REPORT OF
THE METHADONE TREATMENT SERVICES REVIEW GROUP

DEPARTMENT
OF HEALTH AND
CHILDREN
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1. INTRODUCTION

1.1 Terms of Reference of the Review Group

The Review Group was set up to consider the arrangements in place for the management and care of heroin dependent drug misusers by general practitioners and pharmacists and to advise the Minister on the approach to be taken in the future. The group was first convened on 13th January 1997 and its terms of reference were:-

(a) to examine and define the role of general practitioners and pharmacists in the treatment of opiate dependent persons,

(b) to examine the working relationships between the various treatment centres and general practitioners and pharmacists, and

(c) to outline protocols for good practice in the prescribing and dispensing of methadone, including appropriate controls which might be put in place.

1.2 Membership of the Review Group

Membership of the Review Group reflected the various agencies which have a role to play in the provision of services for drug misusers. These were the Department of Health, the Eastern Health Board, the Irish College of General Practitioners and the Pharmaceutical Society of Ireland.

Mr Jimmy Duggan, Principal Officer, Community Health Division *(Chairman)*

Dr Jim Kiely, Chief Medical Officer, Department of Health

Mr Tom McGuinn, Chief Pharmacist, Department of Health

Ms Noreen Quinn, Pharmacist, Department of Health

Dr Joe Barry, Public Health Specialist, Eastern Health Board

Dr Brion Sweeney, Consultant Psychiatrist, Eastern Health Board *(representing the Consultants working in substance misuse in the Eastern Health Board)*

Dr Ide Delargy, Irish College of General Practitioners

Ms Sile O' Connor, Pharmaceutical Society of Ireland
(Ms Eugenic Canauan or Ms Leonie Clarke attended meetings when Ms O'Connor was unavailable).

Ms Mary Jackson, Assistant Principal, Community Health Division

Mr Joe Gavin, Higher Executive Officer, Community Health Division, acted as Secretary to the Group.

The Group met on 13 occasions, which included meetings with representatives from the Merchants Quay Project, Professor Gerard Bury, Department of General Practice, UCD, and the Irish Pharmaceutical Union.

1.3 Protocol for the Prescribing of Methadone

1.3.1 The Report of the Expert Group on a Protocol for the Prescribing of Methadone, which was published in March, 1993, set out recommendations in the form of a Protocol for the involvement of general practitioners and community pharmacists in methadone maintenance programmes (Appendix 1).

This Protocol recommended that general practitioners should become involved by taking on responsibility for the care of opiate dependent persons who had first been stabilised at community drug treatment centres. It also outlined the criteria necessary to ensure that methadone prescribing occurred in a controlled, responsible fashion. Many elements of the Protocol have been implemented. Most notably, a central

treatment list of patients being prescribed methadone has been established on a voluntary basis. Under this arrangement a general practitioner who is considering prescribing methadone for a patient can check whether the patient's name is on this treatment list and so minimise the possibility that the patient concerned is receiving methadone from more than one source.

1.3.2 In March 1996 a methadone maintenance pilot project, involving general practitioners and pharmacists in the Eastern Health Board region, commenced. It involved the selection of a number of patients who had been stabilised in drug treatment centres and who were referred to general practitioners in their own local area for continuation of methadone treatment and overall medical care.

This pilot programme included the key elements of the Protocol which were:-

* the provision of a personalised treatment card to each patient - this card was in turn presented to a local pharmacist who held it for the duration of treatment;

* support to GPs and pharmacists through the appointment of a GP facilitator;

* close liaison and communication arrangements with health board services in the event of a patient destabilising ;

* contractual arrangements with GPs, pharmacists etc.

1.3.3 Professor Gerard Bury, under the auspices of the Department of General Practice in University College Dublin, carried out an independent evaluation of the pilot protocol programme. This evaluation involved a comparison of general practice care and treatment centre care of stable patients over a period of at least six months. While the final results of the study are not yet available, an initial analysis suggests

very similar outcomes for both groups of patients. Feedback from patients and general practitioners involved in the study has also been very positive.

1.3.4 A number of other schemes have developed in parallel with the pilot programme and almost 600 people have been issued with treatment cards to date. Seventy three general practitioners are involved in prescribing and 62 pharmacies are participating in the controlled dispensing of methadone mixture DTF Img/ml-

1.4 Ministerial Task Force Report

In order to address the serious problems relating to drug misuse, particularly in the Eastern Health Board area, a Ministerial Task Force on Measures to Reduce the Demand for Drugs was established in 1996. In its first report, published in October, 1996, the Task Force recommended, inter alia, that the GP/Pharmacist methadone prescription/dispensing scheme should continue to be expanded, evaluated and strictly regulated-

1.5 Pharmaceutical Society of Ireland's Policy on Drug Abuse

In its policy document on drug misuse, which was published in October, 1996, the Pharmaceutical Society of Ireland acknowledged the valuable role played by methadone treatment in the management of opiate addiction. It encouraged pharmacists to participate in methadone dispensing in accordance with specific guidelines (which were in agreement with the recommendations in the Protocol and with Department of Health policy). The document also highlighted important points from a pharmacist's perspective, which would make it more attractive to pharmacists to become involved in methadone dispensing. A copy of the executive summary of this document is attached at Appendix 2.

1.6 Irish College of General Practitioners' Task Group's Report on Drug Misuse

The Irish College of General Practitioners published a Report of the Task Group on Drug Misuse in May, 1997. This report recommends that general practitioners should become involved in the treatment of opiate misusers in their own. local communities, which is in accordance with joint guidelines of the Medical Council. It also recommended that methadone treatment as described in the Protocol should continue as a valid form of treatment for opiate dependence. The executive summary of this document is attached at Appendix 3.

1.7 Eastern Health Board Policy

The Eastern Health Board is engaged in a major expansion of its services for drug misusers with the aim of eliminating waiting lists for drug treatment by the end of 1997, As part of this programme methadone treatment would be provided to opiate misusers either in drug treatment centres or through arrangements being made with their local general practitioner and pharmacist. The Board has recommended that stricter regulation and control of methadone should be applied in the course of this expansion. In particular, it has recommended that it should be compulsory for doctors to notify the central treatment list of all patients for whom they are prescribing methadone. Further examination of this issue is required.

2. EXTENT OF METHADONE USAGE

A central treatment list for the prescribing of methadone was set up in 1993. Since that date a total of about 4,300 persons have been on methadone treatment. On 13th June 1997 there were 2,232 persons on the central methadone treatment list. Of this group approximately half were receiving treatment in an Eastern Health Board treatment centre, or in the Drug Treatment Centre, Pearse Street. The remainder were being treated by general practitioners.

3. GENERAL CONCLUSIONS OF THE GROUP

Having reviewed the issues involved in treatment of opiate dependent persons in their own local communities the Group has come to the following conclusions;-

(a) methadone treatment continues to be a valid treatment for opiate dependent persons, but it must be part of a comprehensive programme of care;

(b) the Protocol for the Prescribing of Methadone, as set out in March, 1993 in the Expert Group report, should be the basis on which the further development of services for opiate dependent persons is undertaken, subject to appropriate controls;

(c) methadone mixture DTF Img/ml should be the only strength of methadone used for the treatment of opiate dependence, because of less scope for confusion and accidental overdose and also because it is more appropriate for the treatment of opiate dependence-Methadone linctus 2mg/5ml should be discontinued, except on a “named-patient” basis;

(d) the sugar-free formulation of methadone mixture DTF Img/ml should be used, except in exceptional circumstances. Bottles should be fitted with child-proof caps;

(e) methadone should be available free of charge to all persons undergoing methadone treatment for opiate dependence;

(f) the methadone treatment protocol scheme should be available nationally;

(g) there is a need to strictly control the prescribing and supply of methadone and a system of close monitoring of the prescribing and dispensing of methadone should be put in place immediately. A special group should be established for this purpose;

(h) regulations should be introduced to require that the prescription and supply of methadone should be restricted to official prescription forms, specifically designed for the purpose;

(i) methadone linctus 2mg/5ml should cease to be used for the treatment of opiate dependence and manufacturers concerned should be requested to cease the marketing of this product with effect from an agreed date, after which it would only be made available on a "named-patient" basis, in appropriate circumstances.

4. RECOMMENDATIONS ON THE ROLE OF GENERAL PRACTITIONERS

4.1 Involvement of General Practitioners

The involvement of general practitioners in prescribing methadone to opiate dependent persons who live in their local area is vital to the overall success of health board drug treatment programmes. The Group examined present practice among GPs, taking into account advice which it had received through the recommendations in the Irish College of General Practitioners' Report of the Task Group on Drug Misuse. Issues which were examined included contracting of GPs by the Health Board and support from local health board services for GPs.

4.2 The GP Contract

The Review Group decided to endorse and adopt the scheme of general practitioner involvement outlined in the Irish College of General Practitioners' Report. Under this scheme general practitioners should be contracted by the Health Board to provide treatment on the basis of one of the two levels outlined below.

4.2.1 Level 1 Contract: This level would relate to doctors treating stabilised opiate dependent persons referred from health board drug treatment centres. The contract would include the following elements:-

* the general practitioner should have adequate training in the knowledge, skills and attitudes required to manage opiate misusers in general practice. This would require completion of a recognised training programme agreed between the Irish College of General Practitioners and the Eastern Health Board;

* the general practitioner should ensure that any opiate dependent person he/she is treating is registered on the Central Treatment List (currently held at the Drug Treatment Centre, Pearse Street);

* the general practitioner should satisfy him/herself as to the identity of any opiate dependent person he/she is treating- He/She should also ensure that the person has a treatment card with a recent photograph, name, signature and date of birth, the correct pharmacist's name and address and that this treatment card is not out of date. He/She should also make contact with the pharmacist at an early stage in order to make appropriate arrangements regarding dispensing- This contact should continue during the course of treatment;

* the general practitioner should agree to provide services to a maximum of 15 patients;

* the general practitioner should agree to liaise with a "keyworker", as set out in the Protocol, for each patient;

* the general practitioner should agree to a regular audit/evaluation of his/her practice by an Irish College of General Practioners/Eastern Health Board team;

* the general practitioner should agree to regular educational updates as arranged by the Irish College of General Practitioners / Eastern Health Board team;

* treatment should be provided in local areas as recommended by the Medical Council of Ireland and the Pharmaceutical Society of Ireland,

* the general practitioner should agree that no fees will be accepted from a patient, or any source other than the Health Board, for providing this service;

* prescriptions for methadone should not enable supply for a period greater than seven days, in the course of a single dispensing. Other arrangements may be necessary in exceptional circumstances. In all cases the general practitioner must be satisfied that it is safe to issue the prescription concerned;

4.2.2 <u>Level 2 Contract</u> would involve general practitioners who had more training and experience of working with opiate dependent persons. These general practitioners could initiate treatment of opiate dependent persons.

The terms of the Level 2 Contract would include all of the Level 1 terms and in addition:-

* the general practitioner should have undergone a more advanced training programme as agreed between the Irish College of General Practitioners and the Eastern Health Board (including supervision by an experienced general practitioner for 1 year in a treatment centre setting);

* the general practitioner should agree to an annual refresher course and regular evaluation of the practice;

* the general practitioner should treat up to a maximum of 35 patients in his or her own practice;

* general practitioners in a practice with 2 or more doctors could cater for a maximum of 50 patients;

* in certain exceptional circumstances general practitioners may, following consultation with the health board's consultant psychiatrists, be approved to treat a greater number of patients.

This may be necessary, particularly in the short term where there is still a difficulty in recruiting new general practitioners to become involved in treatment;

It is intended that only general practitioners who conform to the criteria set out above should treat opiate dependent persons.

5. RECOMMENDATIONS ON THE ROLE OF PHARMACISTS

5.1 Involvement of Community Pharmacists

The involvement of community pharmacists in the dispensing of methadone allows for a large number of opiate dependent persons to be successfully treated in their own local area. Health Boards will enter into a contract with pharmacists to dispense (including the supervised administration of) methadone mixture DTF Img/ml to opiate dependent persons in their local area, on special methadone protocol prescription forms, in accordance with the terms set out below.

5.2 Pharmacist's Contract

* Methadone mixture DTF Img/ml should only be dispensed on receipt of a correctly written prescription, written on a special prescription form, which would allow for a single supply or supply on installment. The prescription should also indicate whether the administration of the dose should be supervised by the pharmacist or not.

* Methadone should only be dispensed to patients who hold a valid treatment card. Each patient should have a treatment card which would show their name, address, signature and date of birth and contain a recent photograph. This card should also indicate the name and address of the prescribing GP and have an expiry date.

The card should be delivered in advance to the pharmacist who should be briefed on how the system works by the GP co-ordinator or the liaison pharmacist.

* The treatment card should be lodged with the pharmacist for the duration of treatment or until it expired or was replaced, or withdrawn.

* Provision should be made for a patient to be referred back to the health board treatment services if the patient fails to comply with an agreed code of behaviour.

* Ideally there should be an upper limit of 50 clients attending any single pharmacy. Provision could, however, be made for numbers in excess of this in certain circumstances, where, for example, it proved impossible to recruit a sufficient number of pharmacists in a locality. The overriding principle should, nevertheless, continue to be that community pharmacists, wherever possible, dispense methadone to patients from their immediate locality.

5.3 Training for Pharmacists

It is essential that pharmacists who wish to become involved in methadone dispensing obtain the relevant training and information in order to assist them in carrying out their role successfully. It is also important that pharmacists get regular updates on drug misuse and specifically on methadone treatment, in order that they keep well informed about current issues. For these reasons it is recommended that training sessions are organised both for pharmacists wishing to become involved in dispensing of methadone and for those already dispensing to opiate misusers.

6. WORKING RELATIONSHIPS BETWEEN TREATMENT CENTRES AND GENERAL PRACTITIONERS AND PHARMACISTS

6.1 Transfer of Patients to General Practice

6.1.1 At present when a patient is transferring to general practice from a health board treatment centre, the Health Board's GP co-ordinator contacts the GP and informs him/her of the details relating to that person. The Health Board provides a designated key worker for each patient and where it is deemed necessary and if the patient so wishes, they will also have access to a community addiction counsellor. Facilities for supervised urines are arranged. The GP enters into a contract with the Board to provide methadone treatment, strictly in accordance with the Protocol. A special prescription form, which is issued by the General Medical Services (Payments) Board, is supplied to the GP.

6.1.2 Contact is made with a local pharmacist who agrees to dispense methadone mixture DTF Img/ml strictly in accordance with the Protocol and a contract is entered into between the Health Board and the pharmacist. The opiate dependent person is provided with a treatment card and is registered on the central methadone treatment list. At the same time the Department of Health is notified of the new patient and of the pharmacist involved so that arrangements can be made for the supply of methadone mixture DTF Img/ml to that pharmacy. The Department of Health then:-

* notifies, if necessary, the pharmacist's wholesaler that methadone mixture DTF Img/ml may be supplied to the pharmacist for a patient;

* notifies the General Medical Services (Payments) Board about the pharmacist's involvement, so that arrangements can be made for payment to the pharmacist for methadone by the Board on receipt of appropriate claim forms;

* writes to the pharmacist stating that methadone mixture DTF 1 mg/ml should only be dispensed to the patient or patients named in that letter and asking the pharmacist to confirm his/her agreement to this process.

6.1.3 The pharmacist replies to the Department, agreeing to the terms of the protocol. The patient presents the treatment card to the pharmacist and on receipt of a correctly written prescription form from that patient, methadone is dispensed. If, for any reason, the patient destabilises or problems are created, the pharmacist contacts the Health Board co-ordinator in order to make arrangements for the patient's return to health board services.

These arrangements were put in place to ensure that strict controls applied to the operation of the scheme. It is recommended that these should continue under the aegis of the Eastern Health Board.

6.2 Future Plans for Co-ordination of Methadone Schemes.

The Eastern Health Board and the Drug Treatment Centre in Pearse Street will provide on-going support to GPs and pharmacists involved in methadone treatment as follows:-

(a) the Eastern Health Board has been divided into 3 sectors for the purpose of co-ordinating drug misuse services. Within each sector the Consultant Psychiatrists, Area Operations Managers and GP Co-ordinators, together with two Liaison Pharmacists, will ensure effective management of services;

(b) patients will be provided with support from health board counselling and outreach staff. The Board is in the process of employing additional counsellors and support workers for this purpose. Voluntary agencies working in the locality of drug users will also be supported to provide this service. The Board has also installed a telephone helpline service,

operating from 10.00 a.m. to 5.00 p.m., Monday to Friday, which can deal with crisis calls from drug misusers or family members and direct them to the appropriate services;

(c) information will be prepared for pharmacists which will include guidelines on the handling of methadone and on supervised consumption;

(d) information will also be provided to GPs which will include guidance on upper limits of dosage, urine screening, maximum number of patients;

(e) The Health Board will provide GPs with an audit form, which will be completed on an annual basis in conjunction with the GP co-ordinator and the Eastern Health Board's Consultant Psychiatrists in accordance with the recommendations of the Irish College of General Practitioners/Eastern Health Board team;

(f) a comprehensive treatment plan will be put in place in respect of each patient. This will include medical, social and psychological care. A regular review will also be made of each patient's progress on methadone treatment.

7. PLAN FOR INTRODUCTION OF THE SCHEME

7.1 Wider Implementation of the Methadone Protocol

7.1.1 The Group recommends that all patients under treatment for opiate misuse should be transferred to the methadone mixture DTP Img/ml product as soon as possible, in strict accordance with the Protocol.

7.1.2 Every general practitioner and pharmacist will be informed of the philosophy behind the new system and of the procedures to be undertaken. All general practitioners and pharmacists will receive a copy of the Protocol for the Prescribing of methadone and details of the arrangements, including the contact persons and their telephone numbers in case of emergency. As and from a specified date methadone mixture DTF Img/ml only will be available and all supplies of DTF will be restricted to patients who have valid treatment cards. It is anticipated that there would be a "lead in" time of some months to accomplish the issuing of treatment cards and auditing of GPs who wish to become involved.

7.1.3 Training seminars for both GPs and pharmacists will be arranged by the Eastern Health Board on a regular basis, commencing immediately.

8. SCHEME OF MONITORING AND CONTROL OF METHADONE USAGE

8.1 Statutory Basis for Scheme of Monitoring

It is recommended that a scheme of monitoring of methadone usage be introduced and that it should be placed on a statutory basis by Regulations under Section 5 of the Misuse of Drugs Act, 1977. The Review Group agreed that the following should form the basic elements of a scheme designed to monitor the prescribing and use of medicinal products containing methadone, its salts and preparations.

(a) prohibition of the writing of prescriptions for methadone except on a prescribed prescription form supplied by, or on behalf of the Minister (i.e. the prescribed form);

(b) prohibition of the dispensing of any prescription for methadone unless it has been written on the prescribed form;

(c) the prescribed prescription form should be available on a multiform basis. One copy would be supplied to a single national centre for review and monitoring. While a separate form may be made available for use in installment dispensing, consideration will be given to the incorporation of single dispensing and installment dispensing facilities within the one prescription form;

(d) any pharmacist who dispenses a prescription for methadone would be required to forward a copy of that prescription to the designated national centre (probably at the end of each month) for the purpose of review and monitoring;

(e) in order to assist in the measurement of the extent of opiate misuse doctors would be required to complete a Health Research Board report form once a year in respect of each person for whom they had prescribed methadone.

9. OTHER RECOMMENDATIONS FOR THE EXTENDED IMPLEMENTATION OF THE METHADONE PROTOCOL

The group has also made the following recommendations:-

(a) all staff involved in the treatment of opiate misusers should be immunised against Hepatitis B. This would include pharmacists and their staff;

(b) a leaflet should be prepared for patients attending pharmacies. This leaflet should outline the main issues involved in the introduction of the new scheme i.e. methadone mixture DTF 1 mg/ml, free of charge, treatment card, expiry date, review of treatment cards, etc;

(c) GPs should be issued with a conversion chart from methadone linctus 2mg/5ml to methadone mixture DTF Img/ml.

10 SUMMARY OF MAIN RECOMMENDATIONS OF THE METHADONE TREATMENT SERVICES REVIEW GROUP.

1. Methadone treatment should continue to be a valid treatment for opiate dependence, as part of a comprehensive programme of care. [3.(a)]

2. The Protocol for the Prescribing of Methadone as set out in March, 1993 should be the basis on which the further development of services for opiate dependent persons is undertaken, subject to appropriate controls. [3.(b)]

3. There should be only one form of methadone used for the treatment of opiate dependence - methadone mixture DTF Img/ml. Methadone linctus 2mg/5ml should be discontinued, except on a “named-patient” basis. [3.(c) and (i)]

4. The sugar-free formulation of methadone mixture DTF Img/ml should be used, except in exceptional circumstances and bottles should be fitted with child-proof caps. [3.(d)]

5. Methadone should be available free of charge to all persons undergoing methadone treatment for opiate dependence. [3.(e)]

6. The methadone treatment protocol should be available nationally. [3.(f)]

7. The prescription and supply of methadone should be strictly controlled and a system of close monitoring of all elements of this scheme should be put in place immediately- A special group should be established for this purpose. [3-(g)]

8. Regulations should be introduced to require that the prescription and supply of methadone should be restricted to official prescription forms specifically designed for the purpose. [3.(h)]

9. Treatment for opiate misuse should be provided in the misuser’s

own local area wherever possible, as recommended by the Pharmaceutical Society of Ireland, the Medical Council and the Irish College of General Practitioners- [1.5 and 1.6]

10. General practitioners should provide methadone treatment to opiate misusers who reside in their local area, in accordance with the terms of the proposed GP Contract, as set out in this document and as endorsed by the Irish College of General Practitioners. [4.2]

11. Pharmacists should dispense methadone to opiate misusers who reside in their local area, in accordance with the terms of the proposed Pharmacist's Contract, as set out in this document. [5.2]

12. The Eastern Health Board (and other health boards where necessary) should ensure that proper structures for effective working relationships between treatment centres and general practitioners and pharmacists are put in place. [6.2]

13. All patients under treatment for opiate misuse should be transferred to the Methadone mixture DTF 1 mg/ml as soon as possible, in strict accordance with the Protocol- [7.1.1]

14. GPs and pharmacists should be informed immediately about the philosophy behind the scheme and they should also receive a copy of this report. [7.1.2]

15. GPs and pharmacists should be provided with specific training and information on the treatment of opiate dependent persons. [4.2. 5.3 and [7.1.3]

16. The methadone monitoring scheme should be placed on a statutory basis by the making of Regulations under Section 5 of the Misuse of Drugs Act, 1977. [8-1]

17. All staff involved in the treatment of opiate misusers should be immunised against Hepatitis B. This would include pharmacists and their staff. [9.(a)]

18. A leaflet should be prepared for patients attending pharmacies. This leaflet should outline the main issues involved in the introduction of the new scheme i.e. methadone mixture DTP Img/ml, free of charge, treatment card, expiry date, etc. [9.(b)]

19. GPs should be issued with a conversion chart from methadone linctus 2mg/5ml to methadone mixture DTF Img/mi. [9-(c)]

In the course of this review it was noted that it may be necessary at a future date to introduce monitoring of other drugs used in the treatment of drug misuse in a similar fashion. However, the Group felt that the controls and regulations which will be introduced regarding methadone and the training and education programmes which will be delivered to both general practitioners and pharmacists will, in turn, lead to a general improvement in the system.

APPENDIX 1

REPORT OF THE EXPERT GROUP ON THE ESTABLISHMENT OF A PROTOCOL FOR THE PRESCRIBING OF METHADONE

26 March 1993

1. INTRODUCTION

1.1 Of the 315 cases of AIDS reported in this country, (to 25 February, 1993), 144 were drug use related; 1,381 persons had tested positive for the HIV antibody in the same period and almost 50% of these cases were drug use related. It is therefore apparent that injecting drug use is extremely high risk behaviour and an important source of transmission of the HIV virus in this country. Methadone therapy together with counselling and needle exchange are recognised strategies in preventing the spread of the HIV virus.

However, the use of methadone presents problems for patients, pharmacists, doctors and health workers. This Group has addressed these difficulties in order to develop a practical protocol that will ensure maximum benefit for the patient while at the same time protecting the pharmacists, doctors and health workers involved in methadone therapy in the community.

1.2 The National AIDS Strategy Committee has accepted the recommendations of the four Sub-Committees which it had previously established to examine various aspects of its brief. The Strategy Committee endorsed the recommendation that it would be necessary to allow methadone prescribing in the proposed satellite clinics in order to ensure that drug users availed of the full range of treatment services. It was also accepted that agreed protocols for the treatment of drug-using individuals needed to be established in order to avoid unnecessary pressure being placed on the general practitioner to prescribe opiates

and other drugs. It was envisaged that this would also lead to the avoidance of double prescribing and inappropriate prescribing- The National AIDS Strategy Committee considered that the appropriate agencies to prepare such protocols were the Drug Treatment Centre, the Eastern Health Board, the Irish College of General Practitioners and voluntary drug agencies.

1.3 Accordingly, the Minister for Health established an Expert Group with the following membership to develop the protocol: -

Dr J. H. Walsh, Department of Health (Chairman)

Dr. J. Barry, Drugs - HIV/AIDS Co-Ordinator,
Eastern Health Board

Mr. T. Geoghegan, Project Leader, Merchant's Quay Project

Dr. J. O' Connor, Clinical Director, Drug Treatment Centre

Dr. F. O' Kelly, Irish College of General Practitioners

Dr. B. Sweeney, Consultant Psychiatrist, Eastern Health Board,
Psychiatric Services.

Mr. D. Ryan, Department of Health, was appointed Secretary to the Group.

1.4 The Group was asked to consider the following in particular:

- Methadone prescribing
- Registration of drugs users and
- Licensing of general practitioners to treat drug users.

1.5 The Group gratefully acknowledges the submissions received from

individuals and organisations which greatly assisted the Group in the preparation of this Report. In particular the supportive and co-operative assistance offered by the Pharmaceutical Society of Ireland and the Irish

Pharmaceutical Union was essential to the preparation of this Report. The Group is also most appreciative of the work and support of the Irish College of General Practitioners in the areas of illicit drug use and drug addiction.

1.6 The Group wishes to record its acknowledgement of the valuable contributions to the work of the Group made by Ms. S. Stafford-Johnson, Senior Clinical Psychologist and Dr. E. Keenan, Senior Registrar, both of the Drug Treatment Centre.

2. COMMUNITY BASED TREATMENT OF DRUG USERS

2.1 Methadone prescribing

The National AIDS Strategy Committee accepted that the prescribing of methadone was necessary to ensure that drug users would be encouraged to avail of the full spectrum of preventative measures and treatment services. This is particularly significant in view of the preponderance of HIV/AIDS in the drug-using community resulting in the spread of the infection as a result of sharing of contaminated needles. The Group discussed its remit at some considerable length and finally agreed on the following basic tenets:-

1. That maintenance programmes represented, for many users, their most feasible option for stabilising their addiction. These programmes had obvious attractions for service users.

2. Methadone prescribing is important to ensure (a) that the maximum number of users avail of treatment services; (b) the prevention of transmission of the HIV virus through infected needles-

3. That mefchadone is the most appropriate drug for use in a maintenance programme for addiction. The Group holds this view

so strongly that it would specifically list the following drugs as being unsuitable for such programmes: Morphine (MST);
Dihydrocodeine (DF118); Buphrenorphine (Temgesic); Dipipanone (Diconal), Dextromoramide (Palfium).

The Group is aware that benzodiazepines have potential for abuse and some of them (e.g. Flunitrazepam (Rohypnol) and Temazepam (Normison)) are being injected thus perhaps contributing to the transmission of HIV. The Group recognises that benzodiazepines are useful in the short term treatment of anxiety and insomnia but stress that prescribing doctors should be aware of the abuse associated with them.

2.2 Methadone, like any other addictive drug, is liable to abuse from a number of sources. Therefore, a number of safeguards must be introduced to avoid problems caused by double prescribing and its subsequent availability on the black market. Consequently it was agreed that control of methadone prescribing was essential. This allows the following advantages: -

(a) The protection of the service and its users

(b) The protection of the service providers

(c) An aid to appropriate and responsible prescribing.

2.3 The Group recognised the validity of Dr. John O' Connor's guidelines entitled: *"Good Clinical Practice in Relation to Methadone Prescribing"* as a basis for clinical practice. Dr. O' Connor's paper is reproduced at Appendix A.

2.4 In recognition of the complexities of the medical and psycho-social issues involved in the treatment of drug use the Group considered that the importance of a multidisciplinary approach should be emphasised. The Group considered that a "team approach" to the admission of a patient to a methadone prescribing regime was most important. This issue is expanded upon later in this Report.

3. THE ROLE OF THE GENERAL PRACTITIONER IN COMMUNITY METHADONE MAINTENANCE PROGRAMMES

3.1 The Irish College of General Practitioners has stated in its "Policy Statement on illicit Drug Use and Problems of Drug Addiction" that the College supports the provision of Community Drug Teams and that these Teams should work closely with local general practitioners- Doctors who wish to prescribe for patients with addiction problems should do so only when satisfied about the adequacy of support from the statutory and voluntary services and the availability of proper resources. The Group endorses this view and would stress that such prescribing should be within the guidelines issued by the Medical Council for the prescribing of controlled drugs.
(The Medical Council Guidelines are at Appendix B).

3.2 In practice it is recommended that a person in difficulty with his/her drug use should be referred either to the Drug Treatment Centre or to the local health board addiction services or to the local Community Drug Team for a full assessment, including a psychiatric evaluation. The initial referral could be from the individual's own doctor, public health nurse, drugs out-reach worker, voluntary agency or by self-referral. Following assessment it is recommended that the individual should be offered a range of options including detoxification, support for a drug-free life, referral to a programme of rehabilitation, or a methadone maintenance programme. A key drug worker would be identified to work with this person on an on-going basis. After stabilisation as drug-free or on a maintenance programme the individual would be introduced to a local doctor who had agreed to continue medical care and/or methadone maintenance at a level agreed between the doctor, the patient and the addiction services. The Group endorses the role of the Community Drug Team and recommends the urgent establishment of other Community Drug Teams in areas of greatest need.

3.3 There should be regular communication between the doctor and the addiction services through the patient's key drug worker. This should ensure that any problems which arise concerning the treatment are quickly identified and dealt with at the most appropriate level. This would give support and protection to the patient, the doctor and the addiction services- The Group therefore recommends that close cooperation should exist between general practitioners and the Community Drug Team/addiction services for their area.

This would also have the effect of establishing the practice of "good care" in the prescribing of methadone to opiate-addicted individuals. All doctors would be encouraged to accept that this was the preferred treatment option for these problems.

General practitioners using such a system of care would work in cooperation with their local pharmacy colleagues. A nominated pharmacist would dispense for each individual drug user on a treatment or maintenance programme and therefore the role of the pharmacist will be essential in the on-going development of Community Drug Teams.

3.4 It is considered that general practitioner sessions would initially take place in the Community Based (satellite) Clinics but ultimately it is envisaged that the scheme would develop to the point where participating general practitioners would see patients in their own surgeries.

3.5 In providing this service the general practitioner would be strongly supported by the appropriate addiction service and by the community care services of the health boards. Liaison with acute and chronic hospital services dealing with HIV/AIDS cases will need to be fully developed to ensure that the service is as integrated and efficient as possible.

3.6 The Group recognises that there are general practitioners who are already prescribing methadone for patients in the community. As previously stated there are considerable difficulties for all concerned if doctors treat patients in isolation. Accordingly it is recommended that such doctors should contact the Drug Treatment Centre or the health board addiction services in order that their patients can avail of the full range of services available and to ensure that their own service is supported and protected (i.e. against the possibility of double-prescribing etc.).

3.7 The Group regards the support of the Drug Treatment Centre and of the health board addiction services as being vital to any methadone maintenance programme and would therefore recommend in the strongest possible terms that general practitioners should not become involved in the provision of such services unless they are provided in cooperation with the Centre and /or the addiction services-

3.8 It is important that all statutory and voluntary bodies working in the area of drug use and HIV/AIDS have good communications and work closely together to ensure maximum co-operation in order that an optimal level of services are provided to drug users and their families-This would serve to help them as individuals and also to prevent the spread of HIV infection which is associated with the identified drug use problem concentrated in certain areas of Dublin City.

4. REGISTRATION OF DRUG USERS

4.1 Registration of drug users

The Group regarded the issue of the registration of drug users as crucial and were cognisant of the need to reach agreement on a formula which would be generally acceptable to all the relevant parties. It was agreed that there was widespread resistance to the term “register” and

accordingly it was decided that the use of the term “register’ was unnecessary and unwelcome.

However, it was agreed that a basic level of control had to be introduced in order:

(a) to protect the service

(b) to protect service users

(c) to protect the service providers

(d) to avoid double prescribing.

4.2 Treatment Card

Having regard to the fact that the Group was established to give effect to proposals that services should, as far as possible, be decentralised or community-based it was agreed that if a common method of entry to the community-based treatment/addiction services could be agreed then the above-mentioned objectives could be achieved- In recognition of the fact that there might be a certain hesitancy and anxiety concerning the provision of services to drug users at local community level, it was agreed that a “TREATMENT CARD” should be introduced to help allay some of these fears. It was decided that a treatment card should be provided for each patient who is admitted to the detoxification/ maintenance programmes in the community. Following the initial assessment and period of stabilisation a patient may be issued with a treatment card and referred to an agreed local general practitioner and pharmacist.

The card would remain the property of the patient at all times. The creation of a treatment card for a particular individual would be the outcome of a consultative process emphasising the benefits accruing to both the service user and to the service provider. One of the obvious benefits would be that it would facilitate integration into the community and therefore the provision of such a card for each treatment user would be desirable and welcomed by both service users and providers.

It is recommended that the following should be included on the treatment card:

- the name of the patient;
- the date of birth of the patient;
- a photograph of the patient;
- the name of the prescribing doctor.

It is also recommended that the card should be deposited with the pharmacist or appropriate dispensing service by the patient for the duration of his/her treatment programme. Acceptance of the card by the pharmacist would not of itself permanently bind him/her to provide services for a particular patient. Likewise the patient could withdraw the card, for example on termination of his/her treatment programme. In order to avoid as far as possible future problems of stolen or mislaid cards and to allay any unwarranted concerns regarding confidentiality, it is recommended that each card should be valid for a specific period and should carry an expiry date after which a new card would be required for continuation of treatment. It is recommended that the cards should issue from two sources only: the Drug Treatment Centre, and the health board addiction services.

4.3 treatment list of service users

In tandem with the proposed treatment card the Group agreed that there was a clear need for a list of patients to be maintained centrally not least for purposes of assessing both current levels of service provision, and of future trends. Having regard to all the circumstances it was agreed that the Drug Treatment Centre, (Trinity Court), would be the preferred centre where such a list should be maintained. This would have a number of advantages including the most obvious that there would be a central resource which would have basic identifying details of all patients seeking treatment throughout the country. The proposed list would include details such as the patient's name and date of birth. A patient's name will be deleted from the list after an appropriate period out of treatment, usually one year.

It is recommended that for the purposes of co-ordination, each health board providing a service such as has been described, should designate a doctor to form a Liaison Group with the Clinical Director (.or his deputy) of the Drug Treatment Centre for the purposes of ensuring the protection of users/providers, the services and the avoidance of double prescribing.

The Group wishes to place particular emphasis on two issues in this general area:-

(a) Confidentiality: in this regard it is recommended that because of the nature of the information, access to the list should be restricted to doctors providing treatment. The maintenance of the list will of course comply with the provisions of the Data Protection Act, 1988- In accordance with the provisions of the Act, individuals who believe that information is being maintained on computer will be able to apply for disclosure of such information in accordance with the usual procedures.

(b) Liaison and Co-operation: the Group wish to stress the need for a high level of liaison and co-ordination between the designated doctors who will have responsibility for the maintenance/operation of the list.

Unlinked statistics will of course be available to the Department of Health, and other interested agencies.

In order to avoid any undue pressure being put on the designated doctors to release information, the Group wish to stress that the list is a treatment list, and is not to be anything other than such a list. The Group would also wish to emphasise that where information is sought regarding a particular individual it should be sought from the initial referring doctor.

4.4 Dispensing of Methadone

The Group met with the Irish Pharmaceutical Union (IPU) and the Pharmaceutical Society of Ireland (PSI). The Group was most encouraged by the positive response of both organisations and their willingness to encourage their members to support the proposed initiatives. In practice it was agreed that the community-based pharmacist would only dispense methadone to an individual for whom he/she held a treatment card. The prescription issued by the doctor would be marked "To be dispensed in _____ pharmacy only" which would be an additional safeguard against double prescribing. It was agreed that the particular time of delivery and collection of prescriptions by users should be agreed locally in order to minimise disruptions to the other activities of the pharmacy and to enable the pharmacist to order methadone as it was required rather than to force the retention of excessive quantities in stock. The Group were strongly of the view that methadone should be dispensed in the same manner as any other similar medication. Individuals should not be forced to consume the methadone on the premises.

4.5 The Group were aware that some drug users may not have access to dispensing community pharmacies. In such cases the Group recognises the validity of centralised arrangements for the dispensing of methadone -

5. LICENSING OF GENERAL PRACTITIONERS TO TREAT DRUG USERS

5.1 The Group recognised that this was a very contentious area not least because of the difficulty of involving general practitioners in the treatment of drug users. The National AIDS Strategy Committee had envisaged that with the provision of adequate facilities and safeguards general practitioners would be prepared to take on a comprehensive role in the care and treatment of drug users. The Group however, was of the

view that licensing would be perceived as very much a negative step and would be opposed by the doctors and their representative organisations. It might therefore discourage general practitioners from becoming involved in the provision of services.

5.2 The Group considered that the need for such a form of control would be partially obviated by the introduction of the treatment card, as recommended earlier in this Report. The introduction of guidelines for good practice will also assist in clearly defining the role of the general practitioner in the treatment of drug users. As previously stated in Paragraph 3.3 the Group strongly recommend that the prescribing of methadone should only take place within the context of a recognised treatment programme with active support from the various addiction services, statutory or voluntary, and following the guidelines recommended by this Group.

5.3 The Group did recognise the value of registration of general practitioners as a positive measure rather than as a means of imposing restrictions or control. A scheme, similar to the combined ante-natal care scheme, was suggested whereby doctors would contract to provide care under agreed conditions and for agreed remuneration. Any doctor would be eligible to apply to participate in the scheme to the appropriate health board. The doctor would keep a list of consultations which would be forwarded for review by the appropriate medical officer and passed for payment in due course.

6. GENERAL ISSUES

6.1 Co-ordination and co-operation

The Group are very aware that the recommendations which are contained in this report have wide-ranging implications for the delivery of services to drug users. The measures which are recommended will

change existing services and offer clear guidelines for the delivery of new evolving services- The Group fully appreciates the difficulties that could arise in the implementation of the recommendations it has made and reiterates the need for the closest possible co-operation and liaison in the delivery of the services.

This Group is confident that the support and co-operation which has been promised by all concerned will help to avoid many difficulties which might otherwise occur. However in order to ensure that any difficulties which do arise are dealt with as expeditiously as possible, in the operation of the protocol and in the implementation of the other recommendations contained in this Report, the Group recommends that it should continue in existence for an initial phase-in period of twelve months in order to monitor and evaluate the proposed arrangements. At the end of this period the situation and necessity for such a Group should be reviewed.

6.2 The following are areas of concern which the Group believe should be monitored for an initial period:

(i) Co-operation and liaison between the various addiction services both statutory and voluntary;

(ii) Co-operation and liaison between the doctors designated by the Drug Treatment Centre and the health board addiction services in the operation of the treatment list;

(iii) The avoidance of double-prescribing and inappropriate prescribing by the implementation of the Group's recommendations and in particular the operation of the proposed treatment card.

7. SUMMARY OF RECOMMENDATIONS

(i) It is recommended that methadone is the most appropriate drug for use in a maintenance programme.

(ii) It is recommended that doctors who wish to prescribe for patients with addiction problems should do so only when satisfied that they are complying with the Medical Council guidelines on the prescribing of controlled drugs and where there is satisfactory support from the statutory and voluntary services.

(iii) It is recommended that before a person is admitted to a maintenance programme he/she should be referred either to the Drug Treatment Centre or to the local health board addiction services or to the local Community Drug Team for a full assessment including psychiatric evaluation.

(iv) It is recommended that, following assessment, the individual should be offered a range of options including detoxification, support for a drug-free life, referral to a programme of rehabilitation, or a methadone maintenance programme.

(v) The group recommends the urgent establishment of other Community Drug Teams in areas of greatest need.

(vi) The Group recommends that close co-operation should exist between general practitioners and the Community Drug Team for their area-

(vii) It is recommended that doctors who are currently treating patients with methadone should contact the Drug Treatment Centre or the health board addiction services in order that their patients can avail of the full range of available services and to ensure that their own service is supported and protected.

(viii) It is recommended that a Treatment Card" should be provided for each patient who is admitted to detoxification/maintenance programmes in the community and that each card should be valid for a specific period.

(ix) It is recommended that the card should issue from two sources only; the Drug Treatment Centre and the health board addiction services.

(x) It is recommended that a list of all patients on methadone therapy should be maintained and operated by a Liaison Group consisting of a designated doctor from each health board addiction service and the Clinical Director (or his Deputy) of the Drug Treatment Centre.

(xi) It is recommended that because of the confidential nature of the information, access to the list should be restricted to doctors providing treatment and comply with the guidelines set out by the Medical Council and the Data Protection Act.

(xii) It is recommended that community-based pharmacists should only dispense methadone for individuals for whom they hold a treatment card and that methadone should be dispensed in the same manner as any other similar medication.

(xiii) It is strongly recommended that the prescribing of methadone should only take place within the context of a recognised treatment/maintenance programme encompassing support from the various addiction services, statutory or voluntary, and following the guidelines recommended by this Group.

(xiv) It is recommended that the Group should continue to monitor and evaluate the proposed arrangements and their operation for an initial phase-in period until the measures recommended in this report are operating satisfactorily.

APPENDIX A

GOOD CLINICAL PRACTICE IN RELATION TO METHADONE PRESCRIBING

Dr. John J. O' Connor, Consultant Psychiatrist/Clinical Director Drug Treatment Centre, Trinity Court.

January 1993

Methadone has a similar pharmacological spectrum to heroin. It is usually taken orally and in view of its longer half-life can be given on a once daily dosage thus ruling out the need to inject drugs and the drug seeking behaviour, that ensues.

MEDICAL
Medical examination should include assessment of Respiratory, Cardiac, G.I.T. and C.N.S- systems. The medical evaluation should also include examination of a patient's upper and lower limbs and groin i.e. injection sites.

PSYCHIATRIC
Psychiatric evaluation includes examination for any co-existing personality disorder, mild mental handicap, psychotic or depressive illness.

SOCIAL
Social history should be obtained at this stage and where possible a collateral history from a relative or concerned person.

URINALYSIS
Obtaining urine should be supervised and analysis is carried out for the following reasons.

(a) Urine checked for particular drugs of abuse, and that the results are consistent with the patients history.

(b) To ensure that the patient is not already receiving Methadone elsewhere.

TREATMENT PLAN

Methadone Detoxification/Maintenance

The decision as to whether a patient should be given a detoxification or maintenance is based on a number of factors. It is good clinical practice to encourage a patient on first presentation to become drug free and avail of the opportunity for an independent lifestyle. Maintenance is usually decided as the best option if; -

(a) Previous failed detoxifications

(b) Inability to remain drug free

(c) Length of time abusing drugs

(d) Physical ill health: medical problems including HIV

(e) In the case of women - pregnancy

For a withdrawal regime a starting dose on 30-40 mgs ought to be sufficient, and thereafter reducing by 5 mgs every three days. It should be remembered that psychological factors play a large part in the manifestations of the withdrawal syndrome and a supportive reassuring approach can often greatly reduce the severity of the symptoms experienced.

Many patients are not as physically dependent on opiates as they assume, particularly if they have been using heroin which can be very impure. Dublin street heroin is on average only 10 - 15 % pure. It is better to prescribe a lower dose and then increase it if the person is experiencing withdrawal symptoms than to prescribe a level that will induce intoxication and increase physical tolerance. Methadone should initially be administered on a daily basis and evidence of improvement in drug taking behaviour should include reference to regular supervised urinalysis. A few days supply of Methadone should only be given to those

who cope well with daily administration.

A patient presenting in obvious withdrawals can either be given symptomatic relief with melleril, ponstan and lomotil or a low dose of Methadone followed by referral the next day to a treatment centre.

ABUSE POTENTIAL

The potential for abuse of Methadone should not be forgotten. Already there is a thriving black market for Methadone on the street. To combat this and the problem of double scripting it is essential that a central register for Methadone prescribing be instituted immediately.

Finally, Methadone should not be seen as an easy solution to a complex problem. Methadone should always be regarded only as a adjunct to treatment and not treatment per se.

Appendix B

RECOMMENDATIONS

OF THE MEDICAL COUNCIL FOR THE PRESCRIBING OF CONTROLLED DRUGS UNDER THE MISUSE OF DRUGS ACTS, 1977 AND 1984

1 Practitioners must ensure that all prescriptions for controlled drugs are written in the format specified in the Misuse of Drugs Regulations. Incorrectly written prescriptions cannot lawfully be dispensed by pharmacists.

2 Practitioners and pharmacists in each area should reach an understanding about prescribing and dispensing controlled drugs. On the basis of such understanding pharmacists should be in a position to meet the legitimate needs of patients promptly.

3 Practitioners should not treat patients from outside their practice areas for addiction problems by prescribing controlled drugs. Practitioners are advised to refer such patients to recognised drug treatment centres.

4 Patients should be discouraged from moving from pharmacy to pharmacy with prescriptions for controlled drugs.

5 A practitioner who has patients referred from a drug treatment centre for continuation of treatment, with the patient's consent, should discuss the likely treatment regimen with the patient's pharmacist.

6 Doctors should report problems in the prescribing of controlled drugs to the Medical Council.

Issued on behalf of the Medical Council and the Pharmaceutical Society of Ireland, January 1987.

Misuse of Drugs Acts, 1977 and 1984

PRESCRIPTION WRITING REQUIREMENTS

It is unlawful for a practitioner to issue, or for a pharmacist to dispense, a prescription for a Schedule 2 or 3 drug unless it complies with the following requirements:

The prescription must:

A be in ink or otherwise indelible and be signed by the practitioner with his/her usual signature and dated by him/her.

B clearly indicate the name of the practitioner issuing it and, except in the case of a health prescription (GMS), specify his/her address

C specify (in the prescriber's handwriting) the name including given name, and address of the person for whose treatment it is issued.

D state that the person issuing it, is a registered medical practitioner, and a telephone number at which the practitioner may be contacted.

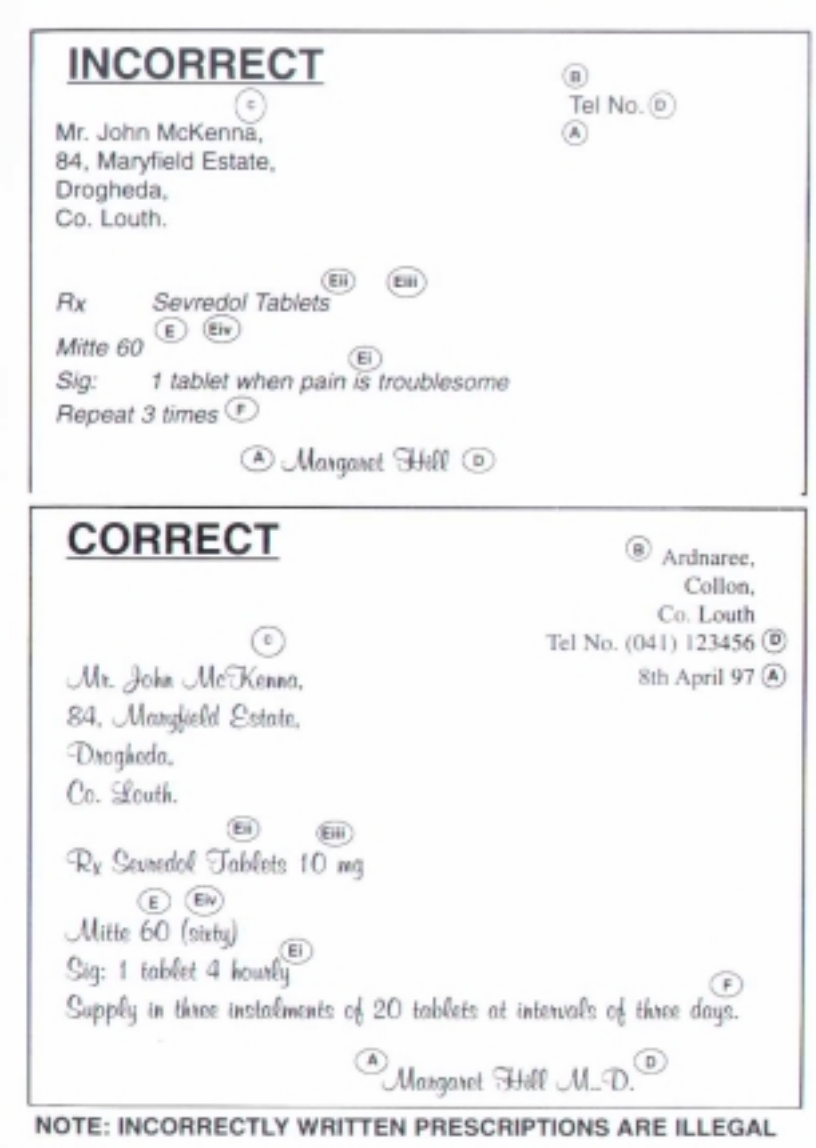
E specify (in the prescriber's handwriting) (i) the dose to be taken, (ii) the form in the case of preparations, (iii) the strength (when appropriate) and (iv) in both words and figures, either the total quantity of the drug or preparation or the number of dosage units to be supplied.

F in the case of a prescription for a total quantity intended to be dispensed by instalments, specify the amount of the instalments and the intervals at which the instalments may be dispensed.

Notes:

1. *The practitioner must also be satisfied as to the identity of the person for whose treatment the prescription is being issued. The pharmacist must also be satisfied in this regard.*

2. *Prescriptions for controlled drugs may not be repeated.*



NOTE: INCORRECTLY WRITTEN PRESCRIPTIONS ARE ILLEGAL

A LIST OF THE MOST COMMON CONTROLLED DRUGS
SCHEDULE 2

Class of Controlled Drug	*Proprietary Products*
Altentanyl	Rapifen
Amphetamine	
Buprenorphine	Temgesic
Cocaine	
Codeine	
Dextromoramide	Palfium
Dihydrocodeine	DF 118, DHC Continus
Dipipanone	Diconal
Fentanyl	Sublimaze, Durogesic
Hydrocodone	
Hydromorphone	Dilaudid, Palladone, Palladone SR
Levactylmethadol	Orlaam
Levorphanol	Dromoran
Medicinal Opium (which includes Papaveretum and Opium Tincture BP)	Omnopon
Methadone	Physeptone
Methylphenidate	Ritain
Morphine	Cyclimorph. Morstet SR. MSTContinus, MXL, Sevredol, Oramorph Concentrate, Qramorph UDV
Pethidine	
Pholcodine	
Phenoperidine	Operidine
Quinalbarbitone	Seconal, Tuinal
Sufentanil	Sufenta
SCHEDULE 3	
Amylobarbitone	Sodium Amytal
Diethylpropion	
Flunitrazepam	Rohypnol
Mazindol	Teronac
Meprobamate	Equagesic, Equanil
Pentazocine	Fortral, Fortagesic
Phenobarbitone	Gardenal Sodium 200mg
Phentermine	Duromine, lonamin
Temazepam	Euhypnos, Normison, Nortem, Tenox

NOTE: The stricter rules for writing prescriptions do not apply to the following:

(i) preparations containing not more than 100mg per dosage unit of metnylphenobarbitone or phenobarbitone (each calculated as base).

(ii) preparations containing not more than 0.1% of cocaine or 0.2% of morphine (each calculated as base).

(iii) preparations (other than injections) containing not more than 100mg per dosage unit of codeine or pholcodine (each calculated as base) or in undivided preparations not more than 2.5% of either drug.

(iv) preparations (other than injections) containing not more than 10mg per dosage unit of dihydrocodeine (calculated as base) or in undivided preparations not more than 1.5%.

APPENDIX 2

RECOMMENDATION OF THE PHARMACEUTICAL SOCIETY OF IRELAND POLICY ON DRUG ABUSE

October 1996

12. Summary of Recommendations

The following are the main recommendations of the Pharmaceutical Society of Ireland on how best the problem of drug abuse may be addressed and how the role of the pharmacist may be employed in this. These are taken from the main body of the policy document and each recommendation is followed by a reference to its location in the document.

12.1 Role of the pharmacist

12.1.1 Sale of medicines

All medicines should be sold from pharmacies and pack size, supplies and usage should be limited to safe, effective levels. (5.5.1)

12.1.2 Counselling on medicines usage

All medicines should be issued to the public with counselling and the pharmacist should be available for consultation with the patient. (5.5.2)

12.1.3 Licensing of pharmacies

A licensing system should be introduced for pharmacies to give an even geographical distribution, highest professional standards and the maximisation of professional services offered. (5.5.3)

12.1.4 Role of the pharmacist

The role of the pharmacist within the community is a most valuable asset which must be utilised to its full potential if the problem of drug abuse is to be tackled effectively. (5.5.4).

12.1.5 Training and service co-ordinator

One of more full-time co-ordinators should be appointed to oversee all aspects of pharmacy involvement in the drug abuse prevention and treatment services. (6.5)

12.1.6 Identification of samples

Requests for identification of suspicious samples from members of the public should be facilitated insofar as possible. (8.3)

12.1.7 Health promotion

A health promotion section for the display of promotional and educational materials should be available to the public in all pharmacies. (8.7.3)

12.2 Education issues

12.2.1 Surveys on drug use among adolescents

Biennial surveys to be carried out to monitor the extent of drug use among adolescents at school and young people outside the school system- (4.2.4.2)

12.2.2 Information on drugs

Pharmacists form a ready-made community network providing easy access to drug information for the general public and as such are ideally placed to play a major role in drug education. (6.6.1)

12.2.3 Survey of training needs

In order to ascertain what level and type of training is required so as to enable pharmacists to become effective community educators, it might be necessary to undertake a survey of pharmacists on this matter. (6-2.4)

12.2.4 Training programme for pharmacists

A training programme for pharmacists who wish to become involved in drug education should be organised. This would provide pharmacists with the necessary presentation and attitude insight skills to enable them to successfully impart their knowledge to others. A suitable support package should be developed for appropriately trained pharmacists. (6.3).

12.2.5 Liaison with other groups

Liaison with the Health Promotion Unit of the Department of Health should be encouraged to enable pharmacists to avail of the excellent range of promotional and educational materials provided by the Health Promotion Unit. (6.4)

12.2.6 Sharing presentations

Pharmacists should not share presentations with speakers who also discuss the effects of drugs unless these speakers are qualified to do so. (6.6.7)

12.2.7 Information on drug use statistics

Liaison with the Garda Siochana should be organised to enable pharmacists to avail of up-to-date statistics on drug use in local areas. (6.6-6)

12.2.8 Substance Abuse Prevention Programme

The efforts of the Departments of Education and Health in organising the Substance Abuse Prevention Programme for secondary schools and the dedication of the hundreds of teachers who participated in it are to be applauded. A similar programme for primary school children, their parents and teachers would be another important step in demand reduction. (6.4.3)

12.2.9 Participation in Substance Abuse Prevention Programme

Pharmacists throughout the country should contribute to the successful implementation of these programmes by

building on the existing technical support given by individuals to the project development. (6.6.8)

12.2.10 Heroin smoking

An education campaign on the dangers of heroin smoking to be initiated as a matter of urgency. (4.2-4.5)

12.3 Maintenance and care of addiction

12.3.1 Participation in methadone dispensing

All pharmacists should be encouraged to dispense methadone for patients in accordance with the guidelines for dispensing of methadone detailed in the report. (7.1.2 and 7.1.3)

12.3.2 Clinical information

Information on all aspects of methadone programmes should be made available to pharmacists to enable them to more fully understand the management of opiate addiction. (7.1.1.4)

12.3.3 Methadone formulations

Methadone Img/lml is the preferred strength for use in treatment programmes. (7.1.1.4)

12.3.4 Alternative treatments

It is hoped that non-opioid alternatives to methadone for the

management of addiction will be considered in the future. (7.1)

12.3.5 Pharmacist/patient contract

Any pharmacist dispensing methadone for a patient should ensure that both they themselves and the patient have signed a pharmacist/patient contract. (7.1.5)

12.3.6 Needle and syringe exchange

The principle of needle and syringe exchange is recognised as a proactive approach to health promotion and a properly co-ordinated, funded and supervised national needle and syringe exchange network with clear policies on the primary practice issues of supply, receipt, safe custody and disposal should be established. (7.2)

12.3.7 Local drug services

Pharmacists should draw up a list of drug treatment and counselling services in their local area, to be used in conjunction with presently available directories to assist people who approach them for advice on these services. (8-2)

12.3.8 Counselling services

The level of services, both general and specialised, for drug abuse counselling should be greatly increased. (8.4)

12.3.9 Methadone treatment charges

Methadone should be supplied free of charge to all persons undergoing a recognised drug treatment programme. (7.3.1.1)

12.4 Legal issues

12.4.1 Solvents

Self-service sales of solvents to be banned. (4.2.4.1)

12.4.2 New schedule to the Misuse of Drugs Regulations

Certain drugs which are used in the treatment of drug addiction should be entered in a new schedule to the Misuse of Drugs Regulations, 1988-1993, to be called Schedule 6. (9.2)

12.4.3 Powers of the Pharmaceutical Society of Ireland

The Misuse of Drugs Regulations, 1988 should be amended to give powers of inspection and entitlement to information in respect of controlled drugs in community pharmacies, hospitals and pharmaceutical wholesalers to the Pharmaceutical Society. (9.3)

12.4.4 Dispensing of controlled drugs

Dispensing of controlled drugs should take place in a community pharmacy, a hospital pharmacy department or an official health board drug treatment service. (9.4)

Dispensing should be carried out by a pharmacist, and where this is not possible, the dispensary service should be overseen by a co-ordinating pharmacist. (9.4)

12.4.5 Treatment referral

Drug addicts convicted of minor drugs related offenses should have the option, when this is considered suitable, of taking a place on a recognised drug treatment service instead of a custodial sentence. (9-5)

12.4.6 Drug-free units in prisons

Insofar as it is practically possible, each prison in the State should have a specially designated drug-free unit. (9.6)

12.4.7 Government initiatives

While the present government initiatives on tackling drug abuse are welcomed, it is regrettable that very little cognisance is taken of the possible contribution which pharmacists could make to a resolution of the problem- (9.7)

12.4.8 Present legal classifications

No change should be made to the legal status of any substance listed in Schedule 1 to the Misuse of Drugs Regulations, 1988-1993. (9.8)

12.4.9 Elimination of illicit drug supply

Further emphasis to be placed on elimination of the supply

side of the drugs problem at all levels, retail, wholesale and import. (4.2.4.3)

APPENDIX 3

RECOMMENDATIONS OF THE IRISH COLLEGE OF GENERAL PRACTITIONERS' TASK GROUP ON DRUG MISUSE

May, 1997

Some recommendations are followed by a reference to their locations in the ICGP report.

SUMMARY OF RECOMMENDATIONS

1. General Practice has an important contribution to make in the management and prevention of drug misuse, together with other medical, social, and political agencies. (Section 1).

2. The causes of drug misuse have major social, economic, and educational roots, as well as medical, and proposed solutions to the problem must address all of these factors. (Section 2).

3. Alcohol and benzodiazepines (whether prescribed or obtained illegally) are the most common causes of drug misuse in Ireland, but this document deliberately confines itself to the problem of opiate addiction.

4. The Task Group recommends a model of care for opiate addicts based in general practice, with GPs providing methadone maintenance (Level 1) where appropriate, or methadone initiation as well as maintenance (Level 2) where appropriate. (Section 4).

5. There must be an adequate number of GP facilitators appointed, who have the necessary expertise and commitment to enroll, support, liaise with, and advise GPs. (Section 4).

6. There must be a confidential national treatment list on which all patients receiving methadone will be entered-(Section 4).

7. All patients receiving methadone must have an individualised treatment card, which is supplied to and kept at their pharmacy. (Section 4).

8. Methadone treatment, including prescriptions, should be free of charge to opiate addicts. (Section 4).

9. Prescribing of methadone should be budget neutral to GPs. (Section 4).

10. Methadone must be dispensed at a local pharmacy, and where indicated in daily doses, preferably with supervised ingestion on the premises. (Section 4).

11. There must be local access to the fall range of services needed to assess, treat, and follow-up opiate dependent patients. (Section 4).

12. There must be a flexible, quick, and easily accessible referral and re-referral system available to GPs-(Section 4).

13. There must be suitable training and education for participating doctors, including assessment for certification and re-certification. (Section 4).

14. There must be adequate, negotiated, and agreed payment for certified participating doctors. (Section 4).

15. The number of addicts being treated by any single GP should not

exceed 10-15 for Level 1 doctors, or 30-35 for Level 2 doctors. (Section 4).

16. The criteria for patients suitable for treatment in general practice by Level 1 and by Level 2 GPs are proposed. (Section 5).

17. A joint ICGP/Health Board Review Group is proposed, which would have responsibility for overseeing and approving education and assessment, as well as policy development. (Appendix C).

18. The field of drug misuse is dynamic and rapidly changing, and ICGP policy in this area will need to be kept under continuous review.

19. The ICGP expects that this policy document, together with the Fact Files, will encourage its members to take part in the medical management of drug misusers at all levels, and to participate in the Methadone Protocol where clinically appropriate.