prescribing were identified; these were across Ayrshire and used multi-agency multi-professional approaches. Structured interviews were undertaken with project leaders, service managers and selected prescribers. Time constraints have prevented interviews with service users and carers, GPs including prescribers, and pharmacists. This work requires to take place. The views of the local advisory committees for general practice and for pharmaceutical services will also be sought.
- 3.4 Aggregated financial, prescribing and service user information was accessed from the Addictions Database, Prescribing Database and Primary Care Trust finance department. Additional information was obtained from the service providers and the monitoring system held by the Addictions Service.
- 3.5 Comparative information was sought from other NHS Board areas on substitute prescribing services provided and their effectiveness. Electronically accessible information from the Information and Statistics Division of the Scottish Executive was used to support, supplement and validate the various information sources.

## 4. FINDINGS

### *Data trawl*

4.1 A preliminary data trawl, based on the task remitted, indicated the need to be clear whether the review addressed substitute prescribing as a whole or the methadone prescribing element. The Pharmacy and Prescribing Team held detailed figures for methadone costs and dispensing which reflected monthly activity. The financial systems information provided substitute prescribing costs covering drugs and dispensing, but was based on a claims system with an associated timelag and potential for distortion. It was therefore determined that the majority of the report would relate to the methadone programme, with reference as necessary to the substitute prescribing programme within which it is subsumed.

### *Literature review*

4.2 There is a wealth of high quality literature in the field of methadone programmes.

4.3 The systematic review of the evidence of the effectiveness of treatment for opiate dependent drug users<sup>7</sup> conducted by the Effective Interventions Unit, whilst not offering a gold standard for services, did provide primary and secondary outcome measures. These are:

#### *Primary outcomes*

- abstinence from opiate use
- reduction in illicit opiate use
- withdrawal severity
- retention in treatment

#### *Secondary outcomes*

- employment status
- housing status
- education
- crime rates

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<sup>7</sup> Effective Interventions Unit. The effectiveness of treatment for opiate dependent drug users. EIU, 2002

- quality of life
- level of injecting.

- 4.4 The literature can be divided into that identifying community maintenance programmes and that on community detoxification programmes. There was little on the combination of the two; those that were found were on the combination of maintenance followed by detoxification.
- 4.5 For community maintenance, it is clear that programmes can be effective at reducing use of illicit drugs and maintaining people in treatment. Methadone is the commonest drug used, and higher doses (above 50mg/day) appear associated with better outcomes. Methadone maintenance is associated with greater retention in treatment, less heroin use (although a significant number of users continue to use illicit opiates) and less criminal behaviour<sup>8</sup>. Treatment can be carried out effectively in primary care settings combining prescribing programmes and psychosocial services<sup>9</sup>.
- 4.6 Detoxification programmes vary widely, both in drugs used and in length of programme. Detoxification programmes using methadone alone tend to have high drop out and relapse rates<sup>10</sup>. In terms of the effectiveness of methadone services, much of the literature is North American and its applicability to the UK's care systems is debatable. However there are some Scottish cost studies of the feasibility of methadone maintenance in general practice<sup>11</sup>.

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<sup>8</sup> Sees KL, Delucchi KL, Masson C et al. Methadone maintenance vs 180 day psychosocially enriched detoxification for the treatment of opioid dependence. *Journal of the American Medical Association* 2000, vol 8, no 10, 1303-1310

Farrell M, Ward , Mattick R et al. Fortnightly Review: methadone maintenance treatment in opiate dependence: a review. *British Medical Journal* 1994, vol 309, 997-1001

Gossop M, Marsden J, Stewart D. NTORS after five years: changes in substance use, health and criminal behaviour during the five years after intake. London: Department of Health, 2001

Hutchinson SJ, Taylor A, Gruer L et al. One year follow-up of opiate injectors treated with oral methadone in a GP-centred programme. *Addiction* 2000, vol 95, no 7, 1055-1068

<sup>9</sup> Kraft MK, Rothbard AB, Trevor R et al. Are supplementary services provided during methadone maintenance really cost-effective? *American Journal of Psychiatry* 1997, vol 154, no 9, 1214-1219

<sup>10</sup> Dawe S, Griffiths P, Gossop M, Strang J. Should opiate addicts be involved in controlling their own detoxification? A comparison of fixed versus negotiable schedules. *British Journal of Addiction* 1991, vol 86, 977-982

<sup>11</sup> Wilson P, Watson R, Ralston GE. Methadone maintenance in general practice: patients, workload, and outcomes. *British Medical Journal* 1994, vol 309, 641-644

- 4.7 Most methadone programmes have planned and random urine testing for opiates as an integral part of service delivery. Urine testing is qualitative and aims at identifying whether the service user is 'topping up' with illicit opiates (either from deliberate choice or from necessity to prevent breakthrough withdrawal symptoms) and whether they are consuming the prescribed methadone. Urine testing appears to be expected and well accepted by service users and is usually carried out by relevant project workers.
- 4.8 The original protocol with assessment, prescribing, urine testing, reviews and psychosocial support over an indefinite period has a robust evidence base. However, the change to a double detoxification programme followed by maintenance does not appear to be strongly underpinned by research evidence.

*Substitute prescribing in Ayrshire and Arran*

- 4.9 There is documentary evidence of substitute prescribing facilities in Ayrshire and Arran since 1989. These were based on the principles of harm reduction and multi-agency working.

*Previous reports and recommendations*

- 4.10 The provision of substitute prescribing in Ayrshire and Arran has been examined and documented in 3 distinct reports, each in response to pressures in capacity.

Methadone Use in Ayrshire (undated) Addictions Services, Community Trust

- 4.11 In 1997-98 activity levels were agreed at 450 clients. By December 1997 actual activity had reached 598 people on the methadone programme with no sign of demand decreasing. Financial and human resource constraints led to the programme being closed in April 1998, re-opening in January 1999 following restructuring of the programme into detoxification prior to maintenance regime. This restructuring focussed on structure and process. It was estimated that the total clientele would reach 1000, with the maintenance group stabilising at around 700 and 300 passing through detoxification programmes at any one time.

Methadone Prescribing- Needs Assessment (1999) Ayrshire and Arran Health Board

- 4.13 This study was commissioned by the Public Health Department of the Health Board and was carried out by the Centre for Health and Social Research. It recommended greater involvement of GPs and better interagency liaison.

Review of the Methadone Dispensing/Supervision programme (2001) Pharmacy, Primary Care Trust

- 4.14 This paper highlighted the need to examine the arrangements for the dispensing of methadone by community pharmacists as well as a range of different models of service provision.

***Current model of service delivery***

*Protocol*

- 4.15 All projects identified a single protocol in place, with a core component and flexible elements across the area. This protocol notes that the general practitioners in Ayrshire and Arran have been reluctant to become involved with the Scottish Office (now Scottish Executive) recommended shared care model. It identifies a model of care that uses a small number of general practitioners to support sessional prescribing clinics at three of the five addiction agencies. Two consultants support the remaining two sites. All methadone prescribing is therefore undertaken under the auspices of the Primary Care Trust (PCT).
- 4.16 The protocol provides for a harm reduction approach using multi-agency working. It identifies a range of benefits that can arise from the prescription of methadone under specific conditions. The conditions are:
- the provision of high quality Rogerian-style (client-centred) counselling
  - access to a wide range of varying interventions ranging from relapse management based cognitive-behavioural techniques to increased leisure options
  - an emphasis on harm reduction
  - a de-emphasis both of abstinence as a goal and detoxification as a universally applicable intervention

- a problem-oriented approach which recognises that ideas of ‘success’ are not simply confined to improvements in drug usage but encompass all other areas of the service user’s life.

4.17 The benefits cover:

- a reduction in illicit opiate use
- a reduction on other illicit drug use
- a stabilising of the level of drug use overall and a reduction in its attendant problems
- a reduction in the transmission of those infectious diseases associated with illicit drug use, especially HIV/AIDS and Hepatitis B and C
- a general improvement in the service user’s health in both physical and psychological terms
- an overall improvement in all areas of social functioning
- a reduction in drug-related deaths
- a reduction in drug related criminality and violence
- a reduction in the disproportionate use of medical, social and police services.

4.18 The process set out in the protocol is service user-based and begins with the referral of the service user to one of five identified addiction agencies where, following an adequate period of assessment, onward referral to the prescribing clinic will be made if this is considered appropriate. The appropriateness is assessed on the extent to which the benefits outlined above can be achieved for the individual service user, demonstration of physical dependency and the potential for harm. At the prescribing clinic, an initial assessment should include urine toxicology and a physical examination if indicated, before the receipt of a prescription for daily dispensing with supervision. At this time an agreement will be made between the service user, addiction agency and the pharmacy.

4.19 The service user will be aided by the prescriber and clinic staff to find a community pharmacist willing to take on the regular dispensing and supervision of administration of methadone.

4.20 Regular attendance for reviews by the prescriber and for services such as relapse management, advice and support with the addiction agency are an integral part of the agreement. Contingency arrangements are in place for non-attendance and for the management of allegations of selling methadone. The protocol indicates the continuance of prescribing after a three month review and six monthly prescribing reviews thereafter.

4.21 From January 1999, all new service users presenting for substitute prescribing have been offered a six-month structured detoxification programme. Service users are only considered for maintenance prescribing following two unsuccessful detoxification programmes with a three month interval between the two.

*Detoxification programme*

4.22 This programme was originally structured as follows:

Initial three months - stabilisation of methadone dose

Second three-months - pre-contracted detoxification, unchanged once started

For both of these elements, participation in counselling and psychosocial support was required.

4.23 In addition to this process, a number of conditions were established for participation in the programme:

- all dispensing of methadone supervised on a daily basis
- service users discharged from the programme should they miss three appointments with their key worker
- a second detoxification programme commencing six months after discharge from the previous programme.

4.24 After around 18 months of operation, the programme was changed to include an option for nine-month detoxification. In addition, the period between the first and second detoxification programme was reduced to three months. Urine testing requirements were originally included in the programme but were later omitted.

*Maintenance programme*

- 4.25 In April 1999, alongside the detoxification programme, a revised maintenance programme was established. This accepted service users only after two attempts at detoxification and following a period of six months. The maintenance programme was aimed at harm reduction with service users receiving prescriptions and attending for advice and support on a regular basis and is open-ended.
- 4.26 After around 18 months of operation, the maintenance programme was changed to enable immediate entry after the second detoxification programme i.e. there was no gap between detoxification and maintenance.

*Local structures**Support service*

- 4.27 Substitute prescribing is delivered through the community addiction projects of the Bridge Addiction Service and North Ayrshire Council Social Work. The Bridge Addiction Service is a non-statutory agency with three service bases – in Cumnock and Kilmarnock (East Ayrshire) and Ayr (South Ayrshire). The Social Work Department of North Ayrshire Council runs the Vernon and Townhead Centres in Saltcoats and Irvine respectively. The substitute prescribing programme is one arm of the work carried out by the community addiction projects although it appears to dominate the remainder of the service. There is a medical officer linked to each project who undertakes the prescribing.
- 4.28 There are two other pan-Ayrshire services to which clients can be referred and receive substitute prescribing – the Harm Reduction Service for more complex addiction problems and the dual diagnosis service for people with mental health and drugs issues. In addition, the home detoxification service (rapid detoxification) is available.

*Pharmacies*

- 4.29 Across Ayrshire and Arran, 74 pharmacies out of 89 have agreed to undertake the dispensing of methadone with or without supervision. Pharmacies with

spare capacity for supervision of methadone are not evenly spread across the three local authority areas, with capacity nearly reached in East and South Ayrshire (Table 1). North Ayrshire still has capacity, but this is mainly located in Arran.

**Table 1 -Pharmacy places for supervised administration of methadone in Ayrshire and Arran, December 2002**

Area	Number of users supervised	Maximum capacity for supervised administration
Three Towns	86	113
Irvine, Kilwinning, Dundonald	102	129
Arran	1	30
Garnock Valley	19	20*
Skelmorlie, Largs	10	50
Ayr, Preswick, Troon	122	150
Maybole	5	5
Tarbolton, Mossblown	16	23
Coylton	0	0
Girvan	23	40
Kilmarnock, Crosshouse	151	177
Irvine Valley <sup>1</sup>	54	63
Cumnock & Doon Valley <sup>2</sup>	96	115
Mauchline, Catrine	12	14

\*1 pharmacy no maximum limit

\*\*2 pharmacy no figure for maximum limit

<sup>1</sup> Irvine Valley includes: Hurlford, Stewarton, Galston, Newmilns, Darvel

<sup>2</sup> Cumnock and Doon Valley includes: Cumnock, New Cumnock, Auchinleck, Ochiltree, Muirkirk, Patna, Dalmellington, Drongan

Source: PCT

*Service information*

4.30 Information about the services available and the service users accessing these is set out below.

*Service Users*

4.31 The number of service users receiving methadone prescriptions has risen significantly over the years (Table 2). Growth across Ayrshire from 1999/00 to 2002/2003 has been 57%.

**Table 2 - Number of service users starting methadone prescriptions in Ayrshire and Arran by community drug project, 1999-2003**

Service	1999-2000	2000 - 01	2001-02	2002-03
Bentinck Centre	23	27	72	110
Ayr Bridge	181	220	251	276
Cumnock Bridge	147	179	185	201
Kilmarnock Bridge	191	203	228	278
Townhead Centre	103	120	127	154
Vernon Centre	112	136	154	171
<b>Total</b>	<b>757</b>	<b>885</b>	<b>1017</b>	<b>1190</b>

Source: Prescribing Database

*Staffing*

4.32 There are different staffing structures in the different agencies. Consequently, direct comparison between providers is not possible. However, the overall staffing levels provide an indication of the distribution of the service and the average caseload for each worker is similar across the agencies. Table 3 sets out this information.

**Table 3 – Community Addiction Project Staffing in Ayrshire and Arran, June 2003**

	Employees	Volunteers	Average caseload	Medical input
<b>East Ayrshire</b>				
Bridge (Kilmarnock)	5+ 0.5WTE	2	30-35 Community drug worker (CDW) 55 project worker 139 support worker	1x weekly clinic consultant 1x weekly clinic SHO
Bridge(Cumnock)	4+ 2x0.5WTE	0	35 CDW 55 project	1x weekly clinic GP prescriber 1x weekly clinic SHO
<b>North Ayrshire</b>				
Townhead	9	0	45-50	1x weekly clinic GP prescriber
Vernon	9	0	45	1x weekly clinic GP prescriber
<b>South Ayrshire</b>				
Bridge (Ayr)	8 core 6 external	1	37 (range from 8- 114)	1x weekly clinic consultant 1x weekly clinic SHO

Source: Interview data

*Waiting times*

4.33 Table 4 provides a snapshot picture of recent waiting times and service user numbers in the local projects.

**Table 4 Service user activity, waiting lists and times during 2003**

	New referrals	Service users on detox	Service users on maintenance	Number on waiting list	Waiting time
Bridge Ayr *April – June 03	58	64	222	42	6+ months
Bridge Cumnock *April – June 03	39	43	132	0	1-2 weeks
Bridge Kilmarnock *April – June 03	84	83	220	110	6 months
Vernon *June – August 03	48	71	76	24	0-3 months
Townhead July 03	62	44	83	15	4-6 weeks

Source: Bridge Project; Social Work Services NAC

***Prescribing Information***

- 4.34 Methadone mixture 1mg/ml is the principal formulation of methadone used for substitute prescribing, which is also its primary use. On occasion it may be used to control symptoms in palliative care, but this volume is so small as to be insignificant in Ayrshire.
- 4.35 There is no legal provision for dispensing of methadone outwith registered pharmacies. However supervision of administration may be undertaken by a range of staff.

***Drug costs***

- 4.36 The pharmacy providing methadone is entitled to reimbursement of the cost of the drug, as with all medications prescribed. This cost is recorded in Ayrshire in two ways:
- Within the Pharmacy and Prescribing Team of the Primary Care Trust (derived from ISD returns, methadone only, based on contemporary scripts)
  - Within the Finance system of the Primary Care Trust (all substitute prescribing medication, based on claims made in time period).

Table 5 sets out this information.

**Table 5- Prescribing costs and number of service users by financial year**

Financial year	99/00	00/01	01/02	02/03	Change 99-03
Number of service users	757	885	1017	1190	57%
Number of scripts	25415	26460	34370	40764	62%
Ingredient(I) costs £	190,926	193,085	236,658	298,110	56%
Dispensing(D) costs £	222,053	296,405	338,783	530,026	139%
Supervision costs* £	72,000	80,421	134,185	182,806	154%
I+D £/ script	16.2	18.5	16.7	20.1	24%
I+D £/ client	546	553	566	702	29%

\* Finance Department

Source: PCT

*Fees*

- 4.37 A fee is payable to the pharmacist each time a medicine is dispensed and a further fee is payable for the supervision of the service user taking the medicine. In addition there is the cost of the drug itself so each time a script is dispensed there may be three components to the payment made to the pharmacist.
- 4.38 The dispensing fee is set locally, funded to the NHS Board from a national allocation and applies to all prescriptions for methadone. The supervision fee is subject to local agreement and the Primary Care Trust has a specified budget for this. Table 6 sets out the fees payable for the past 3 years.

**Table 6 - Pharmacy fees payable per item dispensed and supervised, Ayrshire and Arran NHS Board**

	2000/01	2001/2002	2002/2003
Dispensing fee	£1.94	£2.00	£2.06
Supervision fee	£1.05	£1.08	£1.11

Source: PCT

*Source of prescription*

- 4.39 The vast majority of substitute prescribing is undertaken within the community addiction projects. This is illustrated by Table 7, which details the type of prescription dispensed.
- 4.40 GP10 is a prescription from a General Practitioner and illustrates the number of service users prescribed by their GP. HBP is a prescription from a hospital or associated clinic for dispensing by a community pharmacy and so includes service users who continue to receive a prescription for methadone in hospital. HBPA is a prescription from a hospital or associated clinic for addiction services. This category covers service users who are prescribed methadone within the substitute prescribing programme.

**Table 7 – Methadone usage in Ayrshire and Arran – type (%) of prescription dispensed**

	1999-00	2000-01	2001-02	2002-03
GP10 (general practice)	1244	757	898	776
HBP (hospital pharmacy)	517	295	78	73
HBPA (hospital pharmacy)	22887 (93%)	25024 (96%)	31251 (97%)	37628 (98%)
Other	24	17	19	26
<b>Total</b>	<b>24762</b>	<b>26093</b>	<b>32246</b>	<b>38503</b>

Source: PCT

**Financial information**

4.41 The addictions agencies receive funding from a range of sources. The development of this allocation appears to be due to historical allocation and workload pressures; this has not been examined as part of the substitute prescribing review. The contribution made by the NHS Board is set out in Table 8 and the local authorities in Table 9.

**Table 8 – NHS contribution to substitute prescribing programme in Ayrshire and Arran, 2000/01 – 2002/03 (£s)**

Service	2000/01	2001/2002	2002/2003
<b>Elements provided on Pan-Ayrshire basis (a)</b>			
Sessional GP Costs	24,666	22,884	22,938
Consultant costs*	18,776	19,362	22,064
<b>Drug Agency by locality (b)</b>			
East Ayrshire**	148,251	141,784	149,358
North Ayrshire***	97,128	100,043	103,044
South Ayrshire****	121,104	121,633	168,256
<b>Total (a+b)</b>	<b>409,925</b>	<b>405,706</b>	<b>465,660</b>

Source: PCT

\* Consultants also provide a further 6 sessions for dual diagnosis clients, some of this will involve substitute prescribing but it is impossible to quantify precise amounts

\*\* Bridge Project Kilmarnock, Cumnock

\*\*\* Vernon and Townhead Centres

\*\*\*\*Bridge Project Ayr

**Table 9 – Local Authority contribution to addiction agencies in Ayrshire and Arran in 2003/04 (£s)**

Local Authority	2003/04
East Ayrshire	165,322
North Ayrshire*	72,990
South Ayrshire	140,000

\* 2002/03

Source: East, North and South Ayrshire Councils

### *Measures of effectiveness*

4.42 The review sought to identify outcome measures against two sets of criteria – those given in the local protocol as the local standard and those set out in Drug Misuse and Dependence - Guidelines for Clinical Management (Departments of Health 1999) for the ‘gold’ standard. Individual service user record review would be required to retrieve data on outcomes to enable effectiveness and efficiency to be assessed fully.

#### *Protocol-based outcomes*

##### Reduction in illicit opiate use

4.43 Self-reported information is recorded on a regular basis using the Christo inventory. However, this is used for all service users and not only those receiving substitute prescribing. It is not possible to separate substitute prescribing service users out from others at the Addictions Database although it could be achieved by undertaking a record review. This has not been carried out at this stage.

##### Reduction on other illicit drug use

4.44 Self-reported information is recorded on a regular basis using the Christo inventory. As above, it has not been possible to separate these service users’ information out. There is little or no urine testing carried out in the substitute prescribing programme so objective assessment of this criterion is not available.

Stabilising of the level of drug use overall and a reduction in its attendant problems

- 4.45 The Christo inventory records some items in relation to social functioning as well as drug use.

Reduction in the transmission of those infectious diseases associated with illicit drug use, especially HIV/AIDS and Hepatitis B and C

- 4.46 HIV and AIDS are uncommon in Ayrshire; since 1999, and only three since 1985. Similarly for Hepatitis B, of a total of seven infected injecting drug users since 1985, three of these have been since 1999.
- 4.47 The number of injecting drug users known to be Hepatitis C positive is set out in Table 10. At Scottish level, around two thirds of people reported to be Hepatitis C positive are known to be injecting drug users. Whilst the proportion has risen in Ayrshire, it remains below the Scottish level.

**Table 10 - Persons reported to be Hepatitis C antibody positive: 1996-2001 Ayrshire and Arran Health Board Area**

	1996	1997	1998	1999	2000	2001
IDU	10	15	35	46	72	45
Other <sup>1</sup>	6	3	1	5	1	2
Not Known <sup>2</sup>	21	33	46	67	72	57
IDU % of total	27%	29%	42%	39%	50%	43%
<b>Total</b>	<b>37</b>	<b>51</b>	<b>82</b>	<b>118</b>	<b>145</b>	<b>104</b>

Source: SCIEH

1. Includes sexual contact, body piercing/tattoo, needlestick, bite, perinatal transmission and blood factor/blood transfusion risk
2. It is thought likely that "unknown" cause of transmission will also include a high proportion of injecting users

General improvement in the client's health in both physical and psychological terms

- 4.48 Again this information is recorded as self-reported in the Christo inventory, and may be noted by the prescriber at review appointments. Individual record review could be used to access this information. Proxy indicators such as admissions to general or psychiatric hospitals may be of some value but do not

separate out substitute prescribing service users. The number of general acute admissions has continued to rise whereas that of psychiatric discharges appears relatively stable (Tables 11 and 12).

**Table 11 - General acute admissions for drug misuse by local authority area of residence: 1997/98 – 2001/02**

	1997/98	1998/99	1999/00	2000/01	2001/02
East Ayrshire	84	112	126	134	208
North Ayrshire	57	88	105	168	230
South Ayrshire	64	109	83	111	131
<b>TOTAL</b>	<b>205</b>	<b>309</b>	<b>314</b>	<b>413</b>	<b>569</b>

Source: ISD

**Table 12 - Psychiatric inpatient discharges with a diagnosis of drug misuse<sup>1,2</sup>: 1996/97 – 2000/01**

	1996/97		1997/98		1998/99		1999/00		2000/01	
	Main	All	Main	All	Main	All	Main	All	Main	All
East Ayrshire	41	56	49	62	34	52	63	82	55	67
North Ayrshire	38	48	78	103	96	126	67	95	66	86
South Ayrshire	20	25	35	40	38	59	41	52	37	48
<b>TOTAL</b>	<b>99</b>	<b>129</b>	<b>162</b>	<b>205</b>	<b>168</b>	<b>237</b>	<b>171</b>	<b>229</b>	<b>158</b>	<b>201</b>

Source: ISD

<sup>1</sup> Excludes misuse of tobacco or alcohol

<sup>2</sup> "Main" is the primary diagnosis; "All" includes supplementary diagnoses

#### An overall improvement in all areas of social functioning

4.49 Self-reported information is recorded on the Christo inventory.

#### Reduction in drug-related deaths

4.50 Tables 13 and 14 indicate the numbers of drug related deaths recorded by the General Register Office for Scotland (GROS) and the drugs to which they can be related. The proportion of drug-related deaths which occur in Ayrshire has continued to rise. The picture of drugs involved reflects the national picture with around 20% of deaths involving methadone, and 60% heroin. The

Confidential Enquiry into Drug Related Deaths 2000 notes that methadone related deaths occur even with supervised administration of the drug. The definition of a drug related death is not straightforward and differs between the agencies involved. Within GROS, changes were made in 2000 which affects comparisons with figures before and after these dates. GROS figures include categories such as drug abuse, accidental poisoning, intentional self-poisoning and assault by drugs. The Scottish Police Service also collates information on drug related deaths. These figures are detailed in table 15. These figures do not include self-poisoning, assault by drugs and suicide.

**Table 13 - Drug Related Deaths: 1997-2002**

	1997	1998	1999	2000	2001	2002
Scotland	224	249	291	292	332	382
Ayrshire & Arran	6	4	15	20	35	33
% of Scotland	2.7%	1.6%	5.1%	6.8%	10.5%	8.6%

Source: GROS

**Table 14 - Drug-related deaths; selected drugs involved\* 2002**

	Heroin/ morphine	Diazepam	Methadone	Cocaine	Ecstasy	Temazepam
Scotland	248	214	98	31	20	16
Ayrshire & Arran	22	22	8	2	2	2

Source: GROS

\*Individual deaths often involved more than one of these drugs. The numbers given are mentions of the drug and should not be added to give total deaths.

**Table 15 – Drug related deaths; 2000 – August 2003**

	1999	2000	2001	2002	Jan – Aug 2003
Scotland DEA	N/A	219	231	313	183
Strathclyde Police Whole area	152	124	119	195	93
Strathclyde Police U Division*	13	8	26	25	5

Source: Strathclyde Police

\*The catchment area of Strathclyde Police "U" division is Ayrshire and Arran

Reduction in drug related criminality and violence

- 4.51 Self-reporting using the Christo inventory indicates some elements for this outcome. Local crime figures have not been accessed.

Reduction in the disproportionate use of medical, social and police services

- 4.52 No specific measures have been identified in relation to this outcome.

*Gold standard*

- 4.53 The outcomes identified in Drug Misuse and Dependence - Guidelines on Clinical Management can be separated into three categories – reducing the risk of infectious diseases and other medical and social harm; reducing drug-related deaths; and reducing criminal activity. These are covered in the protocol outcomes. There are no other elements for which we were able to identify data.

## DISCUSSION

- 5.1 Problems with the capacity of drug treatment services are not new. In 1997 the Director of Public Health noted in his Annual Report<sup>12</sup> that ‘... demand on services is outstripping supply in every area. This is particularly significant in both the detoxification and substitute prescribing work.’ Neither is this a problem unique to Ayrshire; statutory and non-statutory agencies across the country have identified significant overspends. The problems that have been identified during this review are set out below.

### *Current programme*

- 5.2 The current substitute prescribing programme of detoxification prior to maintenance is unable to demonstrate clear service user benefits and is at the limit of its capacity. Current evidence demonstrates the effectiveness of a substitute prescribing programme based on methadone maintenance, with the option to detoxify when able to do so. The evidence indicates the combination of methadone maintenance and psychosocial support can be effective in primary care settings and would provide a service in line with national guidance.
- 5.3 However the programme cannot be viewed in isolation from the rest of the addiction services. It must be seen as a part of a spectrum of care and integrate with a range of through and aftercare services with the long term aim of integration of the service user into mainstream society.

### *Capacity of services*

#### Addiction agencies

- 5.4 There are problems with the ability of the addiction agencies to take on new service users, not only due to the recent reduced availability of methadone prescribing, but also to the availability of drug and project workers to provide psychosocial support. Accommodation is also limited but potential exists for increasing outreach, although this would have staffing consequences.

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<sup>12</sup> Health and Ill-health in Ayrshire and Arran. The 1997 Report of the Director of Public Health. Health Ayrshire and Arran Board 1998

Community Pharmacies

- 5.5 The present substitute prescribing programme requires a high level of input from community pharmacies, both for dispensing and supervision. Accurate dosage measurement can be facilitated by additional equipment. A large number of pharmacies have reached, or are very close to, their maximum capacity of service users for supervision. Some of these service users are on stable, long-term doses which could be managed without intense supervision. Other mechanisms for supervision are possible and could be explored.
- 5.6 The reluctance of some pharmacies to engage with drug users is understandable but dispensing should be encouraged to ensure sufficient capacity is available.

Medical input

- 5.7 Each doctor is prescribing for a large number of service users. Part of the prescriber's responsibility is to ensure the medical appropriateness of the prescription. With high numbers of service users, this degree of supervision is reduced. The majority of service users are now in maintenance programmes.

*Service need*

- 5.8 The population eligible for substitute prescribing is not a fixed one. Unlike those for specific conditions such as diabetes, prevalence cannot be readily assessed to act as a proxy for need. The drug using population continues to expand, with the national target of increasing by 10% the number of users in contact with treatment, giving credence to this. At present, demand for services is illustrated by waiting lists and waiting times. Service need as reflected in these, is not reducing. These measures may not reflect accurately the demand as an increase in waiting lists may lead to a reduction in those coming forward to access the service as word spreads amongst service users. Similarly, it is known that improving services and their access results in greater uptake, and there is no reason to indicate that drug users are different in this regard.

- 5.9 Future indicators such as the number of young people reporting drug use, seem to demonstrate a stabilisation of numbers of users at younger ages. It will be some time before it is possible to see if this remains stable as the population ages.

#### *Costs*

- 5.10 There are two principal costs – those linked to prescribing (ingredients, dispensing and supervision) and those linked to staffing (doctors, support staff). The review has identified a disproportionate increase in the supervision and dispensing elements which appears to be due to changes in practice from single to serial dispensings and an increase in the level of supervision. In 2000 the Scottish Executive asked all health boards to report on the steps taken to ensure that, wherever practicable, methadone is taken under supervision.
- 5.11 There has been insufficient time to undertake work on financial models beyond the most basic direct methadone related elements. There will be a marginal cost for each additional service user, which, at some point, will increase significantly as capacity of existing services is reached and new staff and/or premises are needed.

#### *Protocol*

- 5.12 Whilst services are aware of the protocol, its interpretation and application varies across the area. The 1999 and 2000 revisions have not been incorporated into a new written version of the protocol which has left some confusion. Urine testing has not been embraced locally but evidence indicates its acceptability as part of substitute prescribing programmes. A new protocol based on evidence of effectiveness should be developed. Adherence to the protocol may indicate the need for increasing the knowledge and skills of staff, in particular in psychosocial support and Rogerian-style counselling.
- 5.13 There are certain conditions under which the protocol should operate to maximise its effectiveness:
- the provision of high quality Rogerian-style counselling

Formalised counselling is not available. Support and advice is offered, and requires to be accepted for those on the methadone programme.

- access to a wide range of varying interventions ranging from relapse management based cognitive-behavioural techniques to increased leisure options

Evidence exists for a limited range of interventions. This needs to be broadened and deepened to improve effectiveness.

- an emphasis on harm reduction

This can be seen in all projects.

- a de-emphasis both of abstinence as a goal and detoxification as a universally applicable intervention

This is at variance with the revision of the programme introducing detoxification regimes for all service users.

- a problem-oriented approach which recognises that ideas of ‘success’ are not simply confined to improvements in drug usage but encompass all other areas of the service user’s life

This can be evidenced by all projects. However it is apparent that pressure on the services has meant that the willingness to engage with this and the recognition of its importance has not been replicated in development of approaches to throughcare and after care. The development of a seamless transition from substitute prescribing to throughcare and aftercare services is to be encouraged.

#### *Health and social care*

5.14 The medical prescribers are not able to manage the primary care needs of service users. It is unclear whether these are being met adequately, and the work with service users will help ascertain this. In other parts of the country, service users stable on methadone have their care transferred to primary care services. The development of integrated care pathways based on shared care principles would assist this process.

5.15 It is understood that a large proportion of children known to child protection services have parents with addiction problems who may be accessing, or trying to access, the substitute prescribing programme.

*Equity*

- 5.16 People who encounter problems with illicit opiates form a highly vulnerable group. They have taken a major step in coming forward to seek help and require a large amount of support, advice and understanding to assist their move from a chaotic to a more stable lifestyle. Successful management of the drug use may lead to further health and social care needs as the underlying contributory factors to drug misuse are exposed. Methadone maintenance has been shown to be effective in stabilising drug users and is the programme of choice.
- 5.17 A 'one size fits all' approach is encouraged by the present programme structure which does not allow for individual need or choice. However the programme does assist addiction agency staff to challenge the drug culture such that the maintenance programme is not seen as the only or preferred choice. Positive choices are advocated for service users, encouraging them to move on in their lives. It is important that this is retained in moving to an evidence based maintenance programme. A planned programme should link methadone maintenance with psychosocial services, urine testing and daily dispensing to stabilise service users before moving to more individualised programmes.
- 5.18 The levels of service demand and provision are not evenly distributed across the Board area. Waiting times and the length of waiting lists reflect suppressed demand.

*Monitoring*

- 5.19 Monitoring of the projects is carried out within the projects themselves and with aggregated data provided by them to the Addictions Database. There are also specific supervising officers within the funding agencies.

*Management*

- 5.20 There is no overall performance management of the substitute prescribing programme across the individual agencies. Such a requirement would encompass pharmacy, prescribing, GP services and addiction agencies.

Current service design means that management is disparate although cross agency working is strong and positive. A range of mechanisms could be used to achieve a more integrated and managed service. The merging of the Addictions and Prescribing Databases would help support this.

## 6. SERVICE MODELLING

- 6.1 Following discussion with the sub-group, we were able to identify the preferred notional model that an evidence-based methadone programme would follow. The programme would be based on maintenance, with encouragement to detoxify when the service user felt able to do so. Open-ended programmes such as this have been shown to be more effective in the long term, with service users able to cease use of opiates when so motivated, and in the meantime reducing the harm caused by their use.
- 6.2 A typical service user on the methadone maintenance programme would be on a relatively high dose (60-100mg daily). This has been shown to be more effective than low dose maintenance at keeping service users within the programme, the drug would be dispensed two or three times weekly without the requirement for supervision. This model is described for illustrative purposes only.
- 6.3 The following model is based on 2002-3 costings for methadone and dispensing and makes crude assumptions about the increase in numbers of service users and the uniformity of care packages. The costs are as follows:

### Illustrative Model 1

*Methadone associated costs* Ingredients 60ml daily @ £7.50/500ml = £6.30  
weekly = £327.60 per annum

100ml daily @ £7.50/500 ml = £10.50 weekly = £546 per annum

Dispensing 2 dispensings weekly @ £2.06 = £4.12 weekly = £214.24 per annum

3 dispensings weekly @ £2.06 = £6.18 weekly = £321.36 per annum

Supervision Nil

Annual cost £541.84 - £867.36 per service user

For 1190 service users at 2003-04 rates (see below) = £644,790 - £1,032,158

For 1309 service users at 2003-04 rates (see below) =£730,546 - £1,169,435

*Present actual*

Annual costs of methadone dispensing, supervision and ingredients	= £1,010,942
1190 clients	= £849.53 /client/ annum
mean methadone dose	=60ml/dispensing

*Predicted expenditure requirement 2003-04*

Actual expenditure 2002-03	= £1,010,942
3% uplift for inflation	= £1,041,270
10% uplift in number of clients = 1309	= £1,145,397

***Staffing models***

- 6.4 A shared care arrangement between Primary Care and specialist services is the recommended model for addiction services by the Scottish Executive. The present arrangements using consultant psychiatrists and sessional GPs would benefit from enhanced integration with the wider general practice. We are aware that this has proved difficult in the past but recommend further engagement with General Practice to assist the normalisation of service users on methadone maintenance programmes.
- 6.5 Psychosocial services provide valuable support for the substitute prescribing programme. A revised protocol would allow for the development of a service user led package of care which may include options such as advice, support, advocacy, aftercare and throughcare. The staffing implications of this have yet to be considered.

## 7. CONCLUSIONS

7.1 The work presented in this report does not provide the complete picture of the service for reasons outlined within the document. In terms of the remit given to the subgroup, we have:

- examined current problems
- identified current adherence to agreed protocols and
- changes to protocols required
- provided a basis for projection of increased demand and capacity required for future.

7.2 We have been partially successful in:

- differentiating demand and associated costs between new and maintenance clients
- considering recommendations to achieve 10% increase in clients being treated within current budget allocations.

7.3 Further work is required to:

- provide an audit of all cross agency costs, including comparison with other Board areas
- establish the effectiveness and efficiency of cross agency services
- establish timescales for the implementation plan.

7.4 There are specific future externally-generated developments that will have a direct bearing on the substitute prescribing service.

7.5 The introduction of Drug Testing and Treatment Orders (DTTOs) has been funded but uses the same basic resources in terms of accommodation and staffing as the mainstream services. Criminal activity may be seen as providing a fast-track to receiving methadone if services remain restricted.

7.6 The engagement of GPs is a crucial part of shared care arrangements and Ayrshire and Arran has met with only limited success. The new GP contract, operational from April 2004, makes specific provision for the care of drug

users, and may lead to an interest from GPs in becoming appropriately trained and informed to undertake the maintenance of methadone users.

- 7.7 The Joint Future agenda will also impact on the substitute prescribing service since it requires health and local authorities to have local partnership agreements and shared assessments for addiction services by April 2004.

## **8 RECOMMENDATIONS**

8.1 The subgroup makes the following recommendations:

- A more robust study of the totality of addiction services should be undertaken in a realistic timescale and drawing on the work from existing reviews, particularly noting the views of service users (5.2)
- The substitute prescribing programme should encompass methadone maintenance and detoxification (5.2)
- The programme should include progression to throughcare and after care services (5.3)
- The capacity of community pharmacies to dispense and supervise methadone treatment should be increased (5.5)
- The requirement for supervision should be evidence based (5.5)
- Alternative methods of supervision and testing should be assessed (5.5, 5.12)
- The substitute prescribing protocol should be re-written in line with current best practice (5.12)
- The range of available psychosocial services including throughcare and aftercare should be reviewed and appropriate arrangements made (5.13)
- Integrated care pathways based on the principles of shared care should be developed (5.14)
- The revised programme will offer methadone maintenance as a mainstay of treatment for a standard minimum period (5.16)
- The planned programme will be linked to psychosocial services, urine testing and daily dispensing (5.17)

**GLOSSARY**

**Christo Inventory** A standardised form used for evaluation/clinical audit purposes. It provides rough indications of recent drug related problems.

**Detoxification** The process of controlled withdrawal from a drug

**Dispensing** The provision of a drug by a pharmacist following prescription by a doctor

**Dual diagnosis** Service users who have a substance misuse diagnosis and a concurrent significant mental health illness

**Harm reduction** A range of interventions, which seek to reduce the harm that comes from drug misuse

**Methadone** A synthetic opioid used in the treatment of drug dependence

**Primary care** The general practice treatment setting

**Opiates** Naturally occurring heroin-like drugs, including heroin itself

**Opioids** Synthetic heroin-like drugs

**Rogerian style counselling** A type of counselling which is client centred

**Substitute prescribing** The use of a drug substitute for a drug of dependence.

**Supervision** A process to check that the correct service user has consumed the dose of medication for which they are prescribed.