Supplementary prescribing in the substance misuse field

AUTHOR Beverley Harniman, RMN, DipHE, is extended formulary/supplementary prescriber and clinical nurse specialist, substance misuse, at Villa Street Medical Centre, Southwark, London.


Recent legislative changes have enabled nurse supplementary prescribers to prescribe controlled drugs. This article explores the scope of supplementary prescribing for substance misuse clients within a primary care setting and shares practical experiences of incorporating this new development into clinical practice.

Amendments to the 2001 Misuse of Drugs Act in April 2005 enabled supplementary prescribers to prescribe controlled drugs. In the substance misuse field this is known as substitute prescribing and most commonly refers to methadone and buprenorphine. Some controlled drugs can now be prescribed independently in palliative care but in substance misuse supplementary prescribing arrangements remain.

Supplementary prescribing is ‘a voluntary prescribing partnership between an independent prescriber and a supplementary prescriber to implement an agreed patient-specific clinical management plan with the patient’s agreement’ (Department of Health, 2004). It was developed for chronic conditions so is appropriate for substance misuse clients, who usually receive long-term treatment. The National Treatment Agency for Substance Misuse has stated that nurse prescribing in substance misuse has the potential to significantly improve service delivery by ensuring the accessible supply of medication (NTA, 2005).

Increasingly, drug misusers are treated in primary care settings, generally in a shared care frameworks. It is considered poor practice for practitioners to prescribe in isolation (DoH et al, 1999) so clients are usually seen by the shared care drug worker and prescriber, and prescription dosage is a joint decision. Good communication between the prescriber, drug worker and pharmacist is essential.

Planning and assessment

Before commencing a prescription it is important to undertake a thorough assessment and obtain a full history of the client’s drug use, health, social support, housing, legal history and expectations of treatment, and to formulate a care plan with the client. A urine specimen is needed to confirm opiate use. Clinical investigations may include blood tests for liver function, a full blood count test and screening for HIV, hepatitis B and C. Clients should be offered hepatitis B vaccinations and any drug allergies or adverse reactions should be noted.

Discussion needs to take place with the client over what medication they want/would be better suited to, and the appropriate starting dose. It is important to explain the need to start on a low dose – generally 30ml methadone maximum – and then to titrate this dose up at regular intervals.

Buprenorphine is a partial agonist. It binds tightly to the receptors and displaces any opiates, so the client must be in withdrawal from methadone or heroin prior to starting treatment or she or he can experience precipitated withdrawals. The client needs to be clearly informed of this. Buprenorphine is generally titrated over three days and the dose is increased according to the client’s response (Royal College of General Practitioners, 2004).

New prescriptions

Clients starting on a new prescription of methadone or buprenorphine should have the dose supervised by a pharmacist. This is recommended for the first three months. This needs to be discussed with the client and arranged with the local pharmacy. There needs to be a private area in the pharmacy for this purpose. The prescription is issued with ‘supervised dispensing’ written on it. Establishing a good relationship with the pharmacist is crucial as they will be seeing the client daily and will be able to inform the prescriber of any observed changes or if the client fails to collect her or his medication. When the client has become stable they take home the medication on a daily basis and, eventually, if progress is maintained dispensing can be reduced to twice a week then weekly.

For supplementary prescribing to be legal, a clinical management plan needs to be set up and the client’s agreement sought. It is important to agree conditions that would necessitate referral back to the independent prescriber. These could include very chaotic drug use, failure to comply, and medical problems needing review. In practice the shared care team would also be involved with the first two issues. A review period has to be agreed. I use the clinical management plan alongside the care plan and review both together every six months.
Supplementary prescribing is a collaborative role but the supplementary prescriber is professionally accountable for prescribing decisions (Bradley and Nolan, 2005). Recent changes to the Misuse of Drugs Regulations now allow all controlled drug prescriptions to be computer-generated. Previously they had to be handwritten unless the prescriber had Home Office handwriting exemption. Prescriptions should be issued for instalment dispensing and the frequency of dispensing stated on the prescription. Initially this would be supervised daily, probably with a take-home dose for Sunday unless the pharmacy is open on Sundays. Supplementary prescribers can obtain blue MDA–SP prescription forms. A maximum of 14 days is prescribed on a blue instalment form. The daily total and the overall total must be clearly written in words and figures. Clients need to be informed of the need for safe storage of take-home doses of medication. It is also important to inform them of any likely side-effects of the medication.

Concordance

The concept of concordance – the notion of patients having enough knowledge to participate as partners, that prescribing consultations involve patients as partners, and that patients are supported in taking their medication – has become more widely acknowledged in recent years (Medicines Partnership, 2004). A partnership approach to prescribing in the substance misuse field is very important as clients respond well to being involved in decisions about dose adjustments, frequency of dispensing and so on, and the element of negotiation and goal-setting is an important aspect of the therapeutic relationship.

Goal-setting

Once clients are stabilised on the medication it is necessary to review goals with them – for example, establishing whether they want to take maintenance treatment. There is good evidence for clients to be prescribed higher doses of methadone (60ml or more) on a long-term basis, and this is an effective harm minimisation intervention (Ashworth, 2005). Clients are more successfully retained in treatment and it should reduce illicit drug use on top of the script. Historically drug users have been underdosed with methadone and often continued to use street drugs. Clients should not be pressured to start reducing the dose. Many come into treatment concerned that this will occur as this has been their previous experience. Conversely if they want to reduce the dose and become drug-free this should also be planned as they need to take time over this to improve the likelihood of a good outcome. Clients will need support in structuring their time – seeking street drugs and using them will have taken up a lot of their day.

Some clients use street drugs in addition to their prescription. This may be because the dose is not adequate so they use them in the titration period as they feel uncomfortable. Boredom and isolation can also be factors while they may be offered drugs by their peers and find it difficult to refuse. Ongoing urine screening is important, as is working with clients to reduce illicit use and, if necessary, supporting them to switch from injecting to smoking drugs. The risks of overdose should also be made clear. A positive rather than punitive approach is vital, and the goal is to keep clients in treatment. Good documentation of toxicity results and discussions on illicit drug use are essential. I have often found clients reluctant to increase the prescription dose but when evidence for higher dosing is presented to them they will agree and then illicit use is reduced.

Scope

There is a great deal of potential for nurse prescribers to develop supplementary prescribing in the field of substance misuse. Clinical management plans can be developed for prescribing a range of treatments including alcohol detoxifications and acamprosate for alcohol cravings, as well as antidepressants such as fluoxetine.

Improving Mental Health Services by Extending the Role of Nurses in Prescribing: Good Practice Guide (National Prescribing Centre et al, 2005) identifies four potential benefits associated with the process of supplementary prescribing for substance misuse.

1. Increased accessibility to treatment.
3. Provision of improved care of patients.
4. Cost savings to the service and the individual.

References


Mr Blue arrived on Monday morning. He said he had last used heroin the previous evening and was starting to withdraw. He was anxious about the dose assessment and we discussed the process again with me seeking to allay his anxieties. I prescribed 8mg of buprenorphine, and contacted the community pharmacist who would be supervising it. Initial doses are usually 4-8mg (RCGP, 2004). In my experience clients often drop out during dose assessment if they are only prescribed 4-6mg because they experience too much discomfort from the withdrawals.

The next day he was reviewed by the GP. He said he had slept poorly and was feeling uncomfortable, so she increased the dose to 12mg. When I saw him on Wednesday he said he had had another poor night but seemed less anxious. He was pleased to be stabilising and said he liked not having to go out seeking drugs. I increased the dose to 16mg.

By Thursday he was much more settled. I discussed whether he felt the dose should be increased further. He felt he was still withdrawing slightly in the mornings and poor sleep remained an issue and suggested the dose be increased to 20mg. I suggested we try 18mg, to which he agreed. I prescribed 18mg for four days and arranged to review him the next Monday.

He returned on Monday looking well. He had settled on the medication, was sleeping well and had no cravings. He was pleased by his progress. He had accessed complementary therapies – reflexology and shiatsu – and at my suggestion had referred himself for a 12-week day programme at the local drug service, which he was enthusiastic about starting.

Mr Blue remains in shared care, seeing myself and the drug worker weekly. The prescription will be supervised at the pharmacy and treatment goals will be reviewed jointly by ourselves every four weeks. His urine samples have been clean – he has not used illicit drugs and is positive about continuing to make progress. His bloodborne virus screening tests have been negative and liver function tests are normal.