Managing Opiate prescribing and dispensing

By Dr Gideon Felton MRCPsych

Consultant Psychiatrist and Clinical Lead

PLAN OF PRESENTATION

- Impact of addiction on society and journey into addiction
- Medical management of alcohol addiction
- Medical management of opiate addiction
- SCENARIOS

WHY

- Street Heroin £10 - £20 per dime bag (0.2gms)
- In Prison this can be £50-£80
- Average user can start smoking 1-2 bags per day and this easily escalates to 3-4 bags secondary to increased tolerance.
- Habit can cost £50-£100 per day or £350 to £1000 per week of disposable income
- Increasing tolerance leads to injecting

MIXING DRUGS

- Frequently users mix opiates with alcohol, crack or benzos with toxic and lethal results
- Sid Vicious – died due to lethal cocktail of small amounts of methadone, valium and alcohol
- His death raised awareness of drug cocktails and their dangers

NEED TO HAVE INTEGRATED STRATEGY

- Expensive daily habits funded by crime
- Opiate acquisition crimes account for over 70% of imprisonments
- (Alcohol responsible for 30% hospital admissions)
- High social costs in terms of unemployment, child protection, destitution and underacheivement

THE RATIONALE

- EVERY £1 SPENT ON DRUG REHABILITATION AND TREATMENT WILL RESULT IN £2 SAVED FROM THE SOCIAL CONSEQUENCES OF SUBSTANCE MISUSE

PROBLEMS FACED

- Intoxication
- Overdose
- Withdrawal
- Addiction

INITIALLY

- Pt takes drug and gets positive reinforcement
- This results in increasing the number of receptor sites being made by brain
- This results in needing more drug to satisfy the increasing number of receptor sites

- When drug is stopped, number of receptor sites reduces in a few weeks (cf Sid Vicious)

THE PROBLEMS

WITHDRAWALS-symptoms associated when drug discontinued-

happens when # of receptors > amount of drug ie unbound receptors needing drug

OVERDOSE

when amount of drug > # of receptors leading to drug binding receptors in unwanted places(lungs and respiratory depression)

- INTOXICATION describes altered behaviour secondary to drug

- ADDICTION is pt's behaviour in acquiring drug to stave off withdrawals

MEDICATIONS USED TO COUNTER PROBLEMS-ALCOHOL

- Chlordiazepoxide/Diazepam (GABA agonists)
- Used to counter the autonomic overdrive when alcohol stopped suddenly
- Addictive and tolerance inducing

- Acamprosate – GABA agonist
- Treats cravings and anxiolytic for 1 year

- Pregabalin – as above but not label

- Disulfiram(Antabuse) – use only if very motivated

TREATMENT PLAN FOR ALCOHOL DEPENDENCE

- Pt drinking daily with withdrawal shakes and autonomic overdrive on discontinuation

- CAN SEND TO A&E For Medical detox if Hx of DT's
- OTHERWISE GP/self refer to CRI – seen by key worker < 2/52

JOURNEY

- Pre detox-Pt reduces slowly with kw support
- KW plans detox (Inpatient or ambulatory) depending on outside support and PMhx
- decision made by MD

- Post detox – pt attends CRI for aftercare (AA, Relapse Prevention)

SYMPTOMATIC,NON OPIOID MEDICATION FOR OPIOID ADDICTION

- LOFEXIDINE α-2 blocker
- Used to counteract sympathetic rebound effects e.g. sweating
- NSAIDS - Used as analgesia
- LOPERAMIDE-Used for diarrhoea
- METOCLOPRAMIDE-Used for nausea
- MEBEVERINE/QUININE-Used for Stomach Cramps

METHADONE

- Long acting opiate agonist
- Principally used in harm reduction
- Minimises street purchasing/criminality
- Minimises i/v administration
- More addictive than heroin as longer withdrawals
- Encourages stabilisation as opposed to abstinence

OPIATE SUBSTITUTION METHADONE

- + Cheap
- + Easy to start
- + Easy to stabilise patient quickly
- + Well known and understood
- - Much harder to come off
- - Toxic in overdose
- - High street value increases risk of trading
- - If used with heroin can increase toxicity/tolerance

OPIATE SUBSTITUTION SUBUTEX

- Agonist at low dose, Blocker at higher dose
- Blocks out illicit opiates , denying any pleasure from on top usage
- No high-can cause withdrawals
- Often users try and supplement with more heroin
- Long acting
- Pleasure can be derived from snorting or injecting
- More about abstinence seeking as opposed to harm minimisation

METHADONE VS SUBUTEX

- If user smoking < 0.5 gms/day or < 6/12 dependence – subutex better
- If pt more chaotic/polysubstance – then methadone better
- We prefer to prescribe subutex as less risky
- Previously subutex was initiated on ‘IDEAL CLIENTS’ as more expensive
- Subutex allowed in pregnancy only if stable on subutex prior to pregnancy

CHANGE!!!

- Subutex becoming cheaper
- Government policy changing practice with ABSTINENCE main goal instead of HARM MINIMISATION

  (Strang)

DRIVERS OF CHANGE

- Payment by Results
- More pressure to reduce!!
- Subutex becoming more first line
- Greater drive to swich from Methadone to Subutex when Methadone dose has reached 30 or less

CHALLENGES TO THIS CHANGE

- Although > 300,000 registered users
- Fewer new cases into treatment
- Many patients are long-standing with > 10 years opiate dependence and unwilling to reduce.
- Will thwart attempts of service to reduce
- They have prejudicial opinions of subutex

IDEALLY

- We would like to use more subutex and less Methadone
- Need psychosocial interventions to achieve this

TREATMENT PLAN FOR OPIATES TITRATE>STABILISE>REDUCE

- Pt presents to GP stating opiate dependence
- GP/self refer to CRI, seen by KW in < 2/52
- Seen by Dr and Treatment plan made, depending on above
- TITRATED over a few weeks. Pt attends in withdrawal and given methadone 30mls or subutex 4mg and given dose increases every few days until no longer in withdrawal.

- STABILISED – Pt enrolled in psychosocial recovery work alongside scriots
- REDUCED – Pt given slow reductions on either Methadone or Subutex

- Pt's constructive behaviour rewarded by decreasing frequency of supervision and pick up and VICE VERSA

SUPERVISED vs UNSUPERVISED

- Decision made by specialists
- Based on patients reliability, engagement and evidence of no use on top
- Pt must demonstrate documented evidence the above
- Used as behavioural tools and decision complex

SCRIPTING ERRORS

- Common
- Do not dispense autonomously-even if medically risky not to do so. You are not covered
- Contact Out of hours CRI cover
- Possible options are for CRI to instruct GP to issue a script for 1 day to cover absence of script

Non-Collection of Prescriptions

- If there has been no pick up for 3 days then Re-titration as now opiate naive(cf Sid Vicious)

COMMON SCENARIOS

- Solution of scenarios is dependent on
- 1) What is the client's ambition/motivation
- 2) How realistic is the ambition

SCENARIO 1

- 22M
- Has been smoking 0.4 gms of Heroin
- Spends £15-30 per day
- Using for 6 months
- Wants abstinence

SOLUTION

- Motivated
- Under 0.5 gm daily use
- Abstinence achievable
- Plan
- For Subutex substitute prescribing with a view to reductions and detox
- Happens in Out Patients

SCENARIO 2

- 28M smoking 1gm Heroin
- Spends £30-£50 daily
- Long standing use
- History of treatment episodes with relapses
- Wants abstinence

SOLUTION

- Abstinence more ambitious for now
- Plan
- For Stabilisation on Methadone in order to reduce/stop use of street opiates
- This usually happens in Out Patients over longer time

SCENARIO 3

- 30F on 50mls prescribed Methadone
- Drinking more alcohol steadily
- Becoming more dependent on alcohol
- Unpredictable and Unstable
- Her alcohol use is preventing her getting her methadone

SOLUTION 3

- Risky Situation as this person may get opiates from ‘outside sources’
- Individual more agitated
- Plan
- Need alcohol detox – Inpatient or otherwise
- Stabilise on Methadone afterwards
- Provide aftercare package/Rehab

SCENARIO 4

- 38M attends pharmacy for daily pick up of 50mls methadone
- Smelling of alcohol
- Insistent that he has not drunk anything
- Not hostile but making staff feel uncomfortable

SOLUTION

- Difficult to call
- Clinically unwise to dispense as should not dispense if even a suspicion of alcohol
- OPIATE INTOXICATION KILLS OPIATEWITHDRAWAL DOES NOT
- However in this position you need to make judgement on safety

SCENARIO 5

- 36M on 180 mls prescribed Methadone daily
- Admits to using 0.4 gm (£20) on top I/V Heroin
- Risk of precipitating Opiate toxicity/OD with high consumption of opiates
- Dr fearful about prescribing more methadone

SOLUTION 5

- Plan
- Need to manage risk of overdose/toxicity
- Admit in order to stabilize on methadone & stop I/V use as on ward. Aim is to get patient stable on a lower dose of methadone – ideally 60-100 mg daily

SCENARIO 6

- 25F pregnant 14/40
- I/V use of 0.8 gm day Heroin
- Wants opiate abstinence to protect foetus

SOLUTION 6

- Abstinence unrealistic
- Fear of sending neonate into opiate withdrawal
- Premature Labour risk
- Plan
- To Stabilise on Methadone to mitigate withdrawal
- Minimise risk of I/V use

SCENARIO 7

- A Pt arrives to your practice stating he ‘forgot his methadone’ and is in withdrawal

SOLUTION 7

- Do NOT prescribe him any opiate as you may send him in overdose. You have no way of confirming this.

- Symptomatic relief only

SCENARIO 8

- A 45M attends the pharmacy for a supervised collection of 45mls methadone at 6pm. He is drowsy and has pinpoint pupils. You are convinced that he has used but he is denying it

SOLUTION 8

- Dispensing 45mls could be dangerous and plunge him into OD
- Not dispensing can cause withdrawals later in day
- Safer not to dispense

SCENARIO 8b

- Same situation but on a 16mg buprenorphine script

SOLUTION 8b

- Safer to dispense but this may precipitate withdrawals!

SCENARIO 8

- A script from a well known 54 M patient who picks up 100mls methadone twice weekly is lost . It is 6pm and you know that he is on ramipril and atenolol. You are worried about a BP rebound spike if you dont dispense but you wont dispense without a covering script. What are your options?

SOLUTION 8

- You call CRI out of hours cover
- Dont dispense even on phone advice
- NO SCRIPT MEANS NOT COVERED
- Options are that CRI can liaise with a GP for a one off out of hours script for 1 day supervised.

SCENARIO 10

- A 36/40 pregnant 35F arrives without a script, having failed to attend her script collection at CRI. You know her but you are unhappy about dispensing without a script. Your worry is that she may miscarry or become pre-eclamptic if you dont dispense-What do you do?

SOLUTION 10

- Again dont act single handedly by dispensing! Hospital attendance may be necessary as risk of miscarriage high.
- Phone CRI Out of Hours number

SCENARIO 10b

- You phone CRI at 6pm and the Team Leader states that the script was not signed and is still at the Hub but the doctor is not around. The Team Leader asks you to dispense promising that the doctor will sign a backdated script on the following day

SOLUTION 10b

- Dont dispense- The doctor cannot backdate a script.
- The Team Leader can speak to a covering GP to issue a one off script

SCENARIO 11

- A stable patient who you know well on 70mls weekly pick up attends your pharmacy. The script is lost due to your error and you feel guilty so you dispense his 70mls and your search fails to come up with the script – you ring CRI asking them to send you a back-dated script.

SOLUTION 11

- The doctor cannot back date a script. The date must tally with the date he/she signed the script.
- The dispensing has already happened without a script.
- An SUI may follow as it is autonomous dispensing.

SCENARIO 12

- A)A patient misses 1 day of his pick up and attends the next day expecting to be dispensed. CRI were informed of his non-attendance
- B) The same patient misses 4 days and attends your pharmacy

SOLUTION 12

- After 1 day, he will not be opiate naive-Retitration not necessary
- > 3 days-Titration necessary as receptors becoming less primed for opiates.

SCENARIO 13

- A patient on a weekly pick up of 90 mls methadone states that he vomited up his doses on 3 separate occasions. He tells this to you and you advise him to attend CRI. You cannot prove or disprove this.

SOLUTION 13

- Difficult to call. You have no means of confirming his story but not prescribing him may precipitate a heavy withdrawal. Prescribing at original dose may cause overdose as you dont know how much has been consumed. I will take in other factors eg use on top history.

SCENARIO 14

- A 65M arrives with a private script of injectible methadone ampoules 100mg bd, diazepam 40mg od and dexamphetamine 15mg

- How should this be managed

SOLUTION 14

- If this script has been ratified, then dispensing supervised better.
- Allow scripting at this dose for 2 weeks but reductions necessary after that.
- His private doctor also worried about that level of scripting