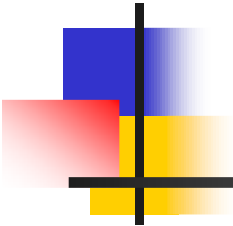


# Prescribing for drug users in Primary Care – looking at the options



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*Special Interest Master Class*

*July 1st 2003*



## Sarah aged 32 years

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- Sarah presents requests help with her drug problem
- She lives with her partner and her son aged 10 years



## Sarah (2)

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- She has been using heroin on and off for 12 years. She is currently injecting x4 / day, about 1+gm/day
- She also uses crack about 3x/week
- She drinks about 2 cans lager / day
- She also uses and has used for 15 years regular benzodiazepines, prefers temazepam
- She also uses dexamphetamine when available



## Sarah (3)

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- She has had 2 previous episodes of opiate treatment in specialist services, for 6 months 6 years ago and a detox 3 years ago – both with methadone
- Only previous treatment in PC - BZ by GP
- Her partner also uses drugs
- He also has a drug problem
- *How would you proceed with Sarah?*



# What would you do next for Sarah?

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- Confirm dependency
- Take a history
- Undertake a full assessment
- Physical examination
- Urine screening



# Aims of treatment

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- To reduce harm to user, family and society
- To improve health
- To stabilise lifestyle and reduce the amount of illicit drug use
- Reduce crime



# Goals

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1. Always find out what the user wants and check against what you are willing to offer
2. Set goals at the beginning of treatment and regularly review them
3. Decide together what additional help is needed (counselling, benefits, housing)
4. Acknowledge that drug use is a chronic relapsing condition and dealing with failure



# Treatment

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- Getting the 'drugs' right
  - Relationship with you and the team
  - Who else do you need to involve?
  - Where else can she get help?
- 
- *Don't forget general health care, social care, finances, housing etc*



# Where to next?

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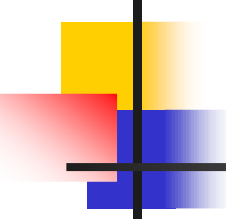
- Poly drug user
- Problem with several drugs
  - Heroin
  - Crack
  - Benzodiazepines
  - Alcohol
  - Amphetamines
- *How/ where to start?*



# Sarah – how to choose?

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- What does she want?
- She decides she wants to stop all drugs
- Sees heroin as her biggest problem
- Doesn't see alcohol as a problem
- Feels needs benzos
- Feels if stops heroin would stop crack
  
- *What do we know about previous treatment history?*
- *What do we know about outcomes?*



# Heroin - opioids

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*Maintenance  
or  
Detoxification?*



# What are our options for heroin?

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- Buprenorphine
- Lofexidine
- Methadone
- Dihydrocodeine



# Buprenorphine

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- A useful alternative to methadone
- 1<sup>st</sup> drug licensed for 25 years
- 0.4mgs, 2mgs, 8mgs tablets
- Used maintenance and detoxification
- Semi-synthetic derivative of opium
- Trade name Subutex



# Induction

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- Rapid transition to buprenorphine over 2-3 days - few side- effects
- Initial dose: 4 mgs
- Time to first dose heroin < 8 hours  
methadone < 24 – 36hrs
- PLUS 1<sup>st</sup> signs of withdrawals
- Increase daily 4 mgs, maximum 32 mgs



# Buprenorphine

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- Detoxification or maintenance
- Maintenance between 12-24mgs
- Detoxification 1-6 weeks
- Most suitable for use in primary care for patients:
  - a) who are opioid dependent
  - b) on either heroin or less than 30mg of methadone (or can reduce to this level)
- 12 to 16 mg BPN = approx 50 to 80mg methadone



# Buprenorphine

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## Advantages:

1. Less dangerous in overdose
2. Between 8- 32mgs use 'on top' markedly reduced, max between 12- 24 mg daily
3. Useful in maintenance and detoxification
4. Easier to withdraw from
5. Clearer head

## Disadvantages:

1. Highly soluble leading to potential for injection
2. Can precipitate acute opiate withdrawal if used incorrectly
3. Less 'opiate-like' or 'clouding' effect
4. More expensive than methadone



# Buprenorphine

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- A gradual dose reduction:

Daily buprenorphine dose reduction rate

Above 16 mg      4 mg every 1-2 weeks

8-16 mg      2-4 mg every 1-2 weeks

> 8 mg      2 mg every 1-2 weeks

> 2 mg      0.4-0.8 mg every 1-2 weeks



# Lofexidine

<b>Day detox</b>	<b>Max Morning</b>	<b>Max Midday</b>	<b>Max 6pm</b>	<b>Max night</b>
<b>1</b>	2	2	2	2
<b>2</b>	2	2	2	2
<b>3</b>	2	2	2	2
<b>4</b>	3	2	2	3
<b>5 can cont</b>	3	3	3	3
<b>6</b>	3	1	2	3
<b>7</b>	4	0	2	3
<b>8</b>	4	0	1	2
<b>8</b>	1	0	0	1
<b>10</b>	0	0	0	1



# Dihydrocodeine

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- Not licensed
- Used a lot in prison
- May have a small place in short detoxification



# Sarah

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- Tries buprenorphine detox but relapses on to injecting heroin when reaches 4mgs but almost stops crack use with support and acupuncture
- Continues to drink and take benzodiazepines
- *Decides wants to stop injecting and stabilise*
- *What are her / our options now?*



# Options

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- Change to maintenance prescribing
  - Increase buprenorphine and reach maintenance dose
  - Has used methadone (but never adequate dose) before and wants to transfer to methadone
- *Are there any other options?*



# Heroin and injectables

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- *Is injectable methadone an option for Sarah?*
- *Is heroin an option for Sarah?*



# Heroin and Methadone

	Heroin	Methadone
Route	Inhale / IV	Oral
Onset	Immediate	30 minutes
Duration	3-6 hours	24 hours
Euphoria	1-2 hours	None
Withdrawals	2-4 hours	After 24 hours



# Methadone

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- Large evidence-base for it
- Long acting, can be taken orally
- Addictive, develop tolerance & dependency
- Difficult to withdraw
- Useful for maintenance
- Need to start low and titrate up against signs of withdrawal
- Need to balance between right dose and preventing overdose or diversion



# Titration – how to do in primary care?

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- Need to start low and titrate up against signs of withdrawal
- Start with 10-40mgs methadone
- Second dose up to 30mgs after 4 hours if withdrawals
- If not possible try to see daily for 1<sup>st</sup> few days
- Increase dose during 1<sup>st</sup> seven days: 5-10 mgs/day (to max 30mgs above start dose)
- Steady state 5 days after last dose increase



# Prescribing methadone safely

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- Need to avoid the dangers of overdose and diversion.
- If you haven't done it before or are uncertain - ask for help and advice
- Always use methadone mixture 1mg/ml
- Before starting methadone for the first time:
  1. carry out urine toxicology.
  2. check for objective signs of opiate dependence
- Arrange for the drug user to receive methadone mixture on a daily basis (if possible, supervised for at least the first 12 weeks)
- *Starting methadone is never an emergency.*



# Methadone maintenance

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- *It works*
- Some schemes better than others
- Reduces illicit use, improves health and reduces crime
- Carrot to get people in treatment
- Better mortality and morbidity in treatment



# Getting the dose right

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- Maintenance most effective dose 80-120mgs
- Some people need above 120mgs
- Higher doses safer
- Increase the dose of methadone rather than prescribe benzodiazepines
- Non consenting slow methadone reduction is totally ineffective!



## Sarah - stabilisation

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- Stabilises well on 115mgs methadone mixture and stops heroin use
- Continues to drink alcohol
- Crack use reduced but continues
- Taking benzodiazepines daily
  
- *What about her alcohol, benzodiazepine and crack use?*



# Alcohol

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- Sarah was drinking 56 units / week
- Reduced in treatment and when stabilised on methadone to 20 units / week
  
- *What treatment can we offer for her alcohol problem?*
- *What are the risks?*
- *Are there any prescribing options?*

# Benzodiazepine prescribing - any value?



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- Sarah has presented with a long-term addiction problem with benzodiazepines
- Benzodiazepine use is a large problem, especially to poly drug users such as Sarah and many with mental health problems/ poor coping strategies
- Self-medicating with benzodiazepines may suppress poor mood
- It may reduce her alcohol?



## But what is the evidence?

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- No evidence maintenance prescribing of benzodiazepines reduces harm
- Prescribing BZ may not affect the use of street drugs
- Long term high dose BZ may cause harm
- More addictive and more difficult to come off than opiates



## Only consider prescribing BZ if:

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- Sarah has been stabilised on substitute opiate first
- She is taking daily and evidence of dependency
- She has attempted some control of her illicit benzodiazepines
- The goals of the prescribing have been established and both you and she are clear how substitute prescribing could help
- Will attempt to abstain from street drugs if prescribed
- Present in at least two positive urine drug screens



# What to prescribe?

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- Only prescribe one benzodiazepine at a time
- Diazepam is the drug of choice
- Change from temazepam that Sarah is using to **diazepam**
- Start low and work up to a maximum of 30mgs



# And don't forget the crack!

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- Evidence that psychological interventions helpful
- *Are there any prescribing options?*
  - Auricular acupuncture, herbal teas, oils, care, information
  - Antidepressants
  - Amphetamines??????



# Prescribing for drug users in primary care

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- It is not rocket science and always rewarding
- Most drug users are poly drug users – don't treat the opiate problem and ignore the rest
- Listen to and work with the patient
- Work to your level of expertise and never be afraid to ask for help, locally and nationally



# Prescribing for drug users in primary care (cont)

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- Can provide a range of interventions that can help, which may include prescribing
- Aim is to stabilise life and improve health
- Use all your skills in managing chronic relapsing conditions
- *Take out the moralising and always put in the humanity!*