Pharmaceutical services for opioid drug users

Annual Update Briefing. Issue 8 2026-28

The aim of this briefing is to:

- Support the pharmacy in meeting the training requirements in the supervised consumption service specification.
- Update staff on the latest national guidance on substance misuse.

Pharmacy service specification 2026-27 training requirements

The contractor should ensure that a lead pharmacist has completed the required mandated training which is to:

- Complete, or refresh every 2 years, the CPPE DoC for supervised consumption of prescribed medicines at https://www.cppe.ac.uk/services/declaration-of-competence.

The lead pharmacist should be assured that all staff are competent to deliver the service and will complete the required mandated training which is to:

- Read the service specification at https://cpdands.org.uk/county-durham-services-2/.

Non-mandated training:

- Read this Annual Update Briefing 2026-28 (available at https://cpdands.org.uk/drug-and-alcohol/) which supports with the completion of the CPPE DoC for supervised consumption of prescribed medicines.

Local training offer

For a summary of the work of the Drug and Alcohol Recovery Service (DARS) see short video at https://codurhamrecovery.co.uk/about-us/.

Training is available from the DARS to adults who live or work in the County Durham area at https://codurhamrecovery.co.uk/get-support/training/adult-courses/ and includes:

- *Basic Drug Awareness* - A basic awareness of the range of drugs currently misused, the appearance and paraphernalia associated with the use of drugs, and the different effects and risks associated with their use. The law surrounding substances and why people use drugs, whether legal or illegal, harm minimisation techniques and signposting to treatment services.
- *Understanding Opioids* – Covers different opioid drugs, heroin use, injecting behaviour, prescription opiates and newer synthetic opiates. Opioid substitute prescribing and harm reduction advice for people who use these drugs.
- *BITESIZE – Substance use brief intervention* - How to initiate and hold conversations about substance use and how to further support those who want to make a change.
- *Basic Harm Reduction* - Understand risks associated with substance use and feel comfortable offering basic harm reduction advice.
- *BITESIZE - Blood Borne Viruses and Substance Misuse* - Prevention, detection, and treatment of infections related to substance use.

National guidance

- Drug misuse and dependence: UK guidelines on clinical management. DHSC. Updated 15/12/17. www.gov.uk/government/publications/drug-misuse-and-dependence-uk-guidelines-on-clinical-management (commonly known as the Orange Book).

- Medicine choices in opioid substitution treatment: Recommendations for prescribing methadone and buprenorphine to people in treatment for opioid dependence in England. DHSC. Published 27/12/24. https://www.gov.uk/government/publications/medicine-choices-in-opioid-substitution-treatment (*Clinicians should use this guidance, alongside the Orange Book, to inform their prescribing of oral methadone and buprenorphine as substitute medication to people who are in treatment for opioid dependence*).

- Community pharmacy: delivering substance misuse services: Guidance and advice for community pharmacies in England providing services to people who use drugs and alcohol. OHID. Published 24/01/24. https://www.gov.uk/government/publications/community-pharmacy-delivering-substance-misuse-services.

- NICE resources:
  1. Drug misuse in over 16s: Opioid detoxification. NICE Guidance CG52. Published 25/07/07. https://www.nice.org.uk/guidance/cg52
  2. Opioid dependence. NICE Clinical Knowledge Summary. Updated Feb 2025. https://cks.nice.org.uk/topics/opioid-dependence/ (provides useful summaries of assessment and treatment).

Key points from Chapter 4 *Drug misuse and dependence: UK guidelines on clinical management* (commonly known as the Orange Book):

Choice of drug for opioid dependence
There is insufficient evidence to recommend one drug over the other. While there is accumulating evidence that buprenorphine is associated with reduced risk of fatal overdose in the first weeks of treatment initiation, there is also evidence that methadone is more effective in retaining patients in treatment and so may indirectly reduce risks longer term for those patients.
In the first weeks of methadone treatment there is an increased risk of death due to overdose. After around a month in treatment, the risk of death due to opioid overdose during maintenance treatment falls to very low levels.
Dose induction should aim carefully, as soon as possible, for a stable dose of opioid that avoids both intoxication and withdrawal. It may take two to four weeks (or more) to achieve an optimal dose with methadone. It usually takes less time with buprenorphine since induction with buprenorphine may be carried out more rapidly with less risk of overdose.

Methadone toxicity and risk of overdose
All staff working with service users who are taking methadone should be aware that there is a risk of death in early methadone treatment. This can be due to excessive initial doses, failing to recognise symptoms of cumulative effects, impaired liver function (due to chronic hepatitis), or failing to inform patients of the dangers of overdose if they are using other drugs (particularly benzodiazepines and alcohol) at the same time (since opioids induce respiratory depression, and sedative drugs potentiate this effect).
Signs and symptoms of methadone toxicity include:

- Drowsiness, slurred speech
- Slow and/or shallow breathing
- Constricted (pinpoint) pupils
- Disorientation/ confusion, dizziness/ feeling faint, balance/ coordination problems.

With methadone, toxicity is delayed at least several hours after exposure, and this may only become apparent after several days of treatment. The reason for the delayed toxicity is methadone's long but variable half-life, of between 13 and 50 hours with chronic administration. It takes five half-lives, or 3-10 days, for patients on a stable dose of methadone to reach steady-state blood levels. During these 3-10 days, blood levels

progressively rise even if patients remain on the same daily dose. A daily dose tolerated on day one may become a toxic dose on day three. Patients must therefore be carefully inducted on to methadone and then monitored, and if necessary, the dosage adjusted during this accumulation period.

Risk factors for buprenorphine

Buprenorphine is widely considered to cause less respiratory depression than methadone. At low doses, buprenorphine is a potent opioid agonist, producing morphine-like effects. However, due to its mixed agonist-antagonist properties, increasing doses become self-limiting and do not produce more intense opioid effects. This may be one reason some patients prefer methadone.

Precipitated withdrawal occurs when buprenorphine is first administered to an opiate-dependent person with circulating opioid agonist drugs present. In this situation, buprenorphine can inhibit the opioid actions of the full agonist without adequately replacing them, leading to the appearance of withdrawal signs and symptoms. Precipitated withdrawal can be very unpleasant and may deter patients from continuing participation in treatment. There are three measures to minimise precipitated withdrawal:

- Administer the first dose of buprenorphine when the patient is exhibiting signs of withdrawal.
- If withdrawal is difficult for the patient to tolerate, delay the administration of buprenorphine until at least 6-12 hours after the last use of heroin (or other short-acting opioid), or 24-48 hours after the last dose of low-dose methadone.
- Provide the anticipated day's doses, for the first day or two, in divided doses (typically using 2mg tablets) so that the speed of the induction can be managed.

Methadone dosing

In general, the initial daily dose will be in the range of 10-30mg.

- *First 7 days*: Where doses need to be increased during the first 7 days, the increment should be no more than 5-10mg on one day. In any event, a total weekly increase should not usually exceed 30mg above the starting day's dose. Patients should be alerted to the risk of over-sedation and the risks with ongoing illicit use.
- *Subsequent optimisation*: Following the first 7 days, doses can continue to be increased incrementally. A total target dose of 60-120mg a day, and occasionally more, may be required.

Buprenorphine sublingual dosing

Most dosing regimens involve starting with a low dose (4-8mg) that is rapidly increased. Effective maintenance treatment with buprenorphine involves doses in the range of 12-16mg for most patients dependent on heroin, with some needing up to 32mg. It makes sense to work towards this dose rapidly, so long as this does not produce side-effects or precipitated withdrawal. A cautious approach is to initiate treatment with 4mg on day one, then 8-16mg on day two and thereafter.

Key points from *Medicine choices in opioid substitution treatment: Recommendations for prescribing methadone and buprenorphine to people in treatment for opioid dependence in England* (should be considered alongside the Orange Book):

When to offer buprenorphine before methadone

You should offer buprenorphine in preference to methadone if:

- you are concerned that the patient may have a low or uncertain level of opioid tolerance
- you are concerned about the patient's use of other prescribed sedatives and of non-prescribed drugs or alcohol consumption (you should advise patients that there is a risk of fatal oversedation regardless of which form of OST medication is prescribed)

- the patient has significant comorbid cardiac or respiratory disease
- a supervised consumption option does not exist, for example in rural areas
- the patient has significant issues with mobility (whether due to physical or psychiatric illness) that prevents them attending a pharmacy regularly

Key points *Community pharmacy: delivering substance misuse services: Guidance and advice for community pharmacies in England providing services to people who use drugs and alcohol*:

Safe storage of medicines
You should tell the person to store and use substances out of the sight and reach of children or vulnerable adults.
Where required, the prescriber, substance misuse service or pharmacy should offer:

- lockable safe storage options
- child-resistant containers
- written information about safe storage suited to the needs of the person

Before dispensing any medicines, you should ask the person about any mitigations they have in place to store them safely.

Communication between pharmacy staff and substance misuse services
You should contact the prescriber or substance misuse service if:

- the person appears unwell or intoxicated
- the person misses multiple doses or collections within a 2-week period (particularly during titration or consecutive doses or if a pattern emerges)
- the person does not take the whole dose
- the person behaves unacceptably, such as shoplifting, verbal and physical abuse, diverting their medicines
- there are any concerns about the suitability of supplying a medicine, such as safeguarding concerns, or worries about the dose or medicine
- there is a dispensing error or near miss (a dispensing error caught in time) and if there are any accidents or injuries
- the person continues to make requests for someone other than themselves to collect their medicine where this is not formally agreed with the prescriber or pharmacist

Further reading

Office for Health Improvement and Disparities (OHID) national guidance at www.gov.uk/government/collections/alcohol-and-drug-misuse-prevention-and-treatment-guidance and https://www.gov.uk/government/collections/preventing-and-reducing-drug-related-harm. Includes:

- *Misuse of illicit drugs and medicines: Applying All Our Health*. Evidence and guidance to help health professionals identify, prevent or reduce drug-related harm. OHID. Updated 23/02/22. https://www.gov.uk/government/publications/misuse-of-illicit-drugs-and-medicines-applying-all-our-health

- Opioid substitution treatment good practice resources. For example:
  1. *The Best practice in Optimising Opioid Substitution Treatment (BOOST)* elearning programme at https://www.e-lfh.org.uk/programmes/best-practice-in-optimising-opioid-substitution-treatment-boost/ which aims to provide drug treatment and recovery professionals with the information they need to deliver good quality opioid substitution treatment to service users.
  2. *Opioid substitution treatment: Guide for keyworkers*. PHE. Published 21/07/21. https://www.gov.uk/government/publications/opioid-substitution-treatment-guide-for-keyworkers