

REVIEW OF METHADONE IN DRUG TREATMENT: PRESCRIBING INFORMATION AND PRACTICE

1. PRESCRIBING INFORMATION

1.1 Background

1. The former First Minister, Jack McConnell, announced a review of the place of methadone in drug treatment programmes on 6 March 2006 following the death of 2 year old Derek Doran. This review was conducted at the same time as the wider inter-departmental programme of work being undertaken across the Executive on children in drug abusing households. There is increasing public, political and media interest in the use of methadone in drug treatment and in the perceived public risk posed by 'leakage' into the wider community, particularly in relation to children.

2. The review consisted of three main phases: "Scoping the Issue", "Reviewing Current Practice" and "Improving Practice". The findings reported here relate to work carried out under phase 1 "Scoping the Issue" on the level and circumstances of methadone use in Scotland. Information was sought primarily from NHS Boards in relation to:

- The number of people receiving methadone treatment for drug misuse
- The number of those who are on a daily supervised consumption regime
- The number of those who receive methadone who have children under the age of 16 living with them, all or part of the time

3. Drug Action Teams (DATs) and Community Health Partnerships were the other main contributors to the review. We were unable to use prescription data from ISD as an indicator of the actual number of people on methadone treatment as the data relates to community dispensing activity and is not patient-specific.

4. On the positive side, in time electronic prescribing and administration systems and electronic records will be able to monitor not just prescriptions written and dispensed in primary care but also in hospitals and clinics. "*Safer Management of Controlled Drugs*", the Government's response to the Shipman 4th Report, also supports collecting consistent and meaningful data on methadone prescription and dispensing.

1.2 Analysis

5. Responses were received from every NHS Board/DAT area in Scotland. The information we received was often qualified because data was either unavailable, incomplete or estimated. The figures presented here must therefore be treated with considerable caution, although they do give a snapshot of the scale of the issue, and the variation in data collection in different NHS Boards. Caution must particularly be exercised in relation to the information received in respect of those living with children under the age of 16. NHS Ayrshire & Arran, Greater Glasgow (in respect of East Dunbartonshire), Grampian, Lothian and Tayside all provided estimates in this respect. NHS Lanarkshire, because of current IT systems, were unable to provide figures on either clients on a daily supervised consumption regime or on those living with children under the age of 16. A further complicating factor was that some organisations submitted data from 2004-2005, others provided 2006 data and some didn't specify. However it should be stressed that we asked for a "snapshot" to

establish the scale of the issue and not a definitive statistical picture. Several organisations were keen to stress that they were taking steps to improve their data collection.

6. NHS Ayrshire and Arran and NHS Lothian both pointed out that as pharmacies are generally closed on Sundays and public holidays, in reality few patients prescribed methadone will ever be on a 7-day supervision (i.e. a daily supervised consumption regime where methadone is consumed under supervision 7/7).

7. Some bodies simply did not record data in the format requested. For example, NHS Lothian were able to state how many patients had had a period of daily supervision in the last year but not the number of those who were currently on a daily supervised regime.

1.3 Key Findings

1.3.1 Number of people receiving methadone treatment for drug misuse

8. In total, 22,224 people were receiving methadone treatment for drug misuse in Scotland, 1,093 of which were in the care of the Scottish Prison Service (SPS). The latest published estimated figures, which exclude the SPS, indicate that in 2004 there were 19,227 people receiving prescriptions for methadone in Scotland. This represents an increase of 1,904 people since 2004 (excluding SPS). However it should be noted that the data did not necessarily cover the same time period.

1.3.2. Number of those who are on a daily supervised consumption regime

9. It is difficult to arrive at a definitive figure. The data suggest that **at least** 12,236 people were on a daily supervised consumption regime. However this figure includes 5,675 people from Greater Glasgow who receive their methadone on an “up to 7 days supervision” basis (some of whom may receive slightly less supervision) and the 1,093 people in the care of the SPS. The figure would be revised up if NHS Lothian had been able to estimate how many of their 2,727 methadone users who had received a period of daily supervision within the last year were currently on a daily supervised consumption regime. In addition NHS Lanarkshire were unable to offer any information on daily supervision in relation to their 1,589 methadone users. Again, the overall figure would rise if we had been provided with this data.

1.3.3 Number of those who receive methadone who have children under the age of 16 living with them, all or part of the time

10. The data indicates that at least 6,752 people who receive methadone have children living with them all or part of the time. This figure must be treated with great caution as some of the data on which it is based was estimated, some was incomplete and some was simply not available. However if we take the figure at face value it suggests that around one third of people who receive methadone have children under the age of 16 living with them. We do not know how many actual children this figure represents.

11. A complicating factor in this calculation is that while some organisations knew how many men and women had children under 16 living with them, they did not know how many of those men and women were couples. For example Lothian could tell us that they had 1,026 problem drug using mothers and 912 problem drug using fathers living with children

under 16 but did not know how many were living in the same household. From this data we can only determine that there must be a minimum of 1,026 and a maximum of 1,938 households where children under 16 are living with a problem drug using parent.

Table 1 summarises the findings.

2. PRESCRIBING PRACTICE

2.1 Background

1. The findings reported here relate to work carried out under phase 2 of the review of methadone in drug treatment “Reviewing Current Practice” on how the current UK guidelines “*Drug Misuse and Dependence – Guidelines on Clinical Management*” and any locally published guidelines on the prescribing of methadone are implemented and monitored in Scotland. The guidelines were last revised in 1999 and it was agreed last year that a UK-wide review group should be convened to update the guidelines. The group, with Scottish representation at clinical level and with the Scottish Executive holding observer status, held its first meeting in September 2006 and plans to publish the updated guidelines in Autumn 2007. While there may be some scope for inputting the outcomes of our review into this work, the guidelines are primarily about clinical best practice.

2.2 Analysis

2. Returns were received from every NHS Board area in Scotland, including the former NHS Argyll & Clyde. However the quality of these varied significantly, as did the volume of information received. The majority of Boards provided general information about how clients access services, how they are assessed for drug treatment and on how substance misuse services are delivered at local level. Not all, however, provided detailed information on how national and local guidelines on methadone prescribing are implemented and monitored locally. For example, one Board responded by outlining their general pathway of care for drug misusers rather than focusing on the specific questions posed. Others (e.g. Orkney, Western Isles) stressed that they have no significant population of heroin users presenting to services.

2.3 Key Findings

2.3.1 Implementation of national and local guidelines on methadone prescribing

3. The national clinical guidelines “*Drug Misuse and Dependence – Guidelines on Clinical Management*” include guidance on areas such as treatment, assessment, the responsibilities and principles of prescribing for drug dependence and the management of dependence and withdrawal. From an examination of the local protocols submitted it is clear that on paper at least, the national guidelines have provided the broad basis from which NHS Boards and partner agencies have developed local protocols. In this way the national guidelines provide the framework for, and are implemented through, prescribers’ adherence to guidance at local level. As well as reiterating factual information such as recommended starting dosages for the titration of methadone, the majority of Boards’ local guidance sets out procedures for treatment and assessment. Many Boards have also developed local protocols on specific issues such as co-morbidity and pregnant drug misusers. However, as with all

high-level strategic guidance, differences in interpretation and emphasis are evident in some areas, leading to differences in the implementation of national guidance at local level. Examples are set out below.

2.3.2 Supervised consumption of methadone

4. The area in which there would appear to be the greatest difference in the interpretation of the national guidelines among NHS Boards is in relation to the minimum time period during which a drug user should be required to take their methadone dosage under supervision. The 1999 national clinical guidelines state:

“In most cases, all new patients being prescribed methadone should be required to take their daily dose under the direct supervision of a professional for a period of time which may, depending on the individual patient, be at least 3 months, subject to compliance.

“Similarly, when the patient restarts methadone after a break, or receives a significant increase in the methadone dose, daily dispensing, ideally with supervised consumption, should be re-instated for a period of time agreed in local guidelines and protocols.

“These arrangements should only be relaxed, so as to allow take-home doses, if the doctor can be satisfied that compliance will be maintained. The relaxation of supervision can be seen as an important component of rehabilitation and re-establishing acceptable responsible behaviour”.

5. From an analysis of returns received it would appear that the majority of local protocols reinforce the national guidelines, recommending that all new clients should take their methadone under supervision for at least the first three months. However, some Boards have adopted a more stringent approach. For example, in NHS Greater Glasgow and Clyde, prescribing is routinely for “daily dispensing under supervision”. Reduced levels of supervision are only permitted when patients can demonstrate a long history of being free of illicit drugs, are working, in further education, or undertaking a programme in a community rehabilitation unit.

6. In contrast, in Lothian prescribers may relax the requirement for supervision at an earlier stage of the treatment process than the recommended three month minimum provided the clinician in charge of treatment is satisfied that compliance will be maintained. Reasons cited for this approach include that NHS Lothian recognises that the supervision of methadone may carry some disadvantages for individual patients in limiting their freedom to rehabilitate and normalise their lifestyles; that any increases in levels of supervision will increase the pressure on prescribing and supervised consumption services which could lead to fewer available treatment places; and that any proposed increases in supervision levels might discourage people from entering or remaining in treatment when it is known that remaining outside of methadone treatment is associated with significantly higher rates of morbidity and mortality. However Lothian also point out that it has always been their policy that these guidelines are for minimum levels of supervision only and that clinical judgement should continue to be used to consider circumstances where a longer period of supervision is required.

7. Not unexpectedly, there are difficulties associated with implementing daily supervised dispensing of methadone for clients who live in rural or remote areas of Scotland. NHS

Highland's general guidance states that while all methadone is dispensed supervised for at least the first three months, thereafter dispensing may be relaxed depending on the client's presentation and circumstances. A client who offered no opiate positive samples during that three month period would normally move to a less stringent regime. However, clients in more rural and remote areas, or clients in employment, may be allowed less than daily pick-up. NHS Highland has developed additional guidelines for methadone treatment in remote and rural areas which acknowledge that "in certain cases normal guidelines for dispensing and support may not be appropriate and more creative measures may need to be considered", for example, negotiating with Practice Nurses to supervise consumption. However these guidelines also stress that the balance between meeting the needs of the client and minimizing the risk of diversion and/or overdose must always be addressed.

8. Dumfries & Galloway's prescribing guidelines also note that in certain parts of the region it may be impractical to travel large distances on public transport to attend the community pharmacy. Their local guidelines state "in these circumstances the prescriber may relax the dispensing arrangements, but...would be swayed by the relative stability or otherwise of the client".

2.3.3 Arrangements when drug misuser stable

9. We also sought information about ongoing arrangements when a drug misuser is stable on methadone. The national guidelines state that longer-term prescribing should be reviewed at regular intervals (at least 3-monthly) and should be part of a broader programme of social and psychological support. The guidelines also note that "random urine checks may be helpful, e.g. at least twice a year".

10. Nine out of 15 NHS Boards confirmed that a review took place at least 3-monthly in line with national guidance, with NHS Lanarkshire advising that all service users in receipt of substitute medication will receive a medical assessment by a GP with Special Interest at least every six months. Eight Health Boards also confirmed that regular urine testing took place, ranging in time from monthly to at least every three months. However it was not clear whether this urine screening was random or not. No specific information was received from the remaining Boards, although some referred generally to the fact that care plans and treatment goals are reviewed at appropriate intervals.

2.3.4 Monitoring of national and local guidelines on methadone prescribing

11. Returns suggest that there are a variety of ways in which national and local guidelines are monitored. At the local level for example, some monitoring activity will occur routinely during a consultation as the GP or drugs worker records the client's progress against their treatment goals. Most local guidelines, in line with national guidance, specify a period during which all clients in receipt of a prescription for substitute medication should be seen by their prescriber.

2.3.5 Scottish Drug Misuse Database

12. The national clinical guidelines state that all doctors treating drug misusers for their problem drug misuse should provide information on a standard form to their local Regional Drug Misuse Database. The monitoring tool cited most frequently in Boards' returns (13 out of 15) was completion of the Scottish Morbidity Record (SMR) 24 or 25 form which is used

to monitor drug misuse among new clients coming to the attention of medical services (general practice, hospital etc) and specialist drug services (statutory and non-statutory). Information from these forms is extracted by ISD Scotland to form the Scottish Drug Misuse Database (SDMD). The SDMD dataset covers:

- demographic information
- presenting information
- prescription profile
- illicit drug profile
- injecting/ sharing details
- social profile
- dependent children
- contact with services

13. While 13 NHS Boards indicated that the SMR 24 or 25 form is used to gather data to monitor drug misuse in their area, we are aware from informal discussions with ISD Scotland that the rate of return of SMR 24 data from GP practices is low. The results of a questionnaire circulated to Scotland's 22 local Alcohol and Drug Action Teams (ADATs) in November 2005 supports this: it found that only six ADATs were able to confirm that SMR 24 forms were being completed by GPs, with four of these action teams within one NHS Board area (Lothian). This suggests a discrepancy between Board policy and practice in some areas.

2.3.6 GP Prescribing

14. Under the new General Medical Services (nGMS) contract which came into effect in April 2004, the treatment of drug addiction is categorised as an Enhanced Service. Enhanced Services are commissioned at local level by NHS Boards and their main purpose is to expand the range of local services to meet local need. Not all GP practices provide an Enhanced Service for patients suffering from drug misuse, as practices now have the choice to opt-out. The Enhanced Service for patients suffering from drug misuse funds GP practices to enable them to participate in audit of prescribing practice. The Enhanced Service is subject to a six-monthly audit of the prescribing of substitute medication and adherence to minimum standards. However the standard Enhanced Service contract does not require GPs to complete the SMR 24 (see above). Only a few (four) Boards provided detailed information about how this audit process is undertaken. It is not possible to determine what specific processes are in place in respect of the other 11 Health Boards.

15. In Lothian, for example, practices providing the Enhanced Service are required to submit six-monthly mandatory data on substitute prescribing. Lothian's Primary Care Facilitator Team (PCFT) are responsible for auditing and feeding back Enhanced Service data to practices. The PCFT also reports on the Enhanced Service to the Lothian Monitoring Group whose members are GPs from the different Lothian Localities, including representatives from the Local Medical Committee and prescribing bodies. The Group meets quarterly and reviews prescribing patterns and the general management of drug users from the data submitted by Enhanced Service practices. It identifies practices whose audit data indicates that they are having difficulty in maintaining standards set by the Monitoring Group, with the aim of improving the quality of care offered to patients in these practices. Practices are sent written feedback on their data comparing the practice performance with the Lothian average and setting each criteria in the context of best practice.

16. In the Greater Glasgow area, the auditing of GP prescribing and supervision levels is carried out by Glasgow Addiction Services (GAS) on behalf of Greater Glasgow NHS & Clyde. This involves a minimum of once yearly visits by senior staff from GAS, with audit reports completed on each visit. These visits also contribute to the development of effective communication between local GPs and their corresponding Community Addiction Team (13 within Glasgow). In a very small number of cases where practice is of a concern a referral is made to local Community Health Social Care Partnership Clinical Directors and the Practice Support Team in Greater Glasgow NHS & Clyde. GAS also employs 3 specialist pharmacists, part of whose role is to help ensure that supervision levels are adhered to in both GAS and GP prescribing. They undertake regular visits to pharmacies and are able to undertake audit of local prescribing and dispensing arrangements. GAS has published its own guidelines on methadone prescribing which state that spot checks, monthly statistical returns and formal audits should be used to monitor compliance with guidelines.

17. NHS Grampian's approach has been to establish a Clinical Effectiveness and Reference Group for Treatment of Addiction whose purpose is to evaluate current clinical practice and ensure that the most effective clinical strategies are being followed. NHS Grampian also pointed out in their return that they are currently in the process of setting up a Quality and Audit team to review the 1,500 methadone cases currently in treatment.

18. Other systems mentioned briefly in terms of monitoring prescribing practice include the prescribing information collected by local pharmacies and the collection of waiting times data.

2.3.7 Tayside Service Redesign

19. The Tayside Drug Problems Service (TDPS) were keen to point out that in 2005 they embarked on a redesign of their substance misuse services which included the development of a new prescribing protocol for the treatment of drug misusers and face to face assessment of all patients on methadone. This redesign included an enhanced clinical governance structure to ensure methadone prescribing achieves appropriate quality standards. These standards will be audited every 6 months in a process administered by the Tayside Addiction Services Clinical Governance Group. All new methadone prescribing is now initiated by TDPS, with patients moving out into general practice only when objectively stable and progressing. The patient's own GP prescribes within TDPS standards as part of the Enhanced Service contract. In addition, all people on a substitute prescription will have a regular review by the doctor which should occur no less than 3 monthly.

20. One product of this work has been the creation of a methadone database which, when fully populated, will contain baseline information on all patients in the system and will enable TDPS to monitor the impact of their model of care on this care group. This includes addictions outcomes information as well as a range of demographics (e.g. childcare responsibilities) and mental health co-morbidity. There is also an ongoing research project through the MEMO GP prescribing database which contains all GP scripts from Tayside. The project is analysing 99,000 scripts for over 4,000 patients over 12 years. The aim is to comment on the quality of prescribing and link this data with SMR data on co-morbidity, hospital admissions, pregnancy and deaths. The overall objective is to use the information to improve the service, directing it more closely to patient need.

2.3.8 Pattern of Prescribing Services

21. In most NHS Board areas methadone prescribing is undertaken by both GPs and prescribers in specialist drug misuse services, with the latter regularly providing this service until such time as the patient is stable. Thereafter the client may be referred back to their GP for ongoing prescribing and care, provided the practice participates in the Enhanced Service for drug misusers. However, there is no GP prescribing in Ayrshire & Arran where all medical support is provided by specialist services. In the Western Isles also, methadone is not normally prescribed through GP surgeries. Where substitute prescribing is required, a service can be provided through the Acute Psychiatry Unit at the Western Isles hospital.

22. NHS Borders stated in their return that because of a currently unfilled medical consultant post in the Community Addictions Team which was established to cover the gap in services where GPs were reluctant to prescribe, they had had to set a cap of 45 clients on the numbers that could safely be managed within this system (Note: We understand this has since been resolved). They pointed out that implementation of the nGMS contract has led to many GP practices in the Borders area opting out of enhanced services for drug misusers altogether. We are aware anecdotally of claims that other areas have imposed such caps, although not necessarily for the same reasons, but as yet have no firm evidence to support this.

23. The survey “Community Pharmacy Services for Drug Misusers 2006” notes that there has been an increase in the number of hospital prescriptions for methadone but little change in general practice prescriptions. This suggests that overall, the nGMS contract may not have impacted significantly on GP prescribing although particular areas (e.g. Borders – see above) may be affected more adversely than others.

2.3.9 Shared Care Guidelines

24. The national clinical guidelines state:

“The development of local shared care guidelines is essential: they should take account of national policy, but be locally determined, so as to incorporate the range of options for local service. The drawing up of guidelines should involve all provider participants, including general practitioners (generalists and specialised generalists), specialists, pharmacists and voluntary agencies”.

25. All NHS Boards indicated that they had developed or were in the process of developing shared care guidance, albeit that some replies only alluded to this. Several Boards emphasised the importance of providing an integrated service for drug misusers.

2.3.10 Transition from drug dependency to drug free lifestyle

26. In an answer to a FMQ on methadone last year from Duncan McNeil MSP, the former First Minister stated “We believe absolutely that everybody who is on a [drug] programme should have an end point in sight and should agree to move from a drug dependent lifestyle to a drug free lifestyle”. In terms of drug reduction regimes, the national UK guidelines state:

“After a patient has become stabilised on the prescription, and has made other changes in lifestyle, it may be appropriate to set up a formal drug reduction regimen. In reality, patient compliance with a drug reduction regimen will only be maintained if patient and doctor both

agree that reduction is desirable. There is usually very little clinical improvement when a reduction regimen is carried out against the wishes of the patient. Hence, if the patient is not going to be fully compliant, it is best to continue with the existing, stable regimen”.

27. We did not ask Boards explicitly about the emphasis they place on moving clients from drug dependency to a drug free lifestyle. However some Boards’ local guidance is explicit in stating that the main treatment goal for clients is a drug free lifestyle. For example, NHS Borders state that a key aim of their integrated care scheme is “to provide good quality accessible, confidential and flexible services which promote stability in drug users lives with a view to moving them on to abstinence and reintegration into the community”. Indeed, one of the factors in assessing whether a client is suitable for a methadone programme is that the client “understands the role of methadone and is willing to aim for complete abstinence from illicit opiates”. Ayrshire & Arran’s guidance stresses that “the ethos throughout this model of treatment and rehabilitation emphasises the need for partnership agencies to enable client progression from a problematic and often chaotic drug addiction to a more stable and ultimately drug free lifestyle. Shetland’s local guidelines state that “the team is not prepared to offer indefinite maintenance prescribing of methadone”.

28. Both NHS Forth Valley and Tayside appear to take a slightly more pragmatic approach. In Forth Valley, while clients are “actively encouraged to look at issues in their life, and move towards reduction and an opiate-free lifestyle”, they also acknowledge that this is “often very difficult for clients to achieve”. One of the main aims outlined in Tayside’s prescribing protocol is “to help the person become drug free when appropriate”.

2.3.11 Alternatives to Methadone - Buprenorphine

29. We are aware that buprenorphine (Subutex) is increasingly being used in the treatment of drug misusers and we therefore took the opportunity to ask Boards to give an indication of the arrangements for prescribing buprenorphine as an alternative to methadone. Like methadone, buprenorphine (oral formulation) is recommended for use in maintenance therapy in the management of opioid dependence and is licensed for use in both detoxification and maintenance treatment. In relation to buprenorphine, the national clinical guidelines note: “While buprenorphine abuse has been well recognised in the UK, there is now good evidence from overseas that, in the context of a well-supervised and well-monitored programme, buprenorphine can be useful as an alternative maintenance agent for those with lower levels of opiate dependence”.

30. The previous administration’s lines-to-take on drug treatment stressed that the Executive did not promote methadone above any other treatment for drug addiction. It was generally held that the decision on which drug to prescribe – methadone, buprenorphine or other drug - should be based on clinical judgement and on the prescriber’s knowledge of their individual client.

2.3.12 Findings from NHS Board returns

31. Eleven out of 15 Boards confirmed that they use buprenorphine for detoxification, but only five of these provided information on the number of clients, with numbers ranging from 6 or 7 (Fife) to 132 (Lanarkshire). Only NHS Borders, Fife, Lanarkshire and Lothian confirmed that buprenorphine was available for maintenance prescribing. NHS Forth Valley reported that they were planning to introduce buprenorphine for maintenance prescribing by

the end of 2006. Only NHS Lanarkshire commented that buprenorphine has the same status as methadone i.e. that it can be prescribed as clinically appropriate for patients requiring opiate substitution treatment. Most Boards commented that buprenorphine prescribing programmes were in very early stages of development.

32. This suggests that at present there remains limited, albeit increasing, use of buprenorphine in the treatment of drug misuse in Scotland. We have been made aware by clinicians in the field that an increasing number of drug misusers are requesting buprenorphine as an alternative to methadone for drug treatment. Buprenorphine is, however, a more expensive drug than methadone.

33. The survey “Community Pharmacy Services for Drug Misusers 2006” notes that buprenorphine was dispensed by 21.4% of community pharmacy respondents to 190 individuals in Scotland. In contrast, the survey reports that the number of individuals receiving methadone has increased to 12,400 which can be extrapolated to 17,226 if non-respondents are included. This illustrates the extent to which methadone remains the prescribers’ drug of choice for maintenance prescribing.

34. The National Institute for Health and Clinical Excellence (NICE) determination on methadone and buprenorphine maintenance therapy for the management of opioid dependence was published in January 2007. While the Appraisal Committee was “persuaded of the importance of having both drug treatment options available”, it concluded that:

“...the decision about which drug to use should be made on a case by case basis and should consider a number of clinical and patient factors, including the person’s history of opioid dependence, their commitment to a particular long-term management strategy, and an estimate of the risks and benefits made by the responsible clinician in consultation with the person. However the Committee was mindful that methadone is cheaper than buprenorphine and therefore concluded that, if both drugs are equally suitable for a person, methadone should be prescribed as the first choice”. This suggests that in the short-term at least, methadone will remain the dominant substitute medication prescribed for maintenance therapy.

2.3.13 Conclusions

35. On the basis of the evidence submitted, the following can be drawn:

- despite evidence of local interpretation, it would appear that the national guidelines provide the broad basis from which NHS Boards and partner agencies have developed local guidance on the clinical management of drug misusers
- there is some evidence, however, that policy may not be being implemented in practice (e.g. submission of SMR data by GPs)
- some, but not all Boards have provided evidence that national and local guidelines are monitored actively
- methadone is likely to remain prescribers’ choice of drug for maintenance therapy for some time, with only four Health Boards currently offering buprenorphine as an alternative to methadone for maintenance prescribing

TABLE 1 - REVIEW OF METHADONE IN DRUG TREATMENT: PRESCRIBING INFORMATION

Area*	No's on Methadone	No's on Daily Supervision	No with resident children under 16
Ayrshire & Arran	1,553	690	887 (estimate)
Borders	69	46	42
Dumfries & Galloway	501	282	212
Drug Treatment & Testing Scheme of Criminal Justice Grouping of East Renfrewshire, Inverclyde & Renfrewshire	44	41	10
Fife	717	636	257
Forth Valley	539	307	167
Greater Glasgow incl Argyll & Clyde	9,615	7,351**	3036 (part estimated)
Grampian	1,747 (part estimate)	1,028	873 (estimate)
Highland	332	216	139
Lanarkshire	1,589	not available	not available
Lothian	3,450	not available	between 1026 & 1938***
Orkney	1	0	0
Shetland****	18	18	5
Tayside	956	528	98 (of sample of 248 only)
Western Isles	0	0	0
Total	21,131	11,143	At least 6,752
Scottish Prison Service	1,093	1,093	0
Grand Total	22,224	12,236	At least 6,752

* Data collected largely from NHS Boards, ADATs & CHPs

**includes 5,675 on “up to 7 days supervision”

*** adult defined as a “problem drug using mother or father”

**** from local drug treatment service only