

Heresy, Dogma and the Inquisition

Supervised Consumption and Dose Assessment of Methadone

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The international perspective – *The Inquisition imported?*

Internationally (at least until recently) methadone take home doses are unusual...*supervised consumption is the norm*

The British system has always used supervised consumption 'sparingly'

The British system is uniquely...

- ...Flexible or...
- ...Flawed

The 1990s

- Rising Drug-related Deaths
- Criticism at home and abroad - '*...irresponsible prescribing and lack of supervision is the cause...*'
- The belief was that diverted methadone was partly the cause of the elevated death rates
- To this date the evidence for this remains scant, *yet treatment choice became restricted - a good or a bad thing...I don't know...because...*
- In my experience debate became polarised and inconclusive, in the sense that it failed to produce a true consensus

This is not a debate!

Not today anyway! - *My view is:*

- To say that methadone causes deaths *because* when it turns up at autopsy the deceased are almost always not in treatment (*ergo it is diverted methadone*) does not prove cause and effect.
- This view *can* be countered by citing the protective effect of being in treatment - *however I do not state this dogmatically...ha ha*

Am I anti-supervision?

No!

...but I believe its real strength lies in dose assessment and I think this is increasingly how many/most of us use it without being all that vocal about it...*perhaps we view reduced diversion as a (beneficial) side effect*

Articles of 'faith'

Article of faith number 1 - The fall in UK drug related deaths is due to a combination of many factors including more people in effective treatment and perhaps measures which lower the diversion of methadone.

Articles of 'faith'

- **Article of faith number 2** – Dose induction and then subsequent assessment, safely to adequate doses under supervised consumption and with appropriate psychosocial intervention is the best way of achieving stability of lifestyle and drug use for the majority of patients and supervised consumption can have a suppressive effect on deaths through this indirect, though highly important mechanism.

Articles of 'faith'

- **Article of faith number 3** – Patients stabilised on optimal doses using supervised consumption are less likely to divert their methadone following the cessation of supervision.

Articles of 'faith'

- **Article of faith number 4** – There can be flexibility in the use of supervision and exemption for some but this should be consistently and fairly managed. Possible criteria for exemptions would be: those who are in regular work, disability, pregnancy and women caring for their own children

'Dose induction' and 'Dose Assessment' for METHADONE

- Dose induction - 2 stages - *first few days and up to first 2 weeks*
- Dose titration (assessment) - *the period during which the dose continues to be increased*

Dose induction - 1

- Methadone induction deaths are rare
- Most deaths occur in the first 2-3 days
- In excess of 20% of all deaths in treatment are within 2 weeks of commencement of prescribing
- Most deaths occur during sleep – during induction avoid patients taking methadone during the evening. Peak methadone level is 2-4hrs after a single dose

Dose induction - 2

- Daily assessment by a pharmacist using Supervised Consumption is the best safeguard against over-sedation in a patient going undetected
- Patients should be informed of 'increasing effect of a dose' as steady state is achieved so that they do not excessively 'top up' with street drugs

Dose induction/titration - 1

We have no national guidelines for this process and practice is very variable.

In Birmingham we recognise 2 groups of patients:

- Those for a 'standard' titration
- Those who need a (more) 'rapid' titration

Dose induction/titration - 2

Patients who may benefit from more rapid induction/titration:

- Long history of use including past and current injecting heroin use
- Higher levels of drug use
- Clear evidence of high tolerance in a patient well known to the service(s)

The rationale for using a more rapid induction (*ie moving to the dose range 60-70mg in the initial period of prescribing*) is that such patients when put on 'inadequate' initial doses use street drugs with their methadone in a way which puts them at an unnecessarily high risk of overdose.

Dose induction/titration - 3

Patients benefiting from a more cautious approach:

- Non-injecting drug use
- Shorter history of drug use
- Lower levels of drug use
- Lack of or unclear evidence of high tolerance
- Other illness – *eg airways disease (eg bronchial asthma) and infections (HIV, hepatitis and others)*

When do we stop - 1?

'Patient Comfort' as a guide to dose assessment:

Persistence of these *may* indicate a need for dose increase:

- Significant street drug use
- Craving
- Dysphoria/low mood, insomnia or anxiety – *if assessed as probably the result of tolerance to opiates. Low mood clearly has to be distinguished from depression*

When do we stop - 2?

Will we end up with lots of people on massive doses?

- Patients don't want it - *my challenge is persuading them of the benefits of the 60-120mg dose range*
- We don't need to chase the 'Holy Grail' - *complete cessation of street drug use in the early stages of treatment? **We should assess the importance/significance of any continuing use.***

Stability/continuing drug use

Assessment checklist:

1. Does the use currently threaten stability or the Care Plan *eg criminal activity/lifestyle?*
2. What are the current health risks?
3. Injecting use? Risky injecting (site)? Is the use?:
 - 1. Daily?
 - 2. Several times weekly?
 - 3. Weekly?
 - 4. Fortnightly?
 - 5. Monthly?
 - 6. Has the frequency of use been significantly impacted by script *i. currently? ii. in the past?*

Discussion?

More detail - 1

- Community Dose Assessment gives prescriber and dispenser the confidence they need in order to provide therapeutic doses of substitute medication as quickly as possible and with optimal safety in mind – *this gives patients access to the dose range 60-120mg (and higher in some cases) for methadone*
- Apart from the exceptions (see below) it is good practice to use Supervised Consumption for all situations where a series of dose increments are considered likely
- Continued use of drugs **other** than opiates and requests for alternative prescriptions eg cocaine, crack/cocaine, anti-depressants, benzodiazepines and related hypnotics/anxiolytics ('Z' drugs eg Zopiclone) are often influenced by under-dosing with opiate substitute medication.

More detail - 2

- If we titrate (assess) the dose simply to 'objective' withdrawal symptoms we will leave our patients with symptoms (specifically **dysphoria, insomnia, anxiety and craving** – *see easy reference CDA Flow Chart*), which may be treatable with opiate substitution. Titrating the dose to 'patient comfort' is in many people's experience a more reliable guide and may result in desirable outcomes more frequently. The best treatment for opiate sleep disturbance and other subtle, continuing opiate withdrawal symptoms is a substitute opiate at an appropriate dose
- Serum methadone estimation may be helpful in investigating why an individual is not stabilising but it is not a good guide as to the desirability or otherwise of a dose increase

More detail - 3

- Published data (though not randomised controlled trials) suggest that psychiatric conditions including major depression and psychosis respond to adequate methadone dosing.
- Patients with significant co-morbidity (Dual Diagnosis) may require significantly higher doses of methadone in order to facilitate control of their drug use and there is evidence that the need for other medications to control their mental illness is reduced by the use of doses of substitute medication which adequately control their drug use

More detail - 4

- **When is supervised consumption not appropriate?:** We need to ask 'Can supervised consumption of substitute medication be offered at a reasonable distance from the patient's address?' ie ideally 10 mins walk and no more than 20mins (within 1-1 ½ miles). Special consideration needs to be given to those having a *disability, those who work, pregnant women and women with children*. However for safety reasons (for some), supervised consumption may be the only option at a particular point in time.
- Once the dose is regarded as optimal or the patient no longer wishes to increase the dose it is good practice to review stability according to established principles and move the patient on to daily dispensing at a named pharmacy, which may or may not mean a move to another pharmacy. Patients may wish to move to a pharmacy closer to where they live

More detail - 5

Enzyme induction/inhibition:

- Concurrent use of the following drugs may affect plasma levels of methadone:
 - **Enzyme induction** (lowered methadone levels) - *alcohol and tobacco*
 - **Enzyme inhibition** (increased methadone levels) - *allopurinol, dextropropoxyphene, chloramphenicol, ciproflaxin, disulfuram, isoniazid and enoxacin*