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Prescribing for Addiction Treatment at the Homeless Health Services

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Scope of prescribing for addiction at HHS

Prescribing for addiction treatment at the Homeless Health service is undertaken by the CHART team in collaboration with prescribing doctors and nurses within the service.

The CHART team includes addiction treatment at HHS, the One25 project and the Buvidal project, which offers injectable buprenorphine for opiate addiction treatment.

Those coming out of prison whilst already on injectable buprenorphine will be accepted to HHS CHART service (Buvidal) as there is a separate funding for this.

Prescribing for addiction treatment offers three choices for those with opiate addiction treatment need and includes methadone therapy, sublingual buprenorphine therapy and injectable buprenorphine therapy.

HHS will also in exceptional circumstances offer a diazepam prescription for patients presenting with diazepam addiction (This is discussed later in the document).

Support is also offered to patients presenting with alcohol dependence. Support will be offered around safe reduction of alcohol consumption as well as medicines to help with symptomatic presentations from alcohol abuse. Thiamine tablets will be prescribed for all patients who are alcohol dependent and omeprazole for those presenting with alcohol induced gastro-intestinal disturbances. Pabrinex should be offered opportunistically whenever a patient has an appointment. The prescribing of Librium or other benzodiazepines in alcohol addiction is limited to patients who are detoxing from alcohol.

Aims of OST prescribing at the Homeless Health Service

Prescribing for the purposes of addiction treatment at HHS serves four main purposes: harm reduction, stabilisation, maintenance and detoxification.

Prescribing for harm reduction

Patients may present for addiction treatment when still not ready to give up the use of street drugs. For such patients, the aim should be to prescribe methadone at optimal doses. High doses of methadone, though will not stop on top use of opiates, will give a higher opiate tolerance hence reducing the risk of opiate overdose from other street opiates. Discussions around safer injecting and harm minimisation needs to continue forming part of consultations for such patients.

Prescribing for stabilisation

Substitute opiates or diazepam is also sometimes prescribed to offer stabilisation from chaotic drug use. Patients using multiple opiates would benefit from all their opiate use being converted into one type of opiate prescription. This makes it easier to monitor and manage how much opiates a patient is taking. This also applies to patients who are using street benzodiazepines whose purity can vary vastly.

Maintenance prescribing

Substitute opiates may continue to be prescribed even after a period of stabilisation with no on top use of other opiates. Maintenance prescribing happens when patients are not yet ready for substitute opiate dose reductions and detoxification from medication. Many patients prefer to

remain longer in this phase of prescribing until when they have enough social capital in place that would support recovery once they have detoxed. Clinicians should recognise that for patients who have been opiate dependent for many years, dose reductions and detoxification will take longer and will need a lot of support.

Opiate Substitute Treatment initiation

Historically, OST initiation at HHS was an instant service upon presentation to the service within opening times. This was later moved to a morning only service following difficulties in managing patients who turned up to HHS a few minutes before the closing time asking an OST prescription. This was successful for a time but did not stop the chaos of patients who would not commit to being on a prescription and would often need weekly restarts or in some cases, present to HHS twice in one week for a restart. This presented a lot of risks to patients due to frequent restarts, increased risk of prescribing errors when patients turned up at the last minutes and no time available for psychosocial support. HHS therefore came up with a solution by ensuring that patients showed some motivation before being started on OST prescription.

From December 2022, all patients seeking to be started on OST prescription must present to HHS in the morning and leave a urine sample to be sent to the lab for testing. Patients are advised to return to HHS after 48 hours but no more than 7 days for OST assessment. This is to allow time for results to come back from the lab but without losing tolerance from date of testing. On some occasions, test results are available after 24 hours and if a patient presents and the results are already available, they will be assessed. Patients must return to HHS between 10am and 12pm for assessment and prescription initiation. Assessments will not be carried out in the afternoon.

Patients will be assessed for initiation into OST treatment following a urine drug screening result that is positive for opiates. During the assessment process, clinicians will have open discussions with patients around their current substance misuse, history of substance misuse, other prescribed medications, housing situation, mental health history/needs and other physical health needs. An opiate initiation template on Emis will be used to help clinicians cover all areas. Female patients should be asked if they may be pregnant and a pregnancy test offered if appropriate. Any pregnant female patient should be referred immediately for specialist prescribing with Bristol Specialist Drugs and Alcohol Service (BSDAS).

Aims of getting into OST treatment will be explored with patients and a suitable OST medication agreed. All OST medication consumption must be supervised for at least 6 days a week at the pharmacy at the start of treatment for a minimum period of 3 months before dispensing regime can be relaxed. Majority of patients attending HHS are either homeless, in unstable accommodations or are chaotic and therefore should remain under supervised consumption during treatment. All prescriptions must be issued with the home office wording so as to allow for dispensing on the days that pharmacies are closed and also to enable the pharmacist to stop dispensing when a patient miss collections for three or more days.

Consent to data sharing and storage

Consent must be obtained from patients regarding sharing of their data with ROADS providers in Bristol and to allow HHS to enter their data on the National Drug Treatment Management Systems data base (NDTMS), Theseus. All patients getting OST from HHS must also consent to HHS accessing all their health records through Connecting Care. This is to ensure that there is no dual prescribing from other GP practices and to also enable HHS to see if there are other

proprietary medications that are being prescribed to the patient from elsewhere that may increase risks in OST prescribing.

Blood Borne Viruses (BBV)

All patients coming to HHS for addiction treatment should be counselled about BBVs and offered testing. Clinicians should explain to patients their risks, available interventions such as vaccinations and treatments. Ideally, a venous blood sample should be obtained otherwise capillary blood samples should be taken if a venous sample is not possible.

Patients who continue to inject drugs should be offered annual BBV testing and monitoring. HHS is in a unique position of having a dedicated hepatology doctor on site. All patients who test positive for BBVs should be encouraged to go for treatment and be booked to see the speciality doctor. To encourage engagement, the appointment with the speciality doctor should be on the same day as the OST appointment. Patients who test negative for Hepatitis B or A with no history of immunisation should be booked with the nurses for vaccination.

Naloxone for overdose intervention

All patients, whether injecting or smoking drugs should be offered either injectable or nasal naloxone at the time of OST assessment. Patients should be taught how to recognise an overdose situation and be shown how to use the form of naloxone provided. A record must be kept of all the naloxone issued and patients should be encouraged to ask for more naloxone should they use what has been provided.

Discussion with pharmacists

All prescriptions must be issued with the home office wording that informs the pharmacist to stop dispensing when a patient misses three or more collections of the prescribed opiate. Before reviewing any patient and issuing a prescription, clinicians must speak to the pharmacist to check for collection patterns. Sporadic patterns of medication collection should be discussed and patients supported in ways that can increase treatment compliance.

Opiate Substitute Maintenance Prescribing

Following a period of initiation and stabilisation (usually 3 months), the aim of prescribing will be to retain patients in treatment and keep them engaged in other services that aid their recovery. Opiate substitute doses should be reviewed at every appointment as well as on top use of other street opiates. Patients with sporadic collections should be supervised for 7 days in order to reduce risk of losing tolerance

Urine samples for drug screening should be taken at least 3 times a year for monitoring on top use of other substances and for monitoring compliance with treatment. Patients who show stability through regular drug free urine samples or engagement in employment and other recovery activities can have a little more relaxed dispensing regime. Unsupervised dispensing should however only be given to patients with accommodation and ability to safely store the prescribed opiate into a lockable cupboard.

Patients will be expected to attend their OST appointment once every fortnight on a regular day and time. Prescription dispensing regime will be reviewed with every missed appointment. On the third consecutive missed appointment, no prescription will be generated, and patients will only get a prescription following a face-to-face review.

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ECG monitoring

All patients starting OST treatment should ideally have a baseline ECG done before the start of treatment. Patients prescribed methadone with other medicines that are likely to increase the QT interval should have an ECG when methadone doses are titrated to 60mls daily or more. Patients prescribed 80mls of methadone daily, regardless of on top use or other prescribed medication, should have an ECG every 6 months and shortly after a methadone dose increase.

Medication dispensing regime

The homeless Health service caters for patients who are either street homeless, unstably housed or are chaotic in their drug use. As such, majority of patients at HHS are unable to provide safe storage of their medication. All patients receiving addiction treatment medication should be on supervised dispensing regime for at least 6 days. Deviation from this protocol should be discussed and agreed with the team and all risks mitigated against as much as possible. Any patient who lives in a household with a child/ children should use a pharmacy that is open 7 days a week and be supervised every day. For such patients, take away doses of their prescribed medicines should be in exceptional circumstances only.

Treatment exit

Patients can come to the end of their treatment and exit either as drug free, moving on to regular primary care services under BDP shared care system, being retained in custody (sent to prison), moving out of area, HHS withdrawing their service (patient being banned), going into long-term hospital care or death.

HHS will ensure that there is no break in treatment when the exit is planned. Relevant healthcare providers will be contacted and patient care and prescription continuation discussed.

Excluded patients

When a patient is banned from the service, a police crime reference number must be obtained and patient transferred to the Special Allocation Service (SAS) within 48 hours. Prescription should be issued to cover a period of no more than 14 days so as to allow patients time to get an appointment with the SAS service. Patients can return to use HHS service after a period of one year at the SAS service.

Moving on to shared care

Patients can move back to regular GP services once they are adequately housed, are less chaotic and able to engage with their registered GP. Patients may also be moved back to their regular GP services if they are living/ homeless too far away from HHS and are unable to make it to appointments at HHS service. In cases where a patient is receiving other treatments regularly from their registered GP, HHS will contact their regular GP to take over the prescribing of methadone as well so as to minimise risks. In such instances, patients will be assessed by our substance misuse practitioner and the transfer documents sent over to BDP. Patients will continue to get their OST prescriptions from HHS until an appointment is offered to them by BDP through their GP surgery (usually 10 working days from assessment date).

Drug free completions

Patients will be classed as drug free at treatment exit if they are no longer using any opiates or cocaine-based drugs of abuse.

Following a successful detox, all drug free completions should be offered continued psychosocial support for a period of up to 6 months and be assisted in engaging in other recovery activities. Post detox medications to support recovery should be offered and monitored through regular appointments.

Patients taken into custody

At present, HHS is rarely informed by the prison authorities when a patient is taken into custody. Some prisons may contact HHS to get care records but others don`t as HHS is not the patient`s registered GP service. Most knowledge about patients going into custody tend to come from the pharmacy or through other patients. However, upon release, patients tend to return straight back to HHS despite the prison release pathway that requires patients to be seen by the After Prison Prescribing Service (APPS). Clinicians will need to check the Theseus data base for any prebooked appointments with APPS before taking anyone on from prison.

Patient death

All patients who have died whilst on OST treatment should be reported immediately to NDTMS. Their episodes on Theseus should be closed as soon as possible and the entire HHS team and the ROADS network notified of death. A “death” debrief with the team should happen as soon as possible and a learning event recorded.

Transferring from other opiates

Patients will sometimes present to HHS when they are already on an opiate prescription and may want to change over to a different form of OST. Sometimes patients are prescribed one type of opiate at the start of treatment but change their mind and may want to have a different OST medication.

Methadone to Buprenorphine changeover

Patients should be assessed for such a change over and all risks explained so that they can make informed choices. Change over from methadone to buprenorphine can be successfully done in the community but on some occasions, may require referral for inpatient change over with BSDAS. Patients with a history of repeated failed change over in the community should be referred for in patient change over.

Community changeover from methadone should be done once a patient is on doses of 30mls or less. Patients can be changed over from much higher doses of methadone but this should be done as an in-patient. Patients with enduring mental health problems especially coupled with a history of trauma tend to do better on methadone than buprenorphine due to its emotional numbing properties.

The risks of precipitated withdrawal should be explained to patients and telephone support or face to face support offered during the changeover period.

All changeovers should wherever possible be started at the beginning of the week so that patients can contact HHS for support in case of any difficulties. In patients with significant health problems, such changes should be discussed with a doctor first.

Buprenorphine to methadone changeover

Buprenorphine is the preferred OST medication for patients who want to be abstinent from the use of heroin and other opiates. However, some patients for one reason or another may struggle being on buprenorphine and may ask to go back on to methadone instead.

Changing over from buprenorphine to methadone should be straight forward as there is no risk of precipitated withdrawal. Again, patients with physical health problems need to be discussed with a doctor before a changeover.

Prescribing for Diazepam addiction at HHS

The majority of patients presenting at HHS with benzodiazepine addiction tend to be poly drug users of other substances such as heroin, crack, alcohol, spice or other prescription medicines. This increases their overall risk, making the initiation of diazepam prescribing a risky undertaking.

The prescribing of diazepam to a patient at HHS for addiction treatment will only be initiated following a team discussion. A urine drug screen must be taken for screening for evidence of benzodiazepine addiction.

If prescribing is agreed, it should be for a time limited period with a clear agreement on the starting dose, rate of reduction and expected treatment exit. This should be put in writing and a signed agreement be put in place before any diazepam prescription is issued.

Prescribing should be stopped if there is evidence of diversion, continued excessive use of street benzodiazepines or a lack of engagement with treatment.

Prescribing for detoxification

HHS will support patients who are ready to detox from their prescribed opiate medication, benzodiazepines or alcohol misuse. Prescribing for detoxification must be planned and agreed collaboratively with patients.

Prescribing for opiate detoxification

The aim of prescribing during detoxification is to offer pharmacological support for opiate withdrawal symptoms. It is good practice to give Pabrinex injection during the preparation stages of a planned alcohol detox. Even when a detox is unplanned, it is still beneficial for patients to have Pabrinex at any point during the detox process. Diazepam is normally prescribed to help with sleep difficulties as well as restless legs. The dose of prescribed diazepam will depend on the last opiate dose and should be initiated from day two following the last opiate dose. Detoxification using diazepam should be for a period of up to 10 days and the medication should be issued in bulk for taking away. Other medicines for the management of gastro-intestinal problems should also be prescribed as appropriate. Some patients may want supportive post detox medication such as naltrexone. This should be agreed with patients as

part of detox planning and should only be given after a period of at least 10 days without the use of any opiates.

Prescribing for alcohol detoxification

Prescribing for alcohol detoxification will normally involve daily appointments with a clinician for Blood pressure monitoring and breathalysing. During the detox process, prescribing will only be continued and a prescription issue if the alcohol reading on the breathalyser is zero. Librium is the preferred medicine for alcohol detox but for some patients, diazepam may be used. Acamprosate is generally prescribed to patients following successful detoxification. Naltrexone may also be prescribed to aid relapse prevention following a successful detox. However, naltrexone cannot be prescribed if a patient is still on any opiate medication. Other patients may prefer to be prescribed disulfiram as a deterrent for future alcohol misuse.

Prescribing of Pregabalin and Gabapentinoids

HHS will not initiate the prescribing of pregabalin or gabapentin. Patients who present to HHS whilst already on such medications will be discussed on a case-by-case basis whether to continue with such prescribing or not. Where there is clear evidence of polydrug use from street drugs, HHS will not continue prescribing gabapentin's or pregabalins even if a patient was already on them from a different practice.

Collaborative working with other services

The HHS works collaboratively with other sectors and organisations for the benefit of patients.

Patients must consent to their information being shared with such organisations and inform staff of any aspects of their addiction treatment that they do not want to be shared. All patients entering OST treatment are expected to consent to information regarding their addiction treatment being entered into the National Drugs Treatment Monitoring System (NDTMS) and will be subject to regular reviews for treatment outcomes.

Information regarding addiction treatment will be shared with other ROADS partners but patients can opt out of sharing with ROADS partners that are not involved with treatment such as housing pathways.

HHS will work closely with the SUST team, St. Mungo's Outreach teams, After Parison Prescribing Service (APPS) and the Bristol Specialist Drugs and Alcohol Service (BSDAS).

It is good practice for clinicians to contact St Mungo's outreach team in the first instant if a patient who was on OST treatment drops off treatment and there are no other ways of knowing about their safety.

Abbreviations

APPS..... After Prison Prescribing Service

BBV..... Blood Borne Viruses

BDP..... Bristol Drugs Project

BSDAS.....Bristol Specialist Drugs and Alcohol Service

GP.....General Practitioner

HHS..... Homeless Health Service

NDTMS.....National Drug Treatment Monitoring System

OST.....Opiate Substitute Treatment

ROADS.....Recovery Oriented Alcohol and Drugs Services

SAS..... Special Allocation Scheme

Change Register

Date	Version	Author	Changes