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Substance Misuse Treatment Framework (SMTF) Guidance for Evidence Based Community Prescribing in the Treatment of Substance Misuse

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1. Background

This document forms part of a suite of guidance that reflects the philosophy of integrated care where the needs of service users are considered from the time they engage with substance misuse services through to recovery.

This framework aims to outline the best available evidence to inform decisions about the effectiveness of community prescribing and associated interventions to improve services and outcomes for individuals who misuse substances. The evidence has been considered in order to determine what works for whom in what circumstances and further, how the evidence is translated and applied in practice. This revised and updated framework replaces the '*Substance Misuse Treatment Framework Service Framework for Community Prescribing'* published in 2004.

The Welsh Government Substance Misuse Strategy for Wales *'Working Together to Reduce Harm 2008-2018'*, includes as one of its key aims the need to make better use of resources by:

- '*supporting evidenced based decision making, improving treatment outcomes, developing the skills base of partners and service providers by giving a greater focus to workforce development and joining up agencies and services more effectively*'
- '*effectively disseminate guidance and research evidence on best practice to inform and facilitate changes to current practice and policy to improve the quality of services*'
- '*assist partners in accessing the most up to date research and evidence to enable them to plan services*'.

(Welsh Government, 2008a)

This is supported by the Welsh Government's guidance for the development and implementation of the *'Integrated Care and Integrated Care Pathways for Adult Substance Misuse Services in Wales'* (Welsh Government, 2010a); and the implementation of the *'National Core Standards for Substance misuse services in Wales'* (Welsh Government, 2010b).

This framework has been developed to assist a range of partners who are in contact with individuals who misuse substances. Members of Substance Misuse Area Planning Boards (SMAPB) along with commissioners, planners and those who deliver substance misuse services need to ensure that any treatments and interventions commissioned and implemented are supported with evidence of effectiveness as outlined in this framework.

The aim of this guidance is to:

- provide evidence-based recommendations for the planning, management and delivery of community prescribing to benefit service users, cares and their families
- plan care according to client needs and within the resources available

- develop the workforce by identifying continuing professional development (CPD) and training needs
- inform and develop integrated care pathways
- promote interagency and multidisciplinary care
- justify funding and other resources.

The evidence and best practice, from a number of sources, have been analysed and synthesised to inform this document.

- The National Institute for Health and Clinical Excellence (NICE) guidance
- National Treatment Agency (NTA) substance misuse guidance
- Meta-analysis, evidence and efficacy based reviews from the Cochrane database
- Peer reviewed papers in key addiction and substance misuse Journals
- Drug Misuse and Dependence: UK Guidelines on Clinical Management. (Department of Health (England) and the devolved administrations, 2007)
- Substance misuse workforce planning and development publications
- National substance misuse strategies.

2. Community prescribing

Community prescribing involves integrated working by a multidisciplinary team of specialist staff. Prescribing should be implemented as a component part of the care-plan managed by a dedicated specialist keyworker.

Dependent on the needs of service users, the following community prescribing regimes should be offered:

- maintenance and stabilisation programmes
- supported withdrawal programmes
- community and home detoxification programmes
- relapse prevention prescribing
- harm reduction
- prescribing regimes for associated conditions and complications.

3. Context and settings

Community prescribing is a Tier 3 service which is implemented across a number of settings. These include:

- primary care
- prescribing clinics
- day programmes
- criminal justice programmes
- prisons and other offending services
- supervised consumption within pharmacies.

Community prescribing for substance misuse has to take place within the context of NHS Clinical Governance arrangements in Wales. Responsibility for this is delegated to Local Health Boards (LHBs) who have to ensure adequate protocols are in place with voluntary sector organisations where appropriate.

The responsibility for prescribing lies with the prescriber who signs the prescription, as this responsibility cannot be delegated. This includes non-medical prescribers working as supplementary or independent prescribers.

Where clinically justified, physicians may prescribe outside these guidelines. However, in such circumstances there should be adequate justification and informed consent sought. Good practice for informed consent is outlined in the *'Reference Guide for Consent to Examination or Treatment'* (Welsh Government, 2008b).

Contractual and legal obligations in relation to prescribing

The Controlled Drugs (Supervision of Management and Use) (Wales) Regulations 2008 came into force on 9 January 2009. Organisations are required to appoint an Accountable Officer to ensure the safe management of the use of controlled drugs. This is overseen by Health Inspectorate Wales (HIW).

Prescriptions must be written in accordance with the Misuse of Drugs Regulations 2001 (The Stationery Office, 2001).

Medical staff who are involved in community prescribing need to follow the guidance set out in the National Enhanced Services and Local Enhanced Service for Drug Misuse.

HIW (2009) state that *'Community Safety Partnerships (CSPs) must ensure that there are contractual arrangements in place with community pharmacists for the provision of supervised consumption.'* However, this should now be the responsibility of the Local Health Board.

Protocols should be in place for the protection of vulnerable adults (POVA) and children (for example, safe storage of medication).

4. Access to community prescribing programmes

The Welsh Government is encouraging localities to develop a single point of access for substance misuse services for both drugs and alcohol. SMAPBs, CSPs and LHBs should ensure that the provision for community prescribing, and related services (such as harm reduction), is accessible and available for all individuals who meet the criteria.

Alongside the specialist statutory and voluntary organisations that provide community prescribing and related services, the development of GP shared care in Wales has increased accessibility.

5. Delivery of community prescribing

There is increasing evidence demonstrating the effectiveness of community prescribing. It is delivered through either specialist substance misuse teams or through GP-led prescribing and shared care. All individuals who are referred or who self-refer to these services need to have sufficient information regarding the treatment and intervention options to make informed choices regarding their care and support.

Many individuals relapse following detoxification and other prescribing programmes (Ghodse, 2010; Raistrick et al, 2006). Thus, in order to improve the outcomes for individuals, prescribing programmes should not be provided in isolation, rather, an integrated care approach should be adopted. Where need is identified, relapse-prevention strategies, support for abstinence, aftercare and psychosocial interventions and support with physical, emotional, social and legal problems should be offered following detoxification and alongside maintenance programmes.

Prescribing programmes and integrated care

Prior to, and alongside, the prescribing programme key workers should ensure that there is:

- a comprehensive assessment to identify client needs and to make appropriate referral. Examples include:
    - oral and dental care
    - GP services
    - counselling and other psychological interventions, including relapse prevention
    - provision of practical social support (e.g. housing, welfare benefits, legal advice, employment and vocational services)
    - harm reduction services such as Human Immunodeficiency Virus (HIV) testing where appropriate, hepatitis testing and immunisation, needle exchange services and other health and welfare interventions.

- a joint review of treatment and care plan undertaken at least three monthly
- ongoing assessment to review clients' requirements and to set appropriate goals
- adequate information given regarding access to aftercare programmes
- access to supportive networks and other self help groups, such as, alcoholics anonymous, narcotics anonymous, Al-Anon, individual and family oriented support networks and community programmes (drop-in centres, peer mentoring programmes).

Planning for the provision of community prescribing

Commissioners, planners and service providers need to consider the following key elements when planning the provision of community prescribing:

- robust clinical governance arrangements (NAW, 2001)
- key Performance Indicators (KPI) for example:
    - Individuals who do not attend (DNA)
    - Time to first appointment/assessment
    - Time to implementation of treatment/intervention
    - Engagement of service users (Welsh Government, 2006)
- development of referral pathways for community prescribing
- the training and supervision needs of staff (to include, GPs, pharmacists, keyworkers, nurses, community psychiatric nurses)
- the need for other related interventions such as, counselling, harm reduction
- accessibility of premises
- flexible opening hours to include evening and weekends.

6. Detoxification

6.1 Home and community detoxification

There is evidence that home and community detoxification programmes are effective for individuals who are mild to moderately dependent on alcohol and who meet the criteria outlined below (Raistrick et al, 2006). In terms of opiates and other drugs, detoxification programmes are either implemented through substitute medication or slow reduction programmes.

The aim of detoxification is to achieve a safe and effective discontinuation of substances while minimising the symptoms of withdrawal. The detoxification process varies in duration depending on the level of dependence, clinical indications and client goals.

Home/community detoxification programmes can only be implemented following a comprehensive assessment to ascertain the level of dependence and withdrawal symptoms and whether the client meets the criteria for detoxification.

The prescribing programme is implemented and managed by a member of the prescribing doctors team (specialist community nurse) or through specialist Tier 3 services where General Practitioners prescribe.

Once a client has been deemed suitable for home/community detoxification the following should be in place:

- a protocol outlining the dosage of medication and duration of detoxification. This will depend on the severity of dependence, the client's physical and psychological health and other medication that may be prescribed
- effective coordination of care by specialist or competent primary care practitioners with daily visits initially (at home, GP or clinic attendance) by a suitably qualified individual to monitor the client's condition and how they are coping with the withdrawal symptoms
- psychosocial interventions where applicable.

6.2 Home and community alcohol detoxification

The criteria for home/community alcohol detoxification includes:

- individuals who have not experienced withdrawal complications in the past, for example, seizures
- individuals who have not got social problems that could jeopardise the programme
- an assurance that there is effective coordination of care by specialist or competent primary care practitioners with daily visits to monitor withdrawal symptoms
- an assurance that there is 24 hour supervision available from relatives/friends.

(Raistrick et al, 2006)

Community detoxification programmes for alcohol, typically, last between 7-10 days, however, shorter programmes can be implemented if clinically indicated. Substitute medication is prescribed daily and reduced gradually over the detoxification period. Withdrawal symptoms are monitored daily by a competent specialist clinician and dosages are adjusted as clinically indicated. In order to prevent overdose or misuse of the prescribing medication the prescribing team should ensure that large quantities of medication should not be left in the client's home.

Outcomes are improved if psychosocial interventions are implemented prior to (to ensure individuals are adequately prepared and committed to the programme), and following detoxification, including relapse prevention interventions that focus on the development of coping strategies.

Following detoxification, other drugs may be prescribed to reduce craving and prevent relapse. Evidence suggests that outcomes for service users are improved when psychosocial interventions are combined with relapse prevention medication.

6.3 Community opiate detoxification

The criteria for community based opiate detoxification programmes

Community based opiate detoxification programmes are suitable for individuals who:

- are physically dependent on opioids
- have the capacity to comply with the prescribing regime
- are motivated to change at least some aspects of their drug misuse
- have a supportive network and stable accommodation.

Community based opiate detoxification programmes are **NOT** suitable for individuals who:

- require complex polydrug detoxification
- have significant comorbid physical or mental health problems
- have significant social problems that could jeopardise the programme
- have experienced withdrawal complications in the past.

(NICE, 2008)

Opiate detoxification is implemented over a period of five to seven days by the administration of a long acting opiate drug (such as Methadone). The dose is gradually reduced until it is terminated.

For some clients a slow withdrawal programme is more appropriate. This can take up to 12 weeks.

During and following detoxification, clients are particularly vulnerable to the risk of overdose should they return to the amount of substance used prior to detoxification. As such, ongoing monitoring of symptoms is important as is after care and giving information to clients regarding the risks.

7. Maintenance programmes

Once a decision to provide a maintenance prescription has been agreed with the client, a number of factors need to be considered to help improve their outcomes. These include:

- information for clients to enable them to make decisions regarding the medication prescribed, the consequences for misuse and their ability to cope with the rigid dispensing regime. This information will include where, when and how the medication will be dispensed and who will be responsible for the prescribing
- appropriate dispensing procedures to ensure that the medication is being taken as directed
- confirmation of monitoring arrangements, which will include random and routine testing. Monitoring arrangements need to be intensive at first (daily for an agreed period of time) but then less frequent as clients become more stable (based on clinical assessment and toxicology tests)

- assessment and management of clinical, social and environmental risk
- ongoing assessment of the client's needs which includes reviewing and updating the care plan to ensure that their treatment and support needs are met and appropriate referrals are made, for example, for psychosocial interventions.

8. Supervised consumption

For maintenance and slow reduction programmes the following should be in place:

- all patients should be on daily-supervised consumption for the first 3 months of treatment as a minimum with consideration given during planned reduction programmes. (The framework recognises the challenges to the provision of this standard in rural areas where balanced decisions have to be taken in the care plan and other user- friendly approaches to supervision may be appropriate)
- agreements must be in place between the specialist team, client and pharmacist (shared care) before any prescription is written or dispensed
- personal contact with the pharmacists should be made to encourage team working
- agreements must include regular feedback from pharmacist to the team which is a precondition for any remuneration
- the dispensing arrangements have to be patient-centred with particular regard to the issue of privacy and confidentiality. This may include the use of discrete areas/rooms if required
- the numbers of patients receiving supervised consumption at each pharmacy should be determined locally in line with their local needs assessment
- the eligibility of pharmacists and designated pharmacy staff to participate in supervised consumption schemes is dependent on their completion of appropriate training
- documented protocols should be in place to ensure clinical governance requirements are met by all agencies providing community prescribing.

The key stages in the management of community prescribing are:

- confidentiality and information sharing
- completion of monitoring information, for example, Treatment Outcomes Profile (TOP) and the Welsh National Database for Substance Misuse (WNDSM)
- decision on type of access (routine, priority, emergency/crisis)
- access management (e.g. waiting list)

- assessment including physical and psychiatric complications of substance misuse and referral on to appropriate specialist services
- risk assessment
- preparation of individual for substitute prescribing (e.g. advice and written information about methadone, risks of overdose, DVLA notifications).

9. Prescribing in other settings and for vulnerable groups

All individuals regardless of the context and situation should have equitable access to treatment and interventions for their substance misuse. The prescribing regime needs to be integrated with existing health and social care services.

9.1 Prison and criminal justice settings

On release from prison, individuals who have undergone detoxification programmes or are maintained on methadone require immediate access to a substance misuse service in the community. As individuals are particularly vulnerable to relapse, self harm and overdose at this time, additional monitoring is essential.

9.2 Pregnant women

The key aim is to manage care to achieve stability for the mother and reduce risks for both the mother and baby. According to the National Collaborating Centre for Women's and Children's Health (2010), to achieve this the following should be in place:

- protocols for joint care between specialist substance misuse and the midwifery/obstetric team
- ongoing communication and the sharing of information between specialist substance misuse and the midwifery/obstetric team
- assessment of risk and needs as early as possible in pregnancy to develop an integrated care plan and support networks
- communicating the necessary information to women to help them make appropriate choices
- close monitoring throughout with particular attention to dosages and compliance with prescribing regime
- routine toxicology testing
- where possible, a specialist midwife should coordinate care and when indicated other appropriate services need to be in place during the postnatal period

- appropriate settings for the provision of maternity care to facilitate access throughout the antenatal and postnatal period
- appropriate setting for prescribing/dispensing to encourage compliance.

9.3 Individuals with co-morbid diagnosis

Where substance misuse is not the primary diagnosis communication with other teams, for example, mental health teams need to be established and maintained throughout the prescribing programme. In some cases, the coordinator of care will be a member of the mental health team and will be supported by keyworkers in substance misuse. The prescribing team need to ensure that the client is able to comply with the prescribing regime as well as any existing medication.

9.4 Individuals with complex polydrug use

For those individuals who are using more than one substance, the prescribing regime for detoxification needs to be prioritised to reduce the risk of multiple withdrawal symptoms and drug interactions.

10. Assessment

A comprehensive assessment underpins integrated care. It is also the lynchpin for keyworkers to engage with, and offer appropriate treatment/interventions for individuals who misuse substances. The aim of the assessment is to identify the needs of clients, including the impact of substance misuse on their physical, psychological and social functioning. In order to recognise the treatment/interventions required, staff who perform the assessment need to be appropriately qualified and competent to be able to interpret the findings of the assessment and use these to plan appropriate care and/or support.

A comprehensive assessment on the initial visit can be overwhelming for clients, therefore, it can be completed over many sessions.

A comprehensive assessment should:

- identify the nature and severity of the problem and issues around substance misuse, for example, history of drug taking, exposure to drugs and alcohol
- explore the reason(s) for misuse
- assess the impact of substance misuse on an individual's physical, psychological and social functioning
- ascertain the client's cognitive ability
- establish the personal resources individuals have to deal with treatment, including support from their family and friends.

11. Aftercare and support

Relapse rates for both alcohol and drug misuse are high, thus, following detoxification, all service users should be offered continued treatment, support and monitoring to promote and maintain abstinence. Aftercare and relapse prevention activities should be built into the care and treatment plan to increase the likelihood of positive lifestyle outcomes for clients.

The length of aftercare should be dependent on individual needs and circumstances. NICE guidance suggest that this should be for a period of at least 6 months (NICE, 2011, 2008).

Aftercare programmes could include:

- structured day care
- community-based relapse prevention
- supported housing
- diversionary activities through community groups, including recovery groups, self-help groups etc
- supportive networks such as peer mentoring
- psychosocial interventions, such as counselling
- ongoing maintenance prescribing programmes
- residential rehabilitation
- vocational support.

If clients relapse, provision should be made for them to re-enter the treatment pathway. Clients need to be reassessed by a competent clinician who should give them an opportunity to reflect on the reasons for their relapse and discuss the treatment/intervention options available to support them.

12. Evaluation

Mechanisms need to be in place to evaluate the effectiveness of community prescribing interventions in practice. In Wales, evaluation tools include the Treatment Outcomes Profile (TOP), data from the Welsh National Database for Substance Misuse (WNDSM) as well as any other systems that are implemented locally.

Substance misuse providers need to ensure that there is adequate training and supervision for staff, to maintain fidelity and integrity of the prescribing regimes and that they are delivered as intended. Commissioners and planners need to ensure that resources are used effectively and that treatments and interventions are based on evidence and prescribed and delivered according to the needs of individuals.

13. Staff competence and workforce development

General Practitioners (GPs) and pharmacists who deliver prescribing services need to be adequately trained and their knowledge and skills maintained through continuing professional development.

Lead GPs who are involved in community prescribing should ensure that all individuals within their practice who are involved in prescribing are adequately trained and supervised.

Specialist keyworkers involved in substance misuse prescribing should demonstrate an appropriate level of competence. They need to be sufficiently skilled to:

- identify the risks of prescribing, the symptoms of withdrawal and other complications
- ensure medications are taken as prescribed
- identify the need for adjunct psychosocial interventions and implement or refer as required
- identify the need for interventions to reduce drug-related harm, especially the risk of overdose, and implement and refer as required
- provide advice and information to reduce drug related harm, for example, information on blood-borne viruses, needle exchange and immunisation programmes
- review and revise care plans and treatment goals at least three monthly or more frequently when necessary
- refer to appropriate services to address social problems, for example family, housing and employment.

Specialist training and ongoing supervision should be in place to ensure the appropriate level of competence is achieved and maintained.

Evidence

Evidence for drugs used in community prescribing

The following tables outline, at a glance, the evidence for the drugs used in community prescribing. Only those that have sufficient evidence to support their use have been included.

Evidence for prescribing treatments for the misuse of drugs

The aims of detoxification and maintenance programmes are to reduce craving, prevent withdrawal symptoms, reduce harm and eliminate the reinforcing properties of drug taking. Also included are the commonly prescribed drugs that are used as adjuncts to detoxification and relapse prevention.

<table>
<tr><th colspan="3">Opioid detoxification and maintenance programmes (NICE, 2008)</th></tr>
<tr><td>Methadone</td><td>A synthetic opioid that acts on the opioid receptors. It is long acting (24-36 hours) therefore a daily dose is sufficient to prevent the symptoms of opiate withdrawal.

Methadone is usually prescribed in liquid form, which is unsuitable for injection. Maintenance doses can be prescribed and reduced gradually over a period of around 12 weeks to achieve abstinence. Methadone can also be used long term as a maintenance dose depending on clinical decisions.</td><td rowspan="2">NICE guidance (2008) suggest that either Methadone or Buprenorphine should be offered as the first line treatment in detoxification. The same medication should be used for detoxification if the service user is already receiving maintenance treatment with Methadone or Buprenorphine.</td></tr>
<tr><td>Buprenorphine</td><td>Buprenorphine is a long acting partial μ receptor agonist and can be used instead of methadone, within a maintenance programme. It is administered sublingually or by injection and is used in withdrawal programmes. Following stabilisation, doses can be reduced gradually to achieve abstinence.</td></tr>
</table>

Opioid detoxification and maintenance programmes (NICE, 2008)		
Lofexidine	Lofexidine is a non-opioid alpha-adrenergic agonist. It is used to relieve withdrawal symptoms in opioid dependent individuals. It is administered for 7 to 10 days during the period of withdrawal. Following the detoxification, the dose is then reduced, gradually, over 2-4 days.	According to NICE guidance **Lofexidine** may be considered for people: - 'who have made an informed and clinically appropriate decision not to use Methadone or Buprenorphine for detoxification - who have made an informed and clinically appropriate decision to detoxify within a short time period - with mild or uncertain dependence (including young people)' (NICE, 2008)
Naltrexone	Naltrexone is an opiate antagonist with a high affinity for opioid receptors. It blocks or counteracts the effects of opiates so individuals do not experience the pleasurable effects associated with opiates. **Naltrexone is hepatotoxic for some individuals and as such should only be given to those who do not have liver disease.**	NICE guidance (2007) confirms the clinical effectiveness of **Naltrexone** as a treatment for maintaining abstinence. However, they suggest that Naltrexone should be used in a "selected, highly motivated group of people" and that further; individuals who are prescribed Naltrexone should be informed of the potential adverse effects of the drug.

Overdose		
Naloxone	Naloxone is an opioid antagonist and is administered following an overdose of an opioid drug to reverse respiratory depression. Ideally, it should be administered intravenously, however, it can be given intramuscularly or subcutaneously. In Wales, the demonstration site programme has been implemented to train service users and their carers to administer a specific dose of Naloxone. An independent evaluation has been carried out with the recommendation that the scheme is rolled out across Wales.	NICE guidance (2008) confirm that Naloxone should be used in the diagnosis and treatment of opiate overdose associated with impaired consciousness and/or respiratory depression.

Evidence for prescribing treatments for the misuse of alcohol

The evidence for drugs prescribed for community and home detoxification programmes for those who misuse alcohol are listed below. Also included are the prescribed drugs that are used as adjuncts to detoxification and relapse prevention.

Alcohol detoxification programmes (NICE, 2011, 2010; Raistrick et al, 2006)		
Benzodiazepines: - Chlordiazepoxide (Libruim) - Diazepam (Valium) - Oxazepam	This group of drugs share similar receptors as alcohol and as such they take effect quickly - usually one hour after being consumed. They have five key actions: - Antianxiety - Anticonvulsant - Muscle relaxant - Sedative hypnotic effect - Amnestic Benzodiazepines may be prescribed to control the symptoms associated with alcohol withdrawal for a maximum of seven days. The dose is dependent on daily alcohol consumption levels.	The evidence suggests that **Benzodiazepines**, and in particular, **Chlordiazepoxide** and **Diazepam** are effective for use in alcohol detoxification programmes to control the symptoms associated with the withdrawal of alcohol (Amato et al, 2010).

	Oxazepam is the preferred Benzodiazepine for individuals who: - have liver disease - must not be over-sedated - have chronic obstructive pulmonary disease.	
Acamprosate	Acamprosate works by affecting levels of a chemical in the brain known as gamma-amino-butyric acid (GABA), which is thought to be partially responsible for inducing a craving for alcohol. The drug is most commonly used to prevent relapse in those individuals who have achieved abstinence by reducing craving.	**Acamprosate** has been shown to be effective for supporting continuous abstinence following detoxification (Rösner et al, 2010). However, the effectiveness of the drug is increased when used in combination with psychosocial interventions.
Disulfiram	Disulfiram interferes with the degradation of alcohol leading to an accumulation of acetaldehyde which when, even a small amount of alcohol is consumed causes unpleasant systemic effects. Symptoms include flushing, tachycardia, sweating, nausea, vomiting and headache. Large amounts of alcohol may cause cardiac arrhythmias, hypertension and collapse and be life threatening. The mechanism of this drug is underpinned by negative behavioural reinforcement and is commonly used in relapse prevention for those individuals who have achieved abstinence. **Given the nature of its action this drug should be prescribed with caution. It is contraindicated in cardiac failure, coronary artery disease, hypertension, pregnancy and in people with a history of psychotic disorder.**	There is evidence that **Disulfiram,** when delivered under supervision (for example, supervised by a family member), is an effective component of relapse prevention strategies.

Naltrexone	Naltrexone is an opioid antagonist that blocks opioid neurotransmitters thus reducing the reinforcement or pleasurable properties of alcohol. Therefore it is usually prescribed following detoxification to maintain abstinence. **Naltrexone is hepatotoxic for some individuals and as such should only be given to those who do not have liver disease.**	

Psychosocial intervention used as an adjunct to community prescribing

The evidence for psychosocial interventions is outlined in the '*Substance Misuse Treatment Framework Guidance for evidence based psychosocial interventions in the treatment of substance misuse*'.

Glossary

CPD	Continuing Professional Development
CSP	Community Safety Partnership
DNA	Do Not Attend
DVLA	Driver and Vehicle Licensing Agency
GABA	Gamma-Amino-Butyric Acid
GPs	General Practitioners
HIV	Human Immunodeficiency Virus
HIW	Health Inspectorate Wales
KPI	Key Performance Indicators
LHBs	Local Health Boards
NAW	National Assembly for Wales
NICE	National Institute for Health and Clinical Excellence
NTA	National Treatment Agency
POVA	Protection of Vulnerable Adults
SMAPB	Substance Misuse Area Planning Board
TOP	Treatment Outcomes Profile
WNDSM	Welsh National Database for Substance Misuse

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