NHS
Greater Glasgow and Clyde

STANDARDS FOR DRUG & ALCOHOL SERVICES IN COMMUNITY PHARMACIES

NHS GREATER GLASGOW & CLYDE
ALCOHOL AND DRUG RECOVERY SERVICES
PHARMACY TEAM

7TH EDITION – July 2019

Produced by Greater Glasgow and Clyde Alcohol and Drug recovery Services Pharmacy Team.

If you require further copies of this book please contact the Pharmacy Team
Tel: 0141 303 8931

Contents

Acknowledgements

Community Pharmacy Development Team

- Allan Harrison
- David Thomson
- Janine Glen

Controlled Drug Governance Team

- Alan Clee

Foreword

These standards are intended to reflect current best practice in NHS Greater Glasgow and Clyde and replace those previously issued in 1995, 1997, 2000, 2005, 2011 & 2015. Pharmacists involved in the supervised self-administration schemes for methadone, buprenorphine and disulfiram should be familiar with the contents. Employers should ensure that these standards are bought to the attention of all pharmacists, technicians and support staff working with the relevant patients, especially locums.

If you have any comments regarding the content or format of these standards, please contact:

Carole Hunter
Lead Pharmacist
NHS Greater Glasgow & Clyde Addiction Services
E-mail: carole.hunter@ggc.scot.nhs.uk
Telephone: 0141 303 8931

"All pharmacy professionals contribute to delivering and improving the health, safety and wellbeing of patients and the public. Professionalism and safe and effective practice are central to that role."

(Standards for pharmacy professionals. General Pharmaceutical Council May 2017)

Summary

1. These standards are provided for community pharmacists and registered technicians who are working in registered pharmacy premises in contract with NHSGGC to supervise patients' consumption of substitution therapy.
2. The standards are also intended to inform prescribers, who are responsible for prescribing substitution therapy (and other relevant medication) and requesting supervised consumption, as the basis on which this service will operate.
3. The standards contain a wealth of information and examples of best practice to help you provide an efficient and effective substitution therapy service to your patients. This document draws on both national and local documents and guidance.

Topics covered by appendices:

A. Addiction services pharmacy team contact details
B. Example treatment agreement
C. Example calibration log
D. Prescriber contact flow chart
E. Procedures for lost/Stolen or misplaced prescriptions
F Police authorisation form
G. Emergency closure information
H. NHSGG&C Community Addiction Teams contact details
I. The pharmacist's role with children affected by parental alcohol and substance misuse
J. Useful contact details

1. Introduction

Substance misuse is a serious public health problem in the NHSGGC area, characterised by drug injecting, alcohol misuse and polydrug misuse. The Health Board has adopted a harm minimisation approach, which not only reduces the harm inflicted on the individual but also minimises the consequences for the immediate family and the community at large.

Pharmacists have an important role to play in two key approaches to harm reduction namely:

1. The dispensing and supervision of substitute drugs, such as methadone and buprenorphine, for those willing to reduce or cease injecting and for those who are alcohol dependent, the dispensing and supervision of disulfiram. These guidelines will focus mainly on this role.
2. The provision of sterile injecting equipment to those who cannot or are not yet ready to give up intravenous drug misuse.

Neither of the approaches above are mutually exclusive. It has been noted that, even in the most effective substitution programmes, about 76% of patients will continue to inject (NESI 2008/2009 & 2010). Some patients on a substitute programme may still require sterile injecting equipment. Findings from the National Treatment Outcome Research Study (NTORS) in England and the Impact of Methadone in Glasgow (IMIG) Study demonstrate that although patients receiving methadone may not entirely give up injecting heroin, they inject less frequently than those people who are not on a methadone treatment programme.

Since early 2015, a significant increase in HIV transmission has been observed among people who inject drugs in Glasgow. By July 2019 this outbreak had reached 156. Hepatitis C remains an issue, despite improved treatment, around 70% of those tested show previous exposure to the virus. Several other recent outbreaks of serious infectious disease among people who inject drugs have been seen across the board area. Of particular concern was botulism (2014-2015) and anthrax (2009-2010).

In order to reduce these harms we must ensure that those at risk have access to enough injecting equipment to meet their needs. We must also promote key harm reduction and safer injecting messages wherever possible.

IEP Programme Overview

Fifty eight (58) pharmacies in NHSGGC are injecting equipment providers (IEPs). In addition to these there are 10 specialist outlets providing provision via outreach, mobile van and a clinic for those people injecting Image and Performance Injecting Drugs (IPEDS). Most drug services provide injecting equipment and the Glasgow Drug Crisis Centre has 24 hour provision.

Details of pharmacy IEPs are regularly circulated to all contractors. For pharmacies that are not involved in needle provision, pharmacists should provide information on the location of all IEPs and the range of services available.

IEP provider training and safer injecting training is available to pharmacists and pharmacy staff on the first Tuesday of each month on an alternating basis. For further information on the availability of IEPs or to enquire about training please contact NHSGGC Addiction Services on 0141 303 8931. The locations and contact details of all IEPs in NHSGGC are available from the Addiction services pharmacy team on 0141 303 8931. Information on other local services is also available at www.scottishdrugservice.com

In addition to the pharmacy IEPs, the Glasgow Drug Crisis Centre (GDCC), 123 West St, provides a 24 hour, 365 days a year needle provision service and the Glasgow Street Team provide a back packing service in the City Centre. In Clyde, 3 nurse led IEPs operate from Renfrew Drug Service, Inverclyde Drug Service and Leven Drug Service. The Community Addiction Teams in Glasgow also provide a Needle Replacement Service which allows addiction staff to supply injecting equipment to service users as part of a drop in consultation or planned appointment. Other services who provide

a Needle Replacement Service include the 218 Project, the Glasgow Drug Court and the Homeless Addiction Team.

Within NHSGGC a Take Home Naloxone Service is provided from some Community Pharmacies, Addiction Teams, Drug Services, hospitals and various other outlets. For information on this service or if you are interested in finding out how to provide it contact 0141 303 8931.

2. Supervision of substitution therapy

2.1 What is substitution therapy?

Substitution Therapy is a replacement therapy in which a substitute substance is used to treat an addiction. It is replacing an addictive substance with a prescribed medication that will support a patient through the recovery process.

2.2 The need for supervised consumption in pharmacies

Supervising the consumption of medication for opiate and alcohol dependence has emerged as a key component of treatment programmes. Supervision of consumption by an appropriate professional provides the best guarantee that a medicine is being taken as prescribed. The principal reason for using supervision is to ensure the safety of the patient and to minimise the risk of toxicity.

The benefits of supervising medication in a community pharmacy include:

a) ensuring adequate blood and tissue levels of methadone and buprenorphine are maintained, therefore reducing the patients need for additional opiates.

b) preventing diversion onto the black market.

c) providing an opportunity for the pharmacist to make a daily assessment of patient compliance with treatment and of the general health and well being of the patient.

d) providing an opportunity for the pharmacist to build a rapport with the patient that is beneficial from a health promotion and harm reduction viewpoint.

e) reducing the number of drug related deaths due to overdose.

f) minimising the risk of accidental consumption by children.

Patients who have just started on OST are generally the most appropriate to receive their medication under direct supervision. Supervision allows the regular monitoring of progress and an ongoing risk assessment to be carried out on the patient. In some cases supervision will be needed for an extended period while for others it may be assessed as only being needed for a short period. Duration of supervision should be dependent on assessed clinical need and its need should be reviewed frequently. Supervision levels should always have been discussed and agreement reached between the prescriber and the patient. Pharmacists may be asked for their input into these decisions as the healthcare professional that sees them most frequently.

The pharmacist should recognise that supervision may need to be reinstated in times of crisis or relapse. This should not be considered a failure of the programme or the patient. Substance misuse is a chronic relapsing condition. A patient may require several attempts before becoming stable and ultimately drug free, if that is their end goal.

2.3 Medication administered under supervision

Methadone

Methadone is a Schedule 2 controlled drug. It is an effective evidence based medication which is prescribed for the treatment of opioid dependence. It is an opiate agonist and its primary function is to reduce (and eventually replace) illicit opioid use. It is most effective when used as a maintenance agent at optimal dosing. According to the 'Drug Misuse and Dependence, UK guidelines on clinical management', an optimal dose for maintenance therapy is between 60mg to 120mg daily although some patients may need doses which are higher or lower than this guide. Optimal methadone doses exert clinical effects for between 24 to 36 hours.

Methadone is most commonly prescribed in the form of methadone oral solution 1mg/ml. Its long acting nature makes it particularly suitable for once daily dosing. Methadone concentrate solution 10mg/1ml is normally only prescribed in exceptional medical circumstances or where a patient requires a dose higher than 150mgs daily. Supervision within the pharmacy on a daily basis is recommended for the first three months of methadone treatment and should continue thereafter depending on the individual patient's circumstances and level of stability in treatment.

As with any other prescription received in the pharmacy, the pharmacist has a responsibility to undertake a clinical check for interactions and appropriateness.

Buprenorphine

Buprenorphine is a Schedule 3 controlled drug. It is an effective, safe medication for use in the treatment of opioid dependence. It is a mixed opiate agonist-antagonist which means it produces opioid responses while also reducing the effect of additional opiates such as heroin or methadone.

Buprenorphine is available as a sublingual tablet in 3 different strengths, 400mcgs, 2mg and 8mg. The tablets are administered sublingually because of buprenorphine's poor oral bioavailability. Buprenorphine is not active if swallowed therefore patients should be encouraged not to swallow excess amounts of saliva when the tablet is dissolving under the tongue. In practice, supervision of the patient is most important for the first 2-3 minutes after administration.

The first dose of buprenorphine should be administered at least 8 hours after the last use of heroin in order to reduce the risk of precipitated withdrawal. Optimal maintenance doses are between 8 to 32mg and duration of action is related to dose. Low doses (2-4mg) exert clinical effects for up to 12hours and higher doses (16 to 32mg) exert clinical effects for up to 48 to 72 hours.

Daily supervision within the pharmacy is recommended for the first three months of buprenorpine treatment and should continue thereafter depending on the individual patient's circumstances and level of stability in treatment

Disulfiram

Disulfiram is used as an adjunct to treatment for alcohol dependence. It inhibits the liver enzyme aldehyde dehydrogenase and therefore prevents the breakdown of acetaldehyde. Therefore if taken with alcohol, acetaldehyde accumulates causing side effects such as throbbing headache, flushing of the face, breathlessness, nausea, vomiting and dizziness on standing. The reaction is rapid and can occur within ten minutes of drinking alcohol and can last for several hours. Disulfiram is therefore used as a deterrent.

Therapy should be commenced after the patient has abstained from alcohol for at least twenty-four hours and the patient should be given advice to avoid products that may contain ethanol (food products, medicines, toiletries).

In the UK, licensed disulfiram is only available as a 200mg tablet. It can be administered once daily or often in NHSGGC it is administered three times a week (e.g. 400mg Monday, Wednesday and Friday) or twice weekly. Supervised consumption of disulfiram has been shown to be an important contributor to effectiveness. NHSGGC funds the Supervision of disulfiram within Community Pharmacies. A safety aspect of the service is that patients are breathalysed before every dose. Patients must obtain a zero result to receive their supervised dose. Tablets should be swallowed whole with a glass of water. The supervisor should ensure the tablet(s) has(ve) been consumed. Any take away doses should be provided after the consumption of the supervised dose. **Any single missed dose or positive breath test should be fed back to the patients' care manager/key worker.**

The Addiction Pharmacy Team trains pharmacies and allocates breathalysers on a patient need/request basis. Any queries regarding the service should be directed to Jennifer Torrens, Alcohol Pharmacist on 07557 012870.

Effective concentrations of disulfiram may last in the body for up to 14 days; therefore there is a strong need for the patient to remain abstinent for 14 days after the last tablet(s) is/are consumed.

2.4 Supervised therapies in pregnancy

The objectives of management are to achieve stability – pharmacological, social, medical and psychosocial. Engagement with and close monitoring in antenatal care and drug treatment are integral to achieving stability. Detoxification is sometimes requested by patients who discover they are pregnant, however, if deemed appropriate, this would normally only be carried out during the second trimester and in very small increments.

Pregnant woman will normally remain on their current treatment, methadone or buprenorphine, with an additional package of support put in place. Transfer to buprenorphine during pregnancy is not normally advised due to the risk of precipitated withdrawal and the risk of inducing withdrawal in the foetus.

Medications for alcohol relapse prevention, such as disulfiram, have not been shown to be safe in pregnancy.

2.5 Provision of a supervised substitution therapy service

The Area Pharmaceutical Committee (APC) supports the supervised consumption of substitution therapies within community pharmacy premises. It has taken the view that the service should ideally be provided from a large number of pharmacies rather than from an identifiable centre. Whilst the APC is satisfied that over 90% of NHS GG&C pharmacy contractors were providing this service in January 2019, it also recognises that not all pharmacists may wish to provide this service. The APC recommends that the provision of such a service should continue to be voluntary and that contractors should take cognisance of the views of their staff, including locums, before entering the service. Those pharmacies that are contracted to supervise consumption on their premises are reminded of the contractual obligation to ensure that supervision is always carried out when requested by the prescriber. The NHS GG&C Pharmaceutical List indicates the pharmacies that have contracts for supervised consumption service provision.

Pharmacists supplying substitution therapy should also remember their professional responsibility to provide a clinical assessment prior to the supply of any medication to a patient. Patients who present with prescriptions for substitution therapies will require this clinical assessment to be carried out and may have complex medical issues to be taken into consideration. The pharmacist must carry out a full clinical assessment including checking for interactions and contra-indications. It must not be assumed that this has been carried out by the prescriber.

It is particularly important with this patient group to provide counselling on side-effects and to provide other information relevant to their medication.

All staff working in pharmacies operating a substitution therapy service, including locums, must ensure they have read, are familiar with and follow the guidelines set out in this document. This will ensure patients accessing the service anywhere in NHSGGC will receive the same high level of service. Responsibility for ensuring this is the case lies with the pharmacy manager and the superintendent pharmacist.

3. Practical aspects of operating a supervised consumption service

3.1 Standard operating procedures

All pharmacy staff involved in providing a supervised consumption service should be adequately trained and feel confident and competent in operating the service.

Each pharmacy should have in place Standard Operating Procedures (SOPs) that outline how their service operates. Any changes to existing SOPs need to be approved by the Superintendent Pharmacist. Each SOP should clearly state which members of the dispensing team the procedures apply to and provide a step-by-step guide for each stage of the service. A training record should be kept for all staff trained on each SOP and signed off by the Pharmacist in Charge. SOP's should be reviewed and updated at regular intervals to ensure they are still relevant. Once updated staff must be re-trained and any changes to the SOP highlighted to them.

Some examples of Standard Operating Procedures are:

- Preparation procedures for daily medication dose
- Checking Procedures
- Supervision Procedures–including checking of patient identity
- Missed Dose Procedures
- Lost and stolen procedures for prescriptions and medication
- Record Keeping Procedures
- Communication procedures for linking in with prescribers and Addiction Services
- Calibration and maintenance of methadone pumps/automated devices

3.2 Addiction services treatment agreement

Before patients start substitution therapy in the pharmacy a discussion should take place between the pharmacist and the patient. Part of this discussion should be around a treatment agreement which outlines the role of the pharmacist and the patient, opening hours, missed dose procedures and unacceptable behaviour as a minimum. It is good practice for the patient's worker or prescriber to contact the pharmacy prior to the start of a prescription to ensure the pharmacy has a place for that patient and knows when to expect them. If a prescription for a new patient is presented at a pharmacy we would ask staff to contact the issuing team or prescriber before dispensing any medication. It is also helpful for the pharmacy to note on the patients PMR the name of the patients worker and prescriber in case of any issues in the future.

The use of treatment agreements is not mandatory; however, the pharmacist must ensure the patient is given all relevant information when the patient starts their treatment in some form. If you decide to use an agreement, this should be discussed and signed by the pharmacist and the patient and the patient given a copy for their records, an example agreement is shown in Appendix B. In addition, pharmacists should provide patients with an information leaflet on other pharmacy services provided such as eMAS, Smoking cessation, EHC etc.

3.3 The supervised consumption procedure

Supervised consumption should be viewed as a situation where therapeutic relationships can be built with patients. The principal reason for using supervision is to ensure the safety of the patient and to minimise the risk of toxicity. It should not be used or viewed as a punishment.

When supervising substitute therapy in the pharmacy, staff should try to make the supervision process as dignified and discrete as possible. All patients should be treated with courtesy and respect and consumption should take place in a private consultation room or a suitably discreet area of the pharmacy.

The following process should be followed:

- When the patient arrives: first, confirm patient's identity. Confirmation should include checking a patients name, address and date of birth. If the patient is attending the pharmacy for the first time ideally a physical description of the patient should be obtained from the worker/prescriber or, if available, ID provided. It is also recommended that you check what dose of medication the patient is expecting to receive. The failure to properly confirm a patient's identity continues to lead to administration errors where patients receive the wrong dose. Staff often report that they are familiar with these patients.
- Each prescription should be checked to ensure it is legally compliant. (Please see current edition of the Medicines Ethics and Practice (MEP) for details on prescription wording.)
- A full clinical check of the prescription should be undertaken by the pharmacist. At this point it is good practice to attach the PC70, purple form, fill in the appropriate dispensing dates and highlight the last date of dispensing.
- Medication should be dispensed in accordance with the Human Medicines Regulations 2012. The daily amount of medication should be dispensed into an individual dispensing container, sealed and labelled.
- All subsequent doses should be prepared in advance (where possible) in order to minimise waiting times.
- Each dose should have an accuracy check carried out, by a suitably trained member of staff, at the point of dispensing regardless of whether the dose has been prepared by hand, using a manual methadone pump or an automated machine. This must be in addition to the clinical check carried out by the pharmacist each time the medication is to be dispensed. A patients situation can change from day to day so it is vital that checks are put in place to ensure that it is clinically appropriate to dispense this medication on each occasion.
- At the point of supervision, substitute medication should be transferred from the dispensing container into a disposable cup ensuring compliance with the legal labelling requirements for dispensed medication. Patients should be discouraged from drinking the dose of liquid medication from the dispensing bottle. New bottles should be used for each dispensing.
- Staff should ensure that medication has been consumed and the patient should be encouraged to drink water after consumption. Supplying water to be swallowed after the dose and conversing with the patient ensure that doses have not been retained in the mouth. (Please Note: Some patients may say that they prefer to use a can of soft drink to wash down their medication however this should be avoided as the patient may divert their medication into the can.)
- Doses that are collected for consumption on 'Take Home' days must be dispensed and supplied in individual dispensing containers with a child resistant closure and patients advised of safe storage of medication. The health board supplied warning label should be applied to each bottle of take home medication. Use of a separate container ensures the patient does not have to measure his or her own dose. This also ensures that if the bottle is lost or damaged then the entire take home dose is not lost. This is of particular importance if there are children present in the patient's home who may inadvertently gain access to the medication. Pharmacists have a professional responsibility to safeguard the welfare of their patient's children and supply doses in individual bottles.
- After consumption patient identifiable labels should be removed from containers prior to disposal.
- The pharmacist must ensure that patients are counselled with regard to the disposal of containers given with take-home doses. Patients must understand the importance of safe disposal and the potential consequences if they do not take responsibility for this.

In situations where the pharmacist considers the patient's behaviour unacceptable i.e. violent or abusive or the patient appears to be intoxicated, the prescriber should be contacted and the dose withheld until further guidance from the prescriber. It is important that the risks of withholding a dose(s) are considered in terms of patient safety. Further guidance on missed doses is given later on in the document.

3.3.1 Additional guidance for the supervision of Buprenorphine

- Before a patient takes their first dose of buprenorphine the pharmacist should confirm with the patient that there has been a period of time between their last dose of heroin or methadone in order to minimise precipitated withdrawal. The patient should wait at least 6-12 hours after the last use of heroin or 24-48 hours after the last dose of methadone.
- The patient should be feeling withdrawal symptoms and showing signs of withdrawal e.g. sweating, before taking their FIRST dose of buprenorphine. The pharmacist needs to emphasise this point to the patient when supervising medication.
- The pharmacist should ensure the patient rinses their mouth with water before taking buprenorphine to stimulate saliva production. This will help to speed up the dissolution of the tablet in the mouth.
- The tablet should be handed to the patient in the blister pack for the patient to handle themselves or the pharmacist should transfer the tablet directly from the blister into a disposable cup. If the patient's dose is made up of more than one tablet, it is encouraged that they be taken together. There is no clinical need for them to be taken one after the other.
- The patient should be instructed to tip the tablet(s) directly under the tongue, leave to dissolve and swallow as little saliva as possible. (**Please Note:** The tablets should NOT be swallowed, as they are not active if swallowed.)
- The patient should be observed for approx 5 minutes in the consultation area. The length of time that the tablets take to dissolve will vary from patient to patient. In general, longer times are required where higher doses are used. In practice, supervision of the patient is most important for the first 2-3 minutes after administration, during which time the tablets will have started to dissolve.
- The patient should remain in the pharmacy until the pharmacist is satisfied that all that remains under the tongue is a chalky residue. This can be easily confirmed by asking to see under the patients tongue.

A prescription for buprenorphine may be written on two separate forms depending on the dose the patient is prescribed. Daily doses that require a combination of two different strengths of buprenorphine will be on separate prescriptions and each prescription should be stamped in red ink with the wording **'Dispense 1 of 2' & 'Dispense 2 of 2'**. Pharmacists should ensure that prescriptions are dispensed together.

Some pharmacists have been crushing buprenorphine tablets before consumption to make the supervision process more straightforward. This practice, while technically off-licence may sometimes be undertaken with appropriate clinical governance approval and protocols.

3.4 Methadone measuring pumps

Most pharmacies now have a methadone pump to facilitate the measuring and preparation of doses for patients. It is important that these devices are cleaned and serviced regularly. The following guidance has been provided by the manufacturers of the Eppendorf pump and is detailed below.

Maintenance of Eppendorf methadone dispensers

Regular cleaning is needed because methadone is a viscous product with high sugar content that crystallises easily resulting in it clogging up and damaging dispensing systems. It is important that the measuring pumps are cleaned and maintained regularly to ensure they are reliable and continue to dispense accurately. Outlined below is a guideline schedule for cleaning and maintenance. All sites should keep records of their cleaning and servicing schedule.

Daily Cleaning

- At the end of the day flush through first with warm soapy water.
- Rinse with clean warm water in exactly the same way as you use the unit for dispensing methadone.
- There is no need to remove the piston.
- N.B. Should you remove the piston from the unit you must put a small amount of silicone grease on the seal at the bottom of the piston before you replace it. Failure to do this could result in damage to the seal and inaccurate dispensing.

Weekly Cleaning

- At the end of the week, rinse the outside of the pump in a soap / Milton solution and then in clean warm water.
- Then fill the unit with the soapy water or Milton solution, this can be left overnight.
- The following morning rinse out the pump with clean warm water in the same way as you would on a daily basis.
- Again there is no need to dismantle.
- N.B. This is a change to previous instructions: the complete unit should NOT be immersed completely in water and left to soak overnight.

Please read and follow the maintenance instructions supplied with each individual methadone dispenser.

Annual Maintenance

The dispensers are precision instruments designed to accurately dispense the volumes you require. Therefore they need to be serviced and calibrated regularly to ensure they continue to dispense accurately. (Please refer to pharmacy's own SOP for the calibration and maintenance of pumps.)

The following is recommended as a minimum:

- Send annually to a qualified servicing centre for a routine service and calibration where it will be stripped down, cleaned, serviced and calibrated.
- For high usage sites (over 60 patients) the pump should be serviced twice a year.

The following is a list of companies who will service manual methadone pumps:

McQuilkin Laboratory Supplies: 01355 590 511

Camlab: 01954 233 110

Eppendorf UK Ltd: 01438 735 888

These companies may provide loan pumps while yours is being serviced. Some provide one as standard and some only as part of a service agreement. Please phone the companies directly to discuss your requirements. Your own company may provide a calibration service. Maintenance records should be kept for each device you have.

Calibration

It is important to ensure that your pump is operating correctly prior to dispensing. Before starting, staff should carry out a test measurement, which should be checked by the Pharmacist and then recorded on a calibration log. This is particularly important after the pumps have been cleaned to ensure they have been reassembled correctly and have not been damaged during cleaning.

An example of a calibration log is given in Appendix D.

3.5 Automated methadone measuring devices

Many pharmacies now use automated measuring devices to assist in the management of methadone supply e.g. Methameasure or Methasoft.

These systems can also identify patients from biometric data e.g. finger prints as an added security measure. It is essential that these systems are maintained as directed by the manufacturers, cleaning of the device should be done daily to prevent any residue build up.

SOPs should be in place for each process involving the automated machine e.g. dispensing, cleaning etc. and all staff involved in its use, included locums, must be trained and signed off.

It is important to remember that the use of an automated measuring device does not negate the need for an accuracy check to be undertaken by a suitably trained person i.e. an ACT or pharmacist, at the point of dispensing. This must be in addition to the required clinical check carried out by a pharmacist.

The pharmacy SOPs should reflect this and it is good practice to have systems in place to be able to identify which member of staff carried out which role e.g. annotating scripts for clinical check, checked by/dispensed by boxes on labels.

3.6 Labelling requirements

It is a legal requirement that all medication dispensed from a pharmacy must have a patient label. This legal requirement includes any methadone, buprenorphine or disulfiram issued to a patient, irrespective of when it is dispensed. Patients arriving in the pharmacy and having their methadone poured for them at this point should still receive their dose in a labelled container. This applies to all situations whether hand poured, prepared using a pump or dispensed from an automated measuring device.

4. CD instalment wording and prescription requirements

- All prescriptions for controlled drugs (CDs) must conform to Regulations 15 and 16 of the Misuse of Drugs Regulations 2001. Regulation 15 refers to the "Form of prescriptions" and Regulation 16 to "Provisions as to supply on prescription". Pharmacists should remember that they cannot supply methadone or buprenorphine against a prescription 'unless the prescription complies' with these regulations (see current edition of BNF section: "Controlled drugs and drug dependence" for details). The wording of the prescription must be in accordance with that of the Home Office, MEP and British Medical Association.

The NHSGGC Controlled Drugs Governance Team on 0141 201 6033 can be contacted if difficulties are encountered with a prescriber on the Requirements of Regulations 15 and 16.

- Prescriptions for Schedule 2 or 3 controlled drugs which are intended to be dispensed by instalments must contain a direction specifying the amount of the instalments which may be supplied and the intervals to be observed when supplying. It is a legal requirement that the instalment amount and the dose are specified separately on the prescription. For example:

  Methadone Oral Solution 1mg/ml

  Send: 700ml (seven hundred mls)

  Label: 100ml daily

  Supply: 100ml daily 200mls Sat

  Supervised on Day of Collection

  The instruction for daily instalment dispensing must be clearly written for each item that has to be dispensed in instalments. In particular, the instalment provisions of the regulations must be strictly adhered to unless the approved Home Office wording is included on the prescription. The approved wording enables those supplying controlled drugs to issue the remainder of an instalment prescription when the person fails to collect the instalment on the specified day. (Please see the Controlled Drug section of the 'Medicines Ethics & Practice' for examples of approved wording). Pharmacists are encouraged, and should NOT be reluctant to, contact the prescriber to clarify his/her intentions if the prescription is unclear or ambiguous.

- The prescription must specify clearly if supervision is required and the frequency.
- Prescribers should be encouraged to clearly state the start date for dispensing on the prescription to avoid overlap. There is no legal requirement for a start date to be specified on the prescription however were one is given it must be complied with. The first instalment must be dispensed within 28 days of the 'appropriate date'. The 'appropriate date' is the later of the date of signing or a date specified by the prescriber as being the date before which the controlled drug should not be supplied. The 'appropriate date' can be more than 28 days after the date of signing.

  Prescribers should also be encouraged to write the name of the pharmacy the patient attends on the prescription. It is good practice to contact the prescriber if a patient presents a prescription one day or more after the 'appropriate date' to clarify for how long the prescription is to be supplied. Care should also be taken to ensure that extra supplies are not made when current prescriptions overlap the start date of subsequent prescriptions. This will ensure there is no risk of double dosing or patients inadvertently missing appointments when it comes to the end of the prescription.
- It is important to make patients aware from the outset that missed doses will not be replaced and contact the prescriber if necessary (please see section on Missed Doses). Missed doses cannot be supplied at a subsequent visit.
- Any problems with a patient's prescription should be discussed with the prescriber. The pharmacist will be held responsible in law if methadone/buprenorphine is supplied against a prescription that does not comply with Regulations 15 or 16.

5. Education and Training

Pharmacists routinely involved in the provision of this service must complete the most recent distance learning package 'Pharmaceutical Care in Substance Misuse', available from NHS Education Scotland, Pharmacy (NES).

In addition pharmacists are encouraged to attend multi-disciplinary training programmes. E.g. Shared Care conferences offered by NHSGGC Addiction Services.

6. Liaison

- Pharmacists should develop and maintain close links with prescribers. The prescriber should contact the pharmacist to discuss acceptance of each new patient to their service, or change of pharmacy the patient is attending. Otherwise the pharmacist should contact the prescriber to confirm the arrangements.
- Pharmacists should report any patient missing **three or more doses** to the prescriber. This means that on the fourth day the pharmacist must contact the prescriber for advice before dispensing the dose. (Please refer to section on missed doses for further guidance.) Be mindful of the implications if the fourth day will fall at a weekend, you may want to consider contacting the prescriber sooner or if you have any specific concerns for the wellbeing of a patient who has missed doses.
- Hospital staff, addiction staff and pharmacist should liaise, with one another, when a patient receiving substitution therapy for opiate dependence is admitted or discharged from hospital.
- Police, prison services, prescribers and pharmacists should liaise, with one another, when a patient receiving substitution therapy for opiate dependence is held or released from custody.
- Daily contact with the patient will allow the pharmacist to provide health promotion advice, monitor patient compliance and monitor suspected alcohol/drug intake, physical appearance and family circumstances/support. Appendix D to these Guidelines makes some suggestions as to when to consider contacting the prescriber.

7. Medico-legal aspects

7.1 Professional standards and guidance for patient consent

Patients have a basic right to be involved in decisions about their healthcare. In medical terms patient consent is a patient's agreement to receive a professional service or treatment. Consent is ongoing and should be obtained again if any changes are to be made to the service or treatment. The patient must be capable of making the decision and understand the information given regarding the treatment or service in order to make an informed decision.

To provide valid consent patients must be provided with sufficient information to enable them to make an informed decision. Information should be clear and accurate and presented in a way that patients can understand.

In emergency situations treatment may be provided without patient consent. For example: administration of naloxone in suspected opiate overdose or administration of adrenaline to treat anaphylaxis.

Pharmacists and Registered Technicians must be familiar with the full GPhC document 'Standards for pharmacy professionals' May 2017. This guidance can be found on the GPhC website **https://www.pharmacyregulation.org/spp**

Information on patient consent can also be found in the appendices of the current MEP edition.

7.2 Guidance for patient confidentiality

Patients have the right to expect that information you obtain about them is kept confidential and is used only for the purposes for which it was given. Information about patients must not be disclosed without their consent other than in exceptional circumstances or where required or permitted by law.

When disclosing patient information you must release only the minimum amount of information necessary for the purpose. Professional judgement must be exercised when considering the information to disclose taking into account who is requesting the information and why. If it is not necessary for the patient to be identified you must make sure that the patient cannot be identified from the information given.

Pharmacists and Registered Technicians must be familiar with the full GPhC document 'Standards for pharmacy professionals' May 2017. This guidance can be found on the GPhC website **https://www.pharmacyregulation.org/spp**

Information on confidentiality can also be found in the appendices of the current edition of the MEP.

7.3 Guidance on the protection of vulnerable groups

In 2011 the Scottish Government introduced a new scheme to replace the Disclosure process, this is called the Protecting Vulnerable Groups Scheme. The PVG scheme will help to ensure that those who have regular contact with children and protected adults through paid and unpaid work do not have a known history of harmful behaviour. The Scheme is designed to be simpler but more robust than the previous process.

Pharmacists providing NHSGGC Pharmaceutical Services will, in general, undertake regulated work with vulnerable groups and are thus within the scope of the PVG Scheme. This is because they are providing a health service under the NHS (Scotland) Act 1978 which includes care and/or advice relating to physical well-being and, therefore, their patients are considered protected adults. They are also likely undertaking regulated work with children and young people if they provide care and advice to them. Some members of pharmacy support staff will also undertake regulated work and fall within the scope of the PVG scheme, however, this is heavily dependent upon the individual's job description and the scope of duties and tasks they will be required, or expected, to carry out in the pharmacy.

Under the terms of the Scheme, since 28th February 2011, any new employees who will be undertaking regulated work are required to be a PVG member. Since February 2015, it has been mandatory for community pharmacy contractor to ensure that ALL employees undertaking regulated work are PVG Scheme members. It is an offence to offer regulated work to an individual barred from doing so and the contractor will be held responsible so it is vital that all contractors comply with these requirements. A guidance document can be found on the Community Pharmacy Scotland website at **http://www.communitypharmacy.scot.nhs.uk/documents/PVG_Scheme_advice_note.pdf**

Pharmacists and pharmacy staff are likely to have regular contact with people classed as being in a Vulnerable Group, or their carers, and should be alert to and act on indications that a vulnerable person may be being abused or at risk of abuse.

The current edition of the MEP also provides guidance around the protection of vulnerable adults and what action to take if you have suspicions or concerns. Further guidance is also available for members from RPS Support Protecting Vulnerable Adults– a quick reference guide at **https://www.rpharms.com/resources/quick-reference-guides/protecting-vulnerable-adults**

7.4 Guidance on Child Protection

Children are classed as a vulnerable group and as such pharmacists and support staff who are in contact with children are required to be PVG members. However, child protection is a specialised area and training is available for pharmacist and pharmacy staff to keep their knowledge up to date. All health professionals who come into contact with children in the course of their work need to be aware of their responsibility to safeguard and promote a child's welfare. Child abuse can occur across all social groups and in a variety of circumstances. Children may be particularly vulnerable if there is history of family violence or abuse, mental health problems or drug and alcohol misuse.

Pharmacists in contact with children should be able to recognise and know how to act upon evidence that a child's health or development is being, or may be, impaired. Guidance is provided in the current edition of the MEP on protecting Children and young people with advice on what to do if you have suspicions or concerns. Further guidance is available from RPS Support Protecting children and young people – a quick reference guide, 2011 (**www.rpharms.com**)

For further information and guidance on children affected by parent alcohol and substance misuse see Appendix J.

7.5 Different formulations of methadone and private prescriptions for substitution therapies

NHSGGC recommends the use of licensed methadone, however, if you choose to use unlicensed extemporaneously prepared methadone (i.e. methadone powder and diluent) you must follow the guidance published by the GPhC for preparing unlicensed medicines in the pharmacy and your SOPs must reflect the additional steps required to comply. The guidance can be found at **http://www.pharmacyregulation.org/sites/default/files/guidance_for_registered_pharmacies_preparing_unlicensed_medicines_23_05_14.pdf**

If you dispense methadone concentrate, precautions must be taken to ensure that there is no possibility of the strengths being mixed up. The concentrate should only be prepared by trained staff and must be checked by the pharmacist. NHSGGC would also recommend that the dose is poured into a cup prior to supervision to allow a further check of the colour.

Methadone tablets (Physeptone) are not licensed for the treatment of opiate dependence. Prescribers working within NHSGGC have been advised not to prescribe tablets or ampoules of methadone for this purpose. Although the number of private prescriptions for methadone is known to be small, pharmacists should be extra vigilant when dealing with such prescriptions and ensure he/she is are aware of the most recent legal requirements of private controlled drug prescriptions, in particular the need for them to be written on a PPCD form and sent to the pricing bureau. Information is available on the Practitioner Services Scotland website **www.psd.scot.nhs.uk**

Do not forget that you should not dispense any prescription unless you are certain of its authenticity.

7.6 Missed doses

It is important to contact the relevant prescriber/addiction service when a patient does not attend the pharmacy to collect their opioid replacement therapy (ORT).

Pharmacies are advised to contact the patient's prescriber/addiction service when a patient has missed 3 or more consecutive daily doses of their ORT medication. Patients who present at the pharmacy after 3 or more missed doses should be referred back to the addiction service where any decision to reduce a patient's daily dose will be made by the prescriber.

The decision to reduce a patient's daily dose will be based on an individual's current drug use, potential loss of opiate tolerance and other relevant clinical factors. If the decision is made to maintain a patient on the same daily dose of ORT, the pharmacy will be contacted by the addiction service to inform them of the clinical decision and directions given for the current prescription to be continued. If a patient is regularly missing doses either in a weekly or random pattern, it is good practice to contact the prescriber to inform them of a patient's poor compliance to treatment.

Any concerns regarding a patient or their prescription should be discussed with the patient's prescriber/addiction service.

7.7 Error Reporting

To ensure patient safety, errors involving any form of substitution therapy should be dealt with as soon as the error is discovered. The welfare of the patient must be put first and steps taken to ensure the patient is contacted, if not still in the pharmacy, and arrangements made to have them treated if necessary depending on the nature of the incident which has occurred.

The responsible pharmacist must contact the prescriber and the patient's care worker as soon as possible to inform them of the error. The Responsible Pharmacist should contact the addiction services team to notify the pharmacy team of the error. They will provide support and assistance as necessary. If immediate contact with the patient is deemed necessary by the Responsible Pharmacist, where pharmacy or addiction staff have been unable to do so, the local police should be contacted immediately, and they will be able to provide assistance. A report containing details of the incident, contributory factors and remedial actions should also be sent to the Accountable Officer via the Controlled Drugs Governance Team.

The Controlled Drugs Incident report used to notify the Controlled Drugs Governance Team of an incident can be found via staffnet on the Controlled Drug Governance page or by contacting the team directly on 0141 201 6033.

Where company error procedures are in place they must be followed.

The form above can be used if the error will not be reported to the Accountable Officer by another mechanism within your company.

It is good practice for the pharmacist and staff to undertake to identify any failings which led to the error and complete CPD cycles to address these.

7.8 Police medication request form

If a patient is taken into custody, it may be necessary for the police to collect their medication to prevent them from missing doses. The police will come to the pharmacy to collect the medication and present you with a form, an example of this is given in Appendix F, which has been signed by the patient and the police surgeon to authorise the collection.

As supervision is only a request from a prescriber, you are allowed to supply the medication to the police. However, you must adhere to the directions on the prescription and only those instalments due on that day can be supplied. You must ensure that your CD register is completed accurately to reflect who collected the medication. It is good practice to keep the signed authorisation in the CD register as well.

7.9 Non-Medical Prescribing

Since the review of 'Prescribing, Supply and Administration of Medicines' final report in March 1999, known as the Crown Review, non medical prescribing (NMP) for nurse, pharmacist and other allied healthcare professionals has developed.

Although initially restricted to a limited list of medicines, legislation was passed in May 2006 enabling nurse and pharmacist prescribers to prescribe from the entire British National Formulary and in April 2012, restrictions were removed allowing Schedule 2, 3, 4 and 5 controlled drugs to be prescribed with the exception of diamorphine, cocaine and dipipanone for addiction.

The NMP Strategy for NHSGGC Alcohol & Drug Recovery Service identifies drug and alcohol dependence as a key area where extended pharmacy prescribing will have a significant benefit. The development of NMP aims to make better use of the skill set of pharmacists, enhance staffing roles as part or workforce development and enable patients to receive timely treatment by the most appropriate health care professional.

Community Pharmacists should be aware that they may receive prescriptions signed by ADRS nurse & pharmacist prescribers on community prescription stationery including GP10, GP10(SS), GP10N(SS), GP10(N), GP10(P) and hospital based prescribing stationery for Addictions, HBPA, HBPA (SS).

Queries around Non Medical Prescribing within ADRS, should be directed to Mary Clare Madden, Senior Clinical Pharmacist & Prescriber on 07557012877.

7.10 Lost/stolen prescriptions or medication

By the prescriber, pharmacy or patient should be reported as per outlined procedures in Appendix E. It is important that the police are notified if dispensed medication is lost to prevent accidental overdose and to aid the recovery of the medication.

7.11 Naloxone

The Human Medicines Regulations 2012 allow for the parenteral administration of naloxone by anyone in an emergency for the purpose of saving a life. Naloxone is an opioid antagonist which will temporarily block the effects of opioids; buying time for emergency services to be called. Individuals at risk of opioid overdose and individuals who are likely to witness an overdose such as family members and friends can access overdose and naloxone training and receive a supply of naloxone. Training is routinely offered in addiction teams, drug services, GP practices and by injecting equipment providers.

Community pharmacies may be required to dispense naloxone on prescription. Prescriptions should NOT be written generically and should specify a brand which is licensed for administration by lay individuals in a non clinical setting. If a generic product is supplied then it may not contain the required needles and relevant patient information. Some community pharmacies, particularly those providing injecting equipment, also offer naloxone training and supply as part of the local naloxone programme.

Pharmacists providing an OST service should be familiar with the signs and symptoms of opioid overdose and how to respond to an opioid overdose. Within NHS GGC several pharmacists and pharmacy staff have administered naloxone to reverse the effects of an opioid overdose within the vicinity of the community pharmacy.

Further information can be obtained from NHS GGC Addiction Services on 0141 303 8931.

8. Drug Misuse and Dependence: Uk Guidelines on Clinical Management (Orange Guidelines)

Drug Misuse and Dependence: UK Guidelines on Clinical Management are intended primarily for clinicians providing drug treatment for people who misuse or are dependent on drugs. Clinicians in this context are psychiatrists and other doctors, nurses, psychologists, pharmacists, key workers and other workers providing drug treatment.

The 2017 Clinical Guidelines provide guidance on the treatment of drug misuse and dependence in the UK. They are based on current evidence and professional consensus on how to provide drug treatment for the majority of patients, in most instances.

The guidelines provide valuable information for community pharmacists providing an OST service for patients including information on writing prescriptions, travelling abroad, drug interactions and driving. It is beneficial for pharmacists to make themselves familiar with the contents of the guidelines and use them as a reference source.

The document is available online at **https://www.gov.uk/government/publications/drug-misuse-and-dependence-uk-guidelines-on-clinical-management**

9. Administrative arrangements

9.1 Alcohol and drug recovery services

NHSGG&C Addiction Services organise and provide a range of services for people who are affected by drugs and alcohol. The integrated NHSGGC Addiction Services operate under a partnership arrangement and provides a multi- disciplinary and multi-agency approach to the provision of care for the substance user.

These services include:

- Help with alcohol support and treatment
- Help with drug use support and treatment, including substitute prescribing
- Hospital services (including outpatient, specialist in-patient and day services)
- Injecting Equipment Provision (IEP) in pharmacies
- Psychiatry/Psychology and Occupational Therapy Services
- Services to offenders with addiction problems
- Support to GP Shared Care
- Acute Addiction Liaison Service
- Harm reduction advice (Naloxone)
- Family support services
- Young people's services
- Rehabilitation services
- Carer services and family support
- 24/7 drug crisis centre

(Contact details for NHSGGC Addiction Services and the pharmacy team are listed in Appendix A).

9.2 Shared Care Scheme

As of March 2019, 150 GP practices in NHSGGC are members of the Shared Care Scheme. Such practices will have a contract with NHSGG&C. The scheme allows GP practices to develop and co-ordinate the care of drug users and develops practice guidelines. Practices must have knowledge of local detoxification procedures. A shared care practice will treat opioid dependant drug users with support. This will be with support from the central Shared Care Support Team, Community

Alcohol and Drug Teams, GPswSI, and specialist providers. The treatment provided will include the prescribing of substitute drugs or antagonists using best practice as outlined in the Department of Health, local Practice Standards and local Prescribing Guidelines.

9.3 Payment

In April 2018, NHS Greater Glasgow & Clyde and Community Pharmacy GG&C moved to a new model of payment for patients receiving methadone or buprenorphine from community pharmacies within the area.

All participants are now paid an agreed fee, per patient, per month for providing this pharmaceutical service.

A web based module which uses the NEO system allows quick and easy recording of the information needed to make your monthly claim. Using this module replaces the need to endorse prescriptions with the number of instalments and supervisions. You are now only required to endorse the total quantity dispensed. PC70 forms should still be completed and submitted for all schedule 2 and 3 instalment prescriptions. We would also encourage the use of PC70 forms for all OST to monitor for missed doses unless this is recorded in another way within the pharmacy.

All participating stores have been issued with a managerial user name and password. This can be used by the pharmacy manager to create user name and log in details for members of staff who will use the module to make claims. The managerial log in will allow you to manage staff log in details, re-set passwords etc. and as such should be kept secure (e.g. in the CD cabinet) and must only be used by the Pharmacy Manager. Only staff registered with the GPhC can have user accounts created and be able to manage and submit claims.

Claims must be submitted on a monthly basis by the 10th of each month to ensure they are processed for payment in the same month.

The full user guide, assistance with lost or forgotten passwords and general support with the module is available from the pharmacy team on 0141 303 8931 and the CPDT team on 0141 201 6049.

For Disulfiram, the appropriate claim form must be completed monthly and submitted to Addiction services.

9.4 Premises

Pharmacies that offer the supervised consumption of methadone or buprenorphine service should have the following facilities:

- a patient medication records (PMR) system;
- appropriate storage facilities for the required stock of methadone / buprenorphine;
- adequate privacy for patient supervised self administration of medication;
- a display area for relevant health promotion leaflets including advice on the safe and secure storage of medicines.

9.5 Injecting Equipment Provision (IEP)

It is important that pharmacies have a list of all IEP sites within NHSGGC area and are able to refer patients to these services for supply or disposal. Details of the addresses and opening hours of all sites in NHSGGC are available from the Pharmacy Addiction team on 0141 303 8931.

9.6 Emergency and Contigency Planning

In the event of a pandemic outbreak of flu, or other emergency situation, there may be a relaxation in the supervision requirement and alteration in the take home allowances. If affected by a pandemic flu outbreak, the patient prescribed should notify the prescriber and prescribing team, who in turn should notify the pharmacy to allow take home doses for the patient to be given to their “flu buddy”. The patient should provide a written and signed letter of consent to authorise the “flu buddy” to uplift the substitution therapy.

Supervision of a dose is not a legal requirement when written on a prescription, it is a best practice agreement, and in the event of a pandemic, it would not be expected that the patient would be supervised if affected. Confirmation of infection should be sought from the prescriber where possible. The person collecting the supply should sign to say they have received and uplifted the dose on the patients' behalf.

In the event of a pharmacy closure due to any other emergency reason, it is important that the local Addiction Teams are informed immediately to allow alternative arrangements to be made for the patients attending the pharmacy. See appendix G.

Situations may arise where a patient requests a third party be allowed to collect their medication. Every effort should be made to avoid this as it is preferable that patients collect themselves. The pharmacist should contact the prescriber or the patients care worker to discuss the request and a decision made. If this is not possible, the pharmacist must use their professional judgement to decide how best to proceed, giving thought to the consequences of both supplying to a third party and to not supplying at all.

If the prescriber has given instruction for the medication to be supervised and the pharmacist makes a supply to a third party, they should contact the prescriber as soon as possible to inform them.

The pharmacist must ensure the CD register accurately reflects who collected the medication and that any regular requests for third party collection are fed back to the prescriber.

11. APPENDICES

Appendix A

Addiction services pharmacy team –

Addiction Services NHSGG&C 1st Floor Festival Business Centre 150 Brand Street Glasgow G51 1DH	**Tel: 0141 303 8931** **Fax no.: 0141 303 8957**
Carole Hunter – Lead Pharmacist	**Tel: 0141 303 8931** **Blackberry: 07557 012874** **Email: carole.hunter@ggc.scot.nhs.uk**
Mary Clare Madden – Senior Clinical Pharmacist	**Tel: 0141 303 8931** **Blackberry: 07557 012877** **Email: MaryClare.Madden@ggc.scot.nhs.uk**
Amanda Laird – Advanced Pharmacist	**Tel: 0141 303 8931** **Blackberry: 07557 012879** **Email: Amanda.laird@ggc.scot.nhs.uk**
Laura Wilson – Advanced Pharmacist	**Tel: 0141 303 8931** **Blackberry: 07557 012875** **Email: laura.wilson5@ggc.scot.nhs.uk**
Jenny Torrens – Alcohol Pharmacist	**Tel: 0141 303 8931** **Blackberry: 07557 012870** **Email: Jennifer.torrens@ggc.scot.nhs.uk**
John Campbell – Improvement and Development Manager for IEP Services	**Tel: 0141 303 8931** **Blackberry: 07557 012871** **Email: john.campbell@ggc.scot.nhs.uk**
Diane Watson – Clinical Pharmacist for Eriskay House & the Kershaw Unit	**Tel: 0141 303 8931** **Blackberry: 07966 280629** **Email: Diane.Watson@ggc.scot.nhs.uk**

Appendix B Example patient agreement

NHS Greater Glasgow and Clyde

NHS GG&C Addiction Services 2 Way Treatment Agreement

Please take time to read all sections of this agreement before signing it

Patient

I agree

To treat with respect all people I have contact with in connection with my treatment

To attend the pharmacy unaccompanied, unless absolutely necessary

To accept responsibility for my prescription and medication, as they cannot be replaced

To accept my prescription being withheld if I am intoxicated or have missed more than two daily doses

To attend to pick up my prescription between times agreed by with the pharmacist and if attending outwith these times to let the pharmacist know

To allow sharing of relevant information by all professionals involved in my treatment

Pharmacist

I agree

To ensure that I and other pharmacy staff treat the above named service user with respect

To provide the service user with information about medications

To ensure that GP requested supervised dispensing takes place in a private / 'quiet' area of the pharmacy

To explain protocols for missed doses

To provide a pharmacy practice leaflet giving information about the service To share relevant information with all professionals involved in the treatment To participate in periodic reviews as necessary

Signatures

Service User: _____ Date: _____

Pharmacist: _____ Date: _____

Appendix C

Calibration Log for Methadone Pump

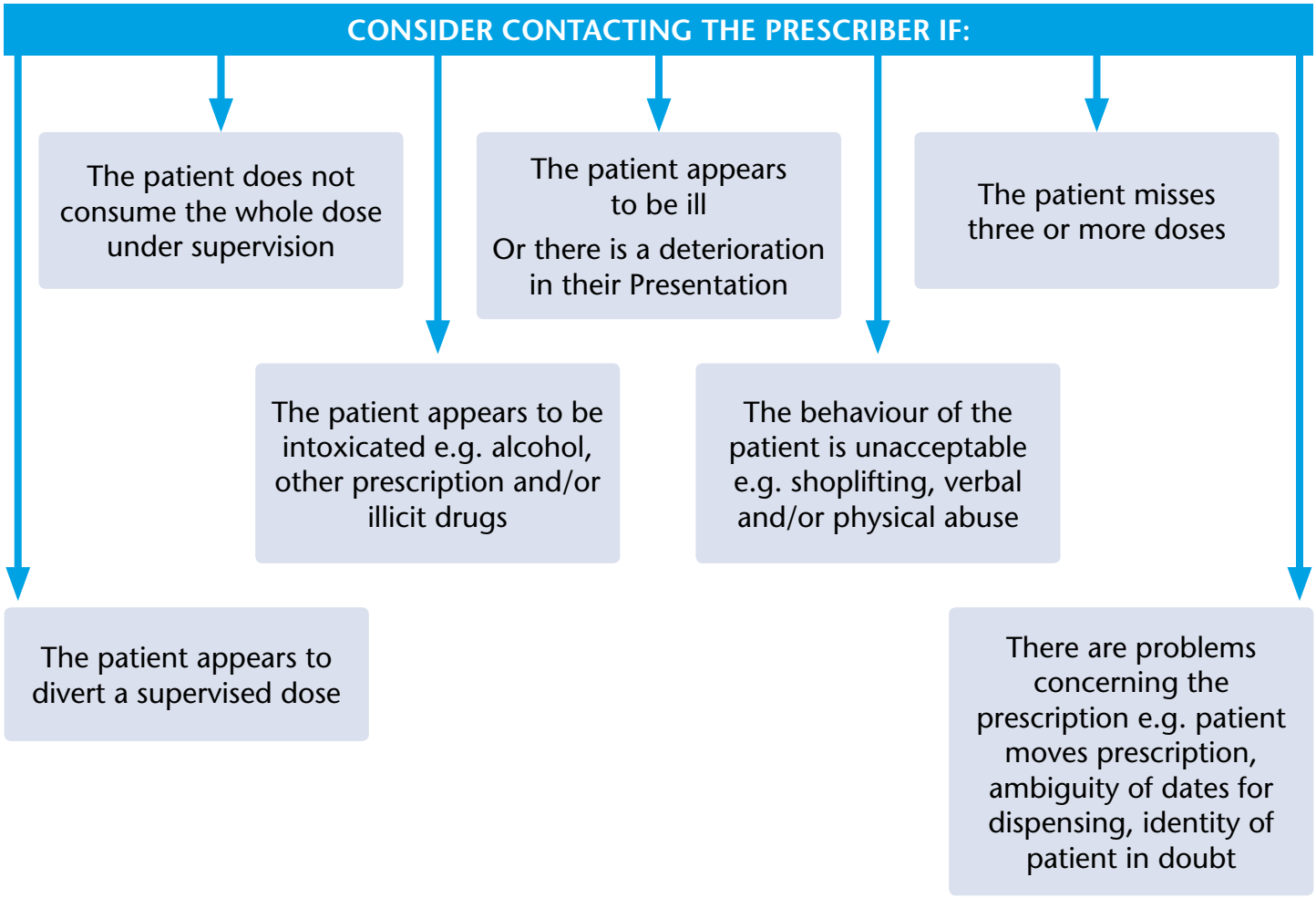
Please calibrate the methadone pump and complete this log at the start of each day. The pump must be calibrated before it is used, please refer to the manufacturer's instructions on how to carry this out.

Date	Time	Pump calibrated at 10 & 30mls & found to be dispensing correctly (Please Circle Yes or No)	Name of person completing log	Signature
		Y / N		
		Y / N		
		Y / N		
		Y / N		
		Y / N		
		Y / N		
		Y / N		
		Y / N		
		Y / N		
		Y / N		
		Y / N		
		Y / N		
		Y / N		
		Y / N		
		Y / N		

* Please Note: If the pump is not dispensing correctly please contact the manufacturer for advice.

Appendix D

NHS GREATER GLASGOW & CLYDE ADDICTION SERVICES – PRESCRIBER CONTACT



Remember

- Missing doses may result in a drop in opiate tolerance with an increased risk of accidental overdose.
- Do not hesitate to contact the prescriber or addiction team if you have concerns regarding a patient and they have missed any number of doses, you do not need to wait until they have missed 3 if you have reason to believe they may be at risk. Use your professional judgement and asses each situation individually.
- Patients stabilised on substitution therapies should be alert and coherent.
- As you get to know the patient you may be in a position to notice deterioration in their health or social functioning.
- Pharmacists must liaise with health care professionals and others involved in the care of the patient having due regard for patient's confidentiality.

Appendix E

Procedures for Lost / Stolen or Misplaced prescriptions. 14.11.16 (Updated)

If it is suspected that a prescription has been lost, stolen or misplaced the following procedures should be followed. The procedures apply to GP10 ,HBP, GP10P and GP10N blank prescription forms and to prescriptions issued to patients.

1. Email standard notification form (available on CPDT site) to GG-UHB.CPdevteam@nhs,net . The details will be circulated to all pharmacy contractors within NHSGG&C and adjoining Health Boards. The Health Board will notify Strathclyde police of all lost/stolen prescriptions at the end of each week.
2. The patient's GP/Prescriber should be contacted.
3. If any advice or guidance is required on procedures please contact addiction services on 0141 303 8971
4. All incidents should be reported to the relevant Senior Medical Officer on 0141 303 8971

If a pharmacy receives a prescription form that they have reason to suspect then they will use the contact number provided within the notification to query authenticity. If it is established that any such prescription is not authentic the pharmacy will contact the local police.

Lost prescriptions should not routinely be replaced. However discretion can be exercised and prescriptions replaced in exceptional circumstances and following full consultation (this should include the patients' regular pharmacy). All details of the incident and resolution should be recorded. Patients must be made aware that safe custody and transfer of prescriptions to the pharmacy is their responsibility.

N.B.

Please note; it is essential that all information is contained in the notification form and is accurate. The CPDT will NOT undertake any checks on notifications received.

Failure to provide all information may result in a delay to the notification being sent.

Appendix F

STRATHCLYDE POLICE

NHS Ayrshire & Arran

NHS Greater Glasgow & Clyde

NHS Highland

NHS Lanarkshire

PRESCRIBED MEDICATION REQUEST

To:..... (Name of Pharmacy)

Name:.....

DOB:.....

Address:.....

Name of Prescriber/GP:.....

I currently receive regular prescribed medication dispensed by the above named pharmacy I am currently in the custody of Strathclyde Police and therefore unable to attend to obtain this medication. I hereby authorise Name.....
Rank..... of .....Police Office
to collect the medication I am due to receive today.

Signature..... Date.....

Witness..... Date.....

Medication supplied by pharmacy? Y/N

Reason if not supplied.....

Pharmacist Name.....

GPhC Number.....

5 : 20 : 20 VI-A0111-P011

NHS Greater Glasgow and Clyde

Emergency Closure of Pharmacy Premises

In the event of an emergency closure, certain procedures need to be followed to maintain continuity of pharmaceutical care and to ensure that patient and staff safety is also considered. Where provision is affected, pharmacy staff have a responsibility to ensure that the relevant Services are notified of any closure.

Addiction Services patients may experience difficulties travelling to the pharmacy to collect their medication and therefore alternative arrangements may need to be put in place. An authorised agent can be used to collect patient medication and should have a written note from the patient, as good practice, authorising collection of their medication on their behalf. A phone call from a patient may also be acceptable if the patient is known to the pharmacist with a record of the call made in the patient's medication record.

In the event of emergency pharmacy closures, pharmacists are requested to follow these procedures:

1. Phone the Community Pharmacy Development (CPD) team on 0141 201 6049 to notify of your intent to close. (or NHS 24 outwith normal working hours via your direct referral procedures and then contact the CPD team the next morning.)
2. Contact local Addiction Teams/drug services and relevant GP prescribers within Shared Care Practices as soon as a decision to close has been made and advise of the closure time.
3. If the pharmacy will be closed on the following day, please adhere to the Home Office wording which should be stamped on CD instalment prescriptions and dispense the following day's medication in advance. (Please refer to your Medicines Ethics and Practice for information on Home Office wording.)
4. Inform addiction and GP practice staff of patients who have collected their medication and obtain contact details for those still to attend. Every effort should be made to contact patients on instalment prescriptions before closing. Addiction staff may find it easier to contact patients directly but offer support if needed.
5. Increase injecting equipment supplied and offer overdose prevention advice including how to access naloxone training sessions.
6. Advise all patients to attend as early as possible in the day in case of early closure.
7. Use CPUS to ensure qualifying patients obtain repeat supply of medication
8. Promote MAS to alleviate demand for GP appointments for minor ailments
9. Update Business Continuity Plans to incorporate lessons learnt

For further advice or support on guidance relating to emergency closing, please contact the Community Pharmacy Development Team on 0141 201 6049 or GG-UHB.cpdevteam@nhs.net or the Pharmacy Team at NHS GG&C Addiction Services on 0141 303 8931.

NHS Greater Glasgow and Clyde

USEFUL CONTACT NUMBERS FOR NHSGG&C COMMUNITY ADDICTION TEAMS

TEAM	ADDRESS	PHONE No
East CAT	The Newlands Centre, 871 Springfield Road, Glasgow G31 4HZ	0141 565 0200
North East CAT	Westwood House, 1250 Westerhouse Road, Glasgow, G34 9EA	0141 276 3420
West CAT (Hecla Sq)	7-19 Hecla Square Drumchapel, Glasgow G15 8NH	0141 276 4330
West CAT (Possilpark H&CC)	Possilpark Health and Care Centre, 99 Saracen Street, Glasgow, G22 5AP	0141 800 0670
North CAT (Closeburn St)	7 Closeburn St, Possilpark, Glasgow G22 5JZ	0141 276 4580
South West CAT	Pavillion 1, Rowan Business Park, Ardlaw St, Glasgow G52 3RX	0141 276 8740
South CAT	New Gorbals Health and Care Centre, 2 Sandiefield Road, Glasgow, G5 9AB	0141 420 8100
Greater Pollok CAT	130 Langton Road, Glasgow, G53 5DP	0141 276 3010
South East CAT	10 Ardencraig Place, Glasgow, G45 9US	0141 276 5040
West Dunbartonshire CAT	120 Dumbarton Road, Clydebank, G81 1UG	0141 562 2311
East Dunbartonshire CAT	Kirkintilloch Integrated Care Scheme, 10 Saramago Street , Kirkintilloch, G66 3BF	0141 232 8211 0141 232 8202
East Renfrewshire CAT	Substance Misuse Team, St Andrews House, 113 Cross Arthurlie Street, Barrhead G78 1EE	0141 577 3368
Homeless Addiction Team	55 Hunter St Glasgow G4 0UH	0141 552 9287
Drug Court Team	80 Norfolk Street Glasgow G5 9EJ	0141 274 6000
218	218 Bath Street, Glasgow, G2 4HW	0141 331 6200
ARBD (Alcohol Related Brain Damage)	55 Hunter Street, Glasgow, G4 0UH	0141 553 2937

TEAM	ADDRESS	PHONE No
Eriskay In-patient	Eriskay House, Stobhill Hospital, 133 Balarnock Road, Glasgow G21 3UR	**0141 232 0600**
Occupational Therapy	Festival Business Centre, 150 Brand Street, Glasgow, G51 1DH	**0141 303 8956**
Psychology	Festival Business Centre, 150 Brand Street, Glasgow, G51 1DH	**0141 303 8956**
Acute Liaison	West Glasgow ACH, Dalnair Street, Glasgow G3 8SJ	**0141 201 0204**
Kershaw Unit – Day service/ In-patient/Out-patient	Gartnavel Royal Hospital, 1055 Great Western Road, Glasgow, G12 0XH	**0141 211 3546**
Leven Addiction Services	Dumbarton Joint Hospital, Cardross Rd, G82 5JA	**01389 812 005**
Inverclyde Integrated Drug Service	Cathcart Centre, 128 Cathcart St, PA15 1BQ Greenock	**01475 499 000**
Renfrewshire Drug Service	Renfrewshire Drug Service 10 St James Street, Paisley PA3 2HT	**0141 889 1223**

Appendix I

THE ROLE OF PHARMACISTS IN ENSURING CHILDREN AFFECTED BY PARENTAL ALCOHOL AND DRUG MISUSE ARE ADEQUATELY SUPPORTED AND PROTECTED

Pharmacists are well placed to contribute to the overall provision of services to children affected by parental alcohol and drug use. In particular the role of pharmacists is developing in Greater Glasgow & Clyde in relation to the wider public health of individuals with drug and alcohol problems and pharmacists have expanded their role in relation to the range of advice and support they can give to those individuals.

Legal Framework

The Children (Scotland) Act 1995 sets out the responsibilities of local authorities and other services for protecting children and promoting their welfare. The key principle of the Act is that the well being of the child is of paramount importance. The Act places a duty on agencies engaging with adults with parental responsibilities to assess the needs of children if their health and well being may be at risk.

The Act states that parents should normally be responsible for their children. This implies that public authorities should not separate the child from the parent unless it is clearly in the interests of the child to do so.

The particular needs of children affected by parental alcohol and drug use have been highlighted in the following documents:

- Getting it right for every child - http://www.gov.scot/Resource/Doc/1141/0065063.pdf

  Getting our priorities right – Good practice guidance. Available at https://www.gov.scot/publications/getting-priorities-right/
- Hidden Harm – The report of the Advisory Council on the Misuse of Drugs, which gives a detailed overview of the issues which children face in living in such households https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/120620/hidden-harm-full.pdf
- All together now – Our strategy to address the harms of alcohol and drugs in Scotland. September 2018 Scottish Government

Pharmacists will often be in daily contact with children affected by parental alcohol and drug use, particular pre- school children under the age of 5 years. Very often these children will accompany their parents to the pharmacy. This gives pharmacists and the pharmacy staff a great opportunity to work with other agencies at the earliest stages to help children and families avoid crises or tragedies. To aid this collaborative working, pharmacists may wish to strengthen their relationships, and communication links, with other local service providers such as Community Addiction Teams, Primary Care Services and Social Work Services.

Pharmacists can play a role alongside other professionals in ensuring that the government's aim for a 'whole family' approach works well in the children they see who are affected by their parents' alcohol and drug use. They will be aware of patients missing doses, or collecting under the influence, which can be a sign that they are struggling or require additional support. Pharmacists must consider the impact this could have on dependents and, when appropriate and/or necessary, ensure communication with prescribers and other relevant bodies is initiated and maintained.

Pharmacists can use the following information as a guide to how and when to respond to issues, which relate to children affected by parental alcohol and drug use.

'What the Guidance says'

The Guidance which has been issued by the Scottish Government (Getting our priorities right – 2018) states that All services have a part to play in helping to identify children that may be 'in need' or 'at risk' from their parent's problematic alcohol and/or drug use and at an early stage. When working with parents with problematic alcohol and/or drug use, all services should consider the possible impacts on any dependent children, be alert to their needs and welfare and respond in a

co-ordinated way with other services to any emerging problems. Pharmacists may be the first to be aware of problems or to have concerns. The most common forms of harm associated with parental alcohol and drug use are: -

- Physical Neglect
- Abandonment
- Physical Injury as a result of lack of parental supervision

Parental Addiction can compromise children's health and development.

Although parental alcohol and/or drug use can have a number of impacts on children and families, it does not necessarily follow that all children will be adversely affected. On the other hand, it is also true that parents and children hide problems - sometimes very serious ones. So where you know substance use is an issue consideration should always be given to the impact this may have on the child/children involved.

The adverse consequences for children are typically multiple and cumulative and will vary according to the child's stage of development. They include:

- failure to thrive
- blood-borne virus infections
- incomplete immunisation and otherwise inadequate health care
- a wide range of emotional, cognitive, behavioural and other psychological problems
- early substance misuse and offending behaviour
- poor educational attainment.

These can range greatly in severity and may often be subtle and difficult to detect.

The role of the pharmacist should be to work collaboratively with other agencies (in the field of addiction and child protection) in the detection and intervention of children who are at significant risk of harm as a result of parental alcohol and drug use and to plan and develop services with such agencies for children who may be in need of protection and support. In approaching these issues, pharmacists should be aware of the guidance issued by Chief Medical Officer for Scotland in relation to the role of the NHS staff and contractors in relation to Child Protection and of the over-riding imperative to share information where a child may be at risk of significant harm. There are circumstances in which confidential information can be shared, for example if there are concerns about a child's safety or an adult's risk of causing harm to themselves or others.

Determining whether a child is at risk is based largely on individual judgment. However the following characteristics may alert the pharmacist to potential risk/abuse. It is important to remember that the presence of any/or more than one of these factors may not automatically be the result of abuse.

IF IN DOUBT CHECK IT OUT!

If you are unsure about whether a child is at risk pass your concerns to your local Social Work Office. Here you can speak to the Duty Children & Families Worker.

What to Look For:

In the Child

- Unexplained or Unusual Injuries
- Bite marks, scalds, bruising, fractures especially in babies
- Evidence of poor overall care e.g. child appears dirty, unkempt, inadequately dressed for elements
- Behavioural problems e.g. child is withdrawn, aggressive
- Lack of Parental Supervision (appropriate to age of child)
- Child fearful of parent

In the Parent

- Inconsistent explanation of the child's injuries
- Delay/Reluctance in seeking medical treatment/advice
- Intoxicated to a level which could compromise parenting capacity
- Aggressive Handling/Behaviour towards child
- Detachment (physically and emotionally unavailable/responsive to the child's needs)

The above lists are not exhaustive however provide some basic guidance.

Acknowledging that parental drug and alcohol use is an additional risk factor for new born children, attached is some information and advice which pharmacists can share with new parents to help Reduce Sudden Unexpected Death in Infants (SUDI).

Reducing Sudden Unexpected Death in Infants (SUDI)

Information and Guidance for Staff

Reducing infant mortality is a major priority for NHSGGC. A prevention pathway has been created to ensure all staff give consistent advice when working with pregnant women and families to reduce the risk of SUDI. This document summarises the main risk factors and advice to be given to parents and carers.

Risk Factors for SUDI

- Poverty and deprivation.
- Babies aged 0-12 months are at greater risk of SUDI.
- Rates of SUDI are higher in low birth weight babies (less than 2,500g or 5lb 5oz).
- Babies born pre-term (less than 37 weeks gestation) are at greater risk compared to babies born at term.
- Placing a baby to sleep on their front or side is a very strong risk factor for SUDI.
- Adults sleeping on a sofa or couch with a baby is a major risk factor.
- Babies are at greater risk when a mother smokes during pregnancy or if there is smoking and second hand smoke in the home.
- Bed sharing and bed sharing with an adult who smokes.
- Bed sharing with an adult under the influence of alcohol and, or drugs (prescribed or illicit).
- Baby deaths are also associated with overheating by overwrapping the baby or placing objects in the cot that increase the temperature.

Advice to parents and carers

- All babies should sleep in the supine position - 'back to sleep' and never on their front or side, regardless of when or where they sleep.
- No parent or carer should sleep on a sofa or couch with a baby.
- A cot is the safest place for a baby to sleep.
- Whilst not recommending bed sharing, parents might decide to take baby into bed to help with night time breast feeding, because they find it easier to comfort baby during the night, or because they want to keep baby in direct contact with them. Whatever their reason, parents and carers need to be aware of the small increased risk to baby of a SUDI when bed sharing.
- The risk of SUDI is increased if parents smoke, have consumed alcohol, taken medication or drugs (prescription or illicit) that may cause drowsiness, or are overly exhausted and they bed share.
- Breast feeding should be encouraged.

- Baby should always be kept smoke free.
- Baby is at greater risk when a mother smokes during pregnancy.

Full document

http://www.nhsggc.org.uk/your-health/public-health/maternal-and-child-public-health/resources-for-staff/

Pharmacists seeking further guidance and assistance on any of the issues above should contact:

Pharmacy team,

Greater Glasgow & Clyde Addiction Services

Tel No: 0141 303 8931

Your local Social Work Area Services contact details are shown below. You should contact the relevant team if you have any concerns over the safety or wellbeing of any child. If it is out-of-hours you can call Glasgow and Partners Emergency Social Work Service on 0300 343 1505.

Glasgow City Council Social Work Services Area Service Teams

North East CHP	North West CHP	South CHP
Springburn 28-30 Adamswell St. Springburn Glasgow G21 4DD **Tel: 0141 276 4710**	**Possilpark** 30 Mansion Street Glasgow G22 5SZ **Tel: 0141 287 0555**	**Castlemilk** 10 Ardencraig Place Glasgow G45 9US **Tel: 0141 276 5010**
Easterhouse Westwood House 1250 Westerhouse Road Glasgow G34 9EA **Tel: 0141 276 3410**	**Drumchapel** Mercat House 31 Hecla Square Glasgow G15 8NH **Tel: 0141 276 4300**	**Pollok** 130 Langton Road Glasgow G53 5DP Tel: 0141 276 3010 **Fax: 0141 276 2914**
Parkhead Newlands Centre 871 Springfield Road Glasgow G31 4HZ **Tel: 0141 565 0100**	**Partick** 35 Church Street Glasgow G11 5JT **Tel: 0141 276 3112**	**Gorbals/Govanhill** Twomax Building 187 Old Rutherglen Road Glasgow G5 0RE Tel: 0141 420 0060 **Fax: 0141 420 8004**
		Govan Pavilion One Rowan Business Park 5 Ardlaw Street Glasgow G51 3RR Tel: 0141 276 8840 **Fax: 0141 276 8940**

Appendix J Useful contact details

Allan Harrison	Lead Pharmacist - Community Care	Pharmacy & Prescribing Support Unit NHS Greater Glasgow and Clyde Clarkston Court 56 Busby Road Clarkston Glasgow G76 7AT **0141 201 6051**
David Thompson	Lead - Community Pharmacy Development and Governance	Pharmacy & Prescribing Support Unit NHS Greater Glasgow and Clyde Clarkston Court 56 Busby Road Clarkston Glasgow G76 7AT **0141 201 6051**
Janine Glen	Contracts Manager	Pharmacy & Prescribing Support Unit NHS Greater Glasgow and Clyde Clarkston Court 56 Busby Road Clarkston Glasgow G76 7AT **0141 201 6049**
Controlled Drug Governance Team		Pharmacy Services NHS Greater Glasgow and Clyde 1st Floor, Clarkston Court 56 Busby Road Clarkston Glasgow G76 7AT **0141 201 6033**
Elayne Harris	Lead pharmacist – Palliative care	**0141 428 8248**
Alison Campbell	Public Health Pharmacist	Glasgow Royal Infirmary **0141 211 5433**
Specialist BBV Pharmacist		Brownlee Centre, Gartnavel Royal Hospital **0141 211 3000**

13. Bibliography

1. University of the West of Scotland, 2012, Needle Exchange Surveillance Initiative (NESI): Prevalence of HCV and injecting risk behaviours among people who inject drugs attending injecting equipment provision services in Scotland, 2017.

   Available from: https://www.hps.scot.nhs.uk/resourcedocument.aspx?id=5863
2. Gossop et al. (1996) NTORS The National Treatment Outcome Research Study. Department of Health: London.
3. Gruer L, et al (1998) The Impact of Methadone in Glasgow Study. Chief Scientist's Office, Edinburgh
4. Medicines Ethics and Practice: A guide for pharmacists. Royal Pharmaceutical Society of Great Britain, Current edition
5. Human medicines regulation. [online] Available from: http://www.legislation.gov.uk/uksi/2012/1916/contents/made
6. Misuse of drugs regulations 2001, regulation 15 & 16. [online] Available from: http://www.legislation.gov.uk/uksi/2001/3998/regulation/15/made and http://www.legislation.gov.uk/uksi/2001/3998/regulation/16/made
7. British National Formulary (latest edition) Controlled drugs and drug dependence. In Guidance on Prescribing, British Medical Association and Royal Pharmaceutical Society, London

   Department of Health; The Scottish Office, Department of Health; Welsh Office; Department of Health and Social Services, Northern Ireland, The Stationery Office, London
8. NHS Education for Scotland, distance learning pack 'Substance Use and Pharmaceutical Care' 2015.
9. GPhC guidance document 'Standards for pharmacy professionals' 2017. [online]

   Available from: https://www.pharmacyregulation.org/spp
10. CPS Scotland website. [online] http://www.communitypharmacyscotland.org.uk/
11. RPS Support 'Protecting vulnerable adults – a quick reference guide'. [online]

    Available as an online resource to members of the RPS.
12. RPS Support 'Protecting children and young people – a quick reference guide'. [online Available as an online resource to members of the RPS.
13. General Pharmaceutical Council, Guidance for registered pharmacies preparing unlicensed medicines, 2018. [online] Available from: https://www.pharmacyregulation.org/sites/default/files/document/guidance_for_registered_pharmacies_preparing_unlicensed_medicines_august_2018_0.pdf
14. Crown review 'Prescribing, supply & administration of medicines, March 1999'. [online Available from: http://webarchive.nationalarchives.gov.uk/20130107105354/http:/www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4077153.pdf
15. Medicines act, 1968. [online] Available from: http://www.legislation.gov.uk/ukpga/1968/67
16. Drug misuse and dependence-UK Guidelines on clinical management 2017, Department of Health
17. Children (Scotland) Act 1995. [online] Available from: http://www.legislation.gov.uk/ukpga/1995/36/contents
18. Scottish Government 2011. Getting it right for every child. [online] Available from: www.scotland.gov.uk/publications/2011/01/11143648/1
19. Scottish Government 2013. Getting Our Priorities Right. [online] Available from: www.scotland.gov.uk/publications/2013/04/2305

20. The Scottish Government 2005. Hidden Harm - Scottish Executive Response to the Report of the Inquiry by the Advisory Council on the Misuse of Drugs. [online] Available from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/120620/hidden-harm-full.pdf

21. Department of Health (England) and the devolved administrations (2007). Drug misuse & dependence: UK Guidelines on Clinical Management. London: Department of Health (England), the Scottish Government, Welsh Assembly Government and Northern Ireland Executive. [online] Available from: www.nts.nhs.uk/uploads/clinical_guidelines_2007.p

14. Further Reading

1. The Scottish government. 2008 The Road to Recovery; A new approach to tackling Scotland's drug problem. Available from:www.scotland.gov.uk/resource/doc/224480/0060586.pdf

2. All together now – Our strategy to address the harms of alcohol and drugs in Scotland, 2018. The Scottish Government. Available from: https://www2.gov.scot/Topics/Health/Services/Alcohol/Strategy

3. The Scottish Government. Children Affected by Parental Substance Misuse (CAPSM) Strategy. Available from: www.scotland.gov.uk/topics/people/young-people/protecting/child-protection/capsm/stategy

4. Central register Office for Scotland. Drug related deaths in Scotland 2012.

5. The Scottish Government 2009. Changing Scotland's relationship with Alcohol: A Framework for Change. Available from: www.scotland.gov.uk/resource/doc/262905/0078610.pdf

6. Scottish Government (2008). Hepatitis C Action Plan for Scotland Phase II: May 2008 – March 2011. Available from: www.scotland.gov.uk/publications/2008/05/13103055/0

7. The Scottish Government 2013. Scottish Drug Strategy Delivery Commission; Independent Expert Review of Opioid Replacement Therapies in Scotland. Available from: www.Scotland.gov.uk/resource/0043/00431024.pdf

8. Exchange Supplies. The Methadone Briefing. Available from: www.exchangesupplies.org/drug_information/briefings/the_methadone_briefing/methadone_briefing/section4.html

9. Addiction Treatment Forum 2008. Methadone-Drug Interactions. Available from: www.atforum.com/siteroot/pages/addiction_resources/drug_interactions.pdf

Greater Glasgow & Clyde NHS Board
Greater Glasgow & Clyde Addiction Services
Greater Glasgow Area Pharmaceutical Committee

First Edition 1995

Second Edition 1997

Third Edition 2000

Fourth Edition 2005

Fifth Edition 2011

Sixth Edition 2015

Seventh Edition 2019