Pharmaceutical services for opioid drug users

Annual Update Briefing. Issue 7 2024-26

Introduction

The aim of this Annual Update Briefing is to:

- Support the pharmacy in meeting the training requirements in the supervised consumption service specification.
- Update staff on the latest national guidance and local practice on substance misuse.
- Compliment the local online training signposted to on the CPNEC website at https://www.cpnec.org.uk/drug-and-alcohol/.

Pharmacy service specification 2025-26 training requirements

The contractor should ensure that a lead pharmacist has completed the required mandated training which is to:

- Complete, or refresh every 2 years, the CPPE Declaration of Competence (DoC) for supervised consumption of prescribed medicines at https://www.cppe.ac.uk/services/declaration-of-competence.

The lead pharmacist should be assured that all staff are competent to deliver the service and will complete the required mandated training which is to:

- Read the service specification.

Non-mandated training:

- View the local online training signposted to on the CPNEC website at https://www.cpnec.org.uk/drug-and-alcohol/ which includes this Annual Update Briefing 2024-26, and a 1 hour pharmacy webinar from DARS to support with the broader aspects of drug misuse and recovery, and hence with the completion of the CPPE DoC for supervised consumption of prescribed medicines (an accompanying signposting briefing is also available).

For 2025 – 26, a PharmOutcomes Declaration needs to be completed for each staff member accessing the claims template.

Local training offer

The quarterly Drug and Alcohol Recovery Service training calendar for online courses includes (signposted on CPNEC website at https://www.cpnec.org.uk/drug-and-alcohol/):

- *Basic Drug Awareness* - This course aims to provide a basic awareness of the range of drugs currently misused, the appearance and paraphernalia associated with the use of drugs, the different effects and risks associated with their use. It also cover the law surrounding substances and why people use drugs, whether legal or illegal, harm minimisation techniques and signposting to treatment services.
- *Basic Harm Reduction* - This course will enable a non-specialist to understand risks associated with substance use and feel comfortable offering basic harm reduction advice.
- *BITESIZE - Blood Borne Viruses and Substance Misuse* - Prevention, detection, and treatment of infections related to substance use, particularly when injecting remains high on the public health agenda in the UK.

- *Understanding Opioids* - This course takes a look at different opioid drugs, covering heroin use, injecting behaviour and prescription opiates and newer synthetic opiates. We also look at opioid substitute prescribing and harm reduction advice for people who use these drugs.

For a summary of the work of the Drug and Alcohol Recovery Service see short video at https://codurhamdrugalcoholrecovery.co.uk/about-us

National guidance

- Drug misuse and dependence: UK guidelines on clinical management. DHSC. Updated 15/12/17. www.gov.uk/government/publications/drug-misuse-and-dependence-uk-guidelines-on-clinical-management
- NICE resources:
  1. Drug misuse in over 16s: Opioid detoxification. NICE Guidance CG52. Published 25/07/07. https://www.nice.org.uk/guidance/cg52
  2. Opioid dependence. NICE Clinical Knowledge Summary. Updated May 2024. https://cks.nice.org.uk/topics/opioid-dependence/
- Office for Health Improvement and Disparities[1] national guidance at www.gov.uk/government/collections/alcohol-and-drug-misuse-prevention-and-treatment-guidance and https://www.gov.uk/government/collections/preventing-and-reducing-drug-related-harm (see Further Reading).

The *Drug misuse and dependence: UK guidelines on clinical management* (commonly known as the Orange Guide) **is the definitive national guidance.**

Key points in *Chapter 4: Pharmaceutical Interventions* include:

Choice of drug for opioid dependence
There is insufficient evidence to recommend one drug over the other. While there is accumulating evidence that buprenorphine is associated with reduced risk of fatal overdose in the first weeks of treatment initiation, there is also evidence that methadone is more effective in retaining patients in treatment and so may indirectly reduce risks longer term for those patients.
In the first weeks of methadone treatment there is an increased risk of death due to overdose. After around a month in treatment, the risk of death due to opioid overdose during maintenance treatment falls to very low levels.
Dose induction should aim carefully, as soon as possible, for a stable dose of opioid that avoids both intoxication and withdrawal. It may take two to four weeks (or more) to achieve an optimal dose with methadone. It usually takes less time with buprenorphine since induction with buprenorphine may be carried out more rapidly with less risk of overdose.

Signs of opiate withdrawal include

- Coughing, sneezing, runny nose, watering eyes
- Raised blood pressure, increased pulse
- Yawning, dilated pupils, cool and clammy skin, fine muscle tremor
- Diarrhoea, nausea
- Restlessness, irritability, anxiety

Methadone toxicity and risk of overdose
All staff working with service users who are taking methadone should be aware that there is a risk of death in early methadone treatment. This can be due to excessive initial doses, failing to recognise symptoms of cumulative effects, impaired liver function (due to chronic hepatitis), or failing to inform patients of the dangers of overdose if they are using other

[1] Previously Public Health England

drugs (particularly benzodiazepines and alcohol) at the same time (since opioids induce respiratory depression, and sedative drugs potentiate this effect).
Signs and symptoms of methadone toxicity include:

- Drowsiness, slurred speech
- Slow and/or shallow breathing
- Constricted (pinpoint) pupils
- Disorientation/ confusion, dizziness/ feeling faint, balance/ coordination problems.

With methadone, toxicity is delayed at least several hours after exposure, and this may only become apparent after several days of treatment. The reason for the delayed toxicity is methadone's long but variable half-life, of between 13 and 50 hours with chronic administration. It takes five half-lives, or 3-10 days, for patients on a stable dose of methadone to reach steady-state blood levels. During these 3-10 days, blood levels progressively rise even if patients remain on the same daily dose. A daily dose tolerated on day one may become a toxic dose on day three. Patients must therefore be carefully inducted on to methadone and then monitored, and if necessary, the dosage adjusted during this accumulation period.

Risk factors for buprenorphine

Buprenorphine is widely considered to cause less respiratory depression than methadone. At low doses, buprenorphine is a potent opioid agonist, producing morphine-like effects. However, due to its mixed agonist-antagonist properties, increasing doses become self-limiting and do not produce more intense opioid effects. This may be one reason some patients prefer methadone.
Precipitated withdrawal occurs when buprenorphine is first administered to an opiate-dependent person with circulating opioid agonist drugs present. In this situation, buprenorphine can inhibit the opioid actions of the full agonist without adequately replacing them, leading to the appearance of withdrawal signs and symptoms. Precipitated withdrawal can be very unpleasant and may deter patients from continuing participation in treatment. There are three measures to minimise precipitated withdrawal:

- Administer the first dose of buprenorphine when the patient is exhibiting signs of withdrawal.
- If withdrawal is difficult for the patient to tolerate, delay the administration of buprenorphine until at least 6-12 hours after the last use of heroin (or other short-acting opioid), or 24-48 hours after the last dose of low-dose methadone.
- Provide the anticipated day's doses, for the first day or two, in divided doses (typically using 2mg tablets) so that the speed of the induction can be managed.

Methadone dosing

In general, the initial daily dose will be in the range of 10-30mg.

- *First 7 days*: Where doses need to be increased during the first 7 days, the increment should be no more than 5-10mg on one day. In any event, a total weekly increase should not usually exceed 30mg above the starting day's dose. Patients should be alerted to the risk of over-sedation and the risks with ongoing illicit use.
- *Subsequent optimisation*: Following the first 7 days, doses can continue to be increased incrementally. A total target dose of 60-120mg a day, and occasionally more, may be required.

Buprenorphine sublingual dosing

Most dosing regimens involve starting with a low dose (4-8mg) that is rapidly increased. Effective maintenance treatment with buprenorphine involves doses in the range of 12-16mg for most patients dependent on heroin, with some needing up to 32mg. It makes sense to work towards this dose rapidly, so long as this does not produce side-effects or precipitated withdrawal. A cautious approach is to initiate treatment with 4mg on day one, then 8-16mg on day two and thereafter.

Key points in *Chapter 2: Essential elements of treatment provision* include:

2.2.2 Assessment

The Clinical Opiate Withdrawal Scale (COWS) Opiate withdrawal scale is used along with physical observations.[2]

The COWS rates the common signs and symptoms of opiate withdrawal to help clinicians determine the stage or severity of opiate withdrawal and assess the level of physical dependence on opioids.

2.4 Drug testing

Drug testing can be used for:

- initial assessment and confirmation of drug use (although testing does not confirm dependence or tolerance and should be used alongside other methods of assessment)
- confirming treatment compliance – that a patient is taking prescribed medication
- monitoring illicit drug use, including as a drug-specific treatment goal (for example, as part of a psychosocial intervention)

Urine remains the most versatile biological fluid for drug testing and has the advantage of indicating drug use over the past several days. As well as being physically non-invasive, drugs are present in relatively high concentrations and large samples can quickly and safely be collected.

Oral fluid has the advantage of being easier to collect and harder to switch or adulterate samples, although drugs are present in lower concentrations and the sample size is usually much smaller than for urine.

The detection window for oral fluid testing is normally 24-48 hours for most drugs, so only very recent drug use can be detected.

The NICE Opioid Dependence Clinical Knowledge Summary at https://cks.nice.org.uk/topics/opioid-dependence/ also provides extremely useful summaries of assessment and treatment.

[2] https://nida.nih.gov/sites/default/files/ClinicalOpiateWithdrawalScale.pdf.

Supervised consumption service – key points

It is very important to inform the Service if the pharmacy does not routinely provide supervised consumption on a day(s) when the pharmacy is normally open.

All take-home daily doses of methadone should be dispensed in separate containers.

Medication should be withheld, and the Service contacted if the client misses 3 or more doses consecutively. This is an essential clinical and safety requirement since the Service will then contact the client to attend for a re-titration appointment and to check on the client's general welfare.
To feedback to the Service when a client has missed 3 or more consecutive days of medication use the PharmOutcomes template *Supervised Consumption - Missed 3 or more dose notification* to send an email to the Service (Note: This email address is monitored Monday – Friday 9am – 5pm).

In the event of any pharmacy service disruption, the pharmacy should contact the local Recovery Centre (see pharmacy mobile numbers below), and ring all affected clients to make suitable alternative arrangements e.g. asking clients to attend the pharmacy at a time when a pharmacist will be available. Pharmacies are required to confirm clients' telephone numbers once a month.

For urgent enquiries to the Service telephone the clinical administrators on:
•Horden / Peterlee: 07974 861000
•Bishop Auckland: 07974 861058
•Durham: 07974 861001
These telephone numbers are available Monday - Friday 9am – 5pm.
To urgently contact the Service on Saturday mornings 9am – 12pm, telephone 03000 266 666 and select the option for Durham.

The fee per supervision is per client supervision (i.e. one supervision claim per client visit to the pharmacy) and not, for example, for each different strength of buprenorphine given to a client to make up a specific dose - therefore if a client has more than one prescription for buprenorphine (to make up a specific dose) only one of those prescriptions should then be entered onto PharmOutcomes in order to claim the supervision fee for that occasion.

The pharmacy naloxone (Prenoxad) supply service

Pharmacies providing the supervised consumption and/or needle exchange services should also consider providing this important service, in order to reduce the number of drug misuse deaths.

Why is this service so important in County Durham?

- Opioid-related deaths make up the largest proportion of drug-related deaths across the UK, with an average of 40 deaths per week.
- Opioids were involved in 73% of drug misuse deaths registered in England in 2022, and the North-East of England continues to have the highest rate of drug misuse deaths.
- Naloxone can almost immediately and temporarily reverse the effects of an opioid overdose, and therefore prevent drug-related deaths by reversing breathing difficulties.

- Naloxone supply is therefore a critical intervention, particularly with the increasing use of potent synthetic opioids.[3]

What is the legislation?
Naloxone injection (Prenoxad) is a POM, however following legislative changes:
In 2015: It can be supplied without a prescription by persons engaged in the provision of drug treatment services (e.g. on behalf of a local authority) for the purposes of saving life in an emergency.[4]
In 2024: In December 2024, legislation enabling pharmacy professionals to supply take-home naloxone came into force.[5] This is in addition to the 2015 exemptions in the Human Medicines Regulations which allow drug treatment services to supply take-home naloxone without a prescription for the purposes of saving life in an emergency.

In County Durham this commissioned service will pay a supply fee of £8 exVAT (plus drug cost) for each supply made, and any trained member of the pharmacy team can make these supplies.

This service has been remodelled to make it a much quicker intervention (with minimal data recording requirements) based on the lessons learnt from successful pharmacy services elsewhere.

See a summary briefing and a non-mandated training video at https://www.cpnec.org.uk/drug-and-alcohol/.

Further reading

Useful resources in *Alcohol and drug misuse prevention and treatment guidance* at www.gov.uk/government/collections/alcohol-and-drug-misuse-prevention-and-treatment-guidance include:

- *Community pharmacy: delivering substance misuse services.* Guidance and advice for community pharmacies in England providing services to people who use drugs and alcohol. OHID. 29/01/24. https://www.gov.uk/government/publications/community-pharmacy-delivering-substance-misuse-services
- *Misuse of illicit drugs and medicines: Applying All Our Health*. Evidence and guidance to help health professionals identify, prevent or reduce drug-related harm. OHID. 23/02/22. https://www.gov.uk/government/publications/misuse-of-illicit-drugs-and-medicines-applying-all-our-health
- Opioid substitution treatment good practice resources. For example:
    1. *The Best practice in Optimising Opioid Substitution Treatment (BOOST)* elearning programme at https://www.e-lfh.org.uk/programmes/best-practice-in-optimising-opioid-substitution-treatment-boost/ which aims to provide drug treatment and recovery professionals with the information they need to deliver good quality opioid substitution treatment to service users.
    2. *Opioid substitution treatment: Guide for keyworkers*. PHE. 21/07/21. https://www.gov.uk/government/publications/opioid-substitution-treatment-guide-for-keyworkers

[3] https://www.cas.mhra.gov.uk/ViewandAcknowledgment/ViewAlert.aspx?AlertID=103236; https://www.gov.uk/government/publications/fentanyl-preparing-for-a-future-threat
[4] https://www.gov.uk/government/publications/widening-the-availability-of-naloxone/widening-the-availability-of-naloxone
[5] https://pharmaceutical-journal.com/article/news/legislation-enabling-pharmacy-professionals-to-supply-take-home-naloxone-comes-into-force; https://pharmaceutical-journal.com/article/news/pharmacists-and-pharmacy-technicians-to-be-able-to-supply-naloxone-without-a-prescription