

Naltrexone In Primary Care

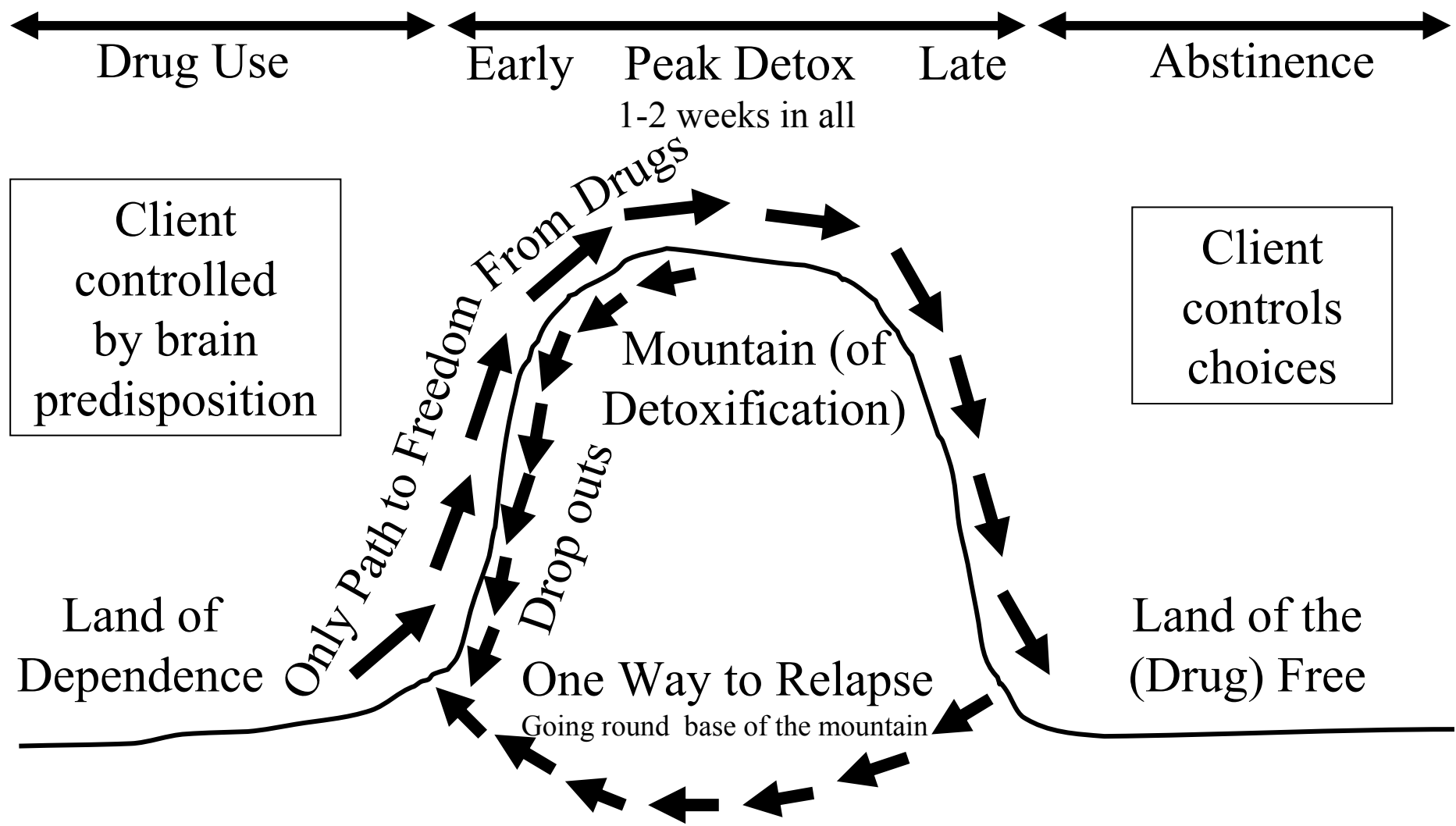
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GP Best Practice Meeting 13/02/09

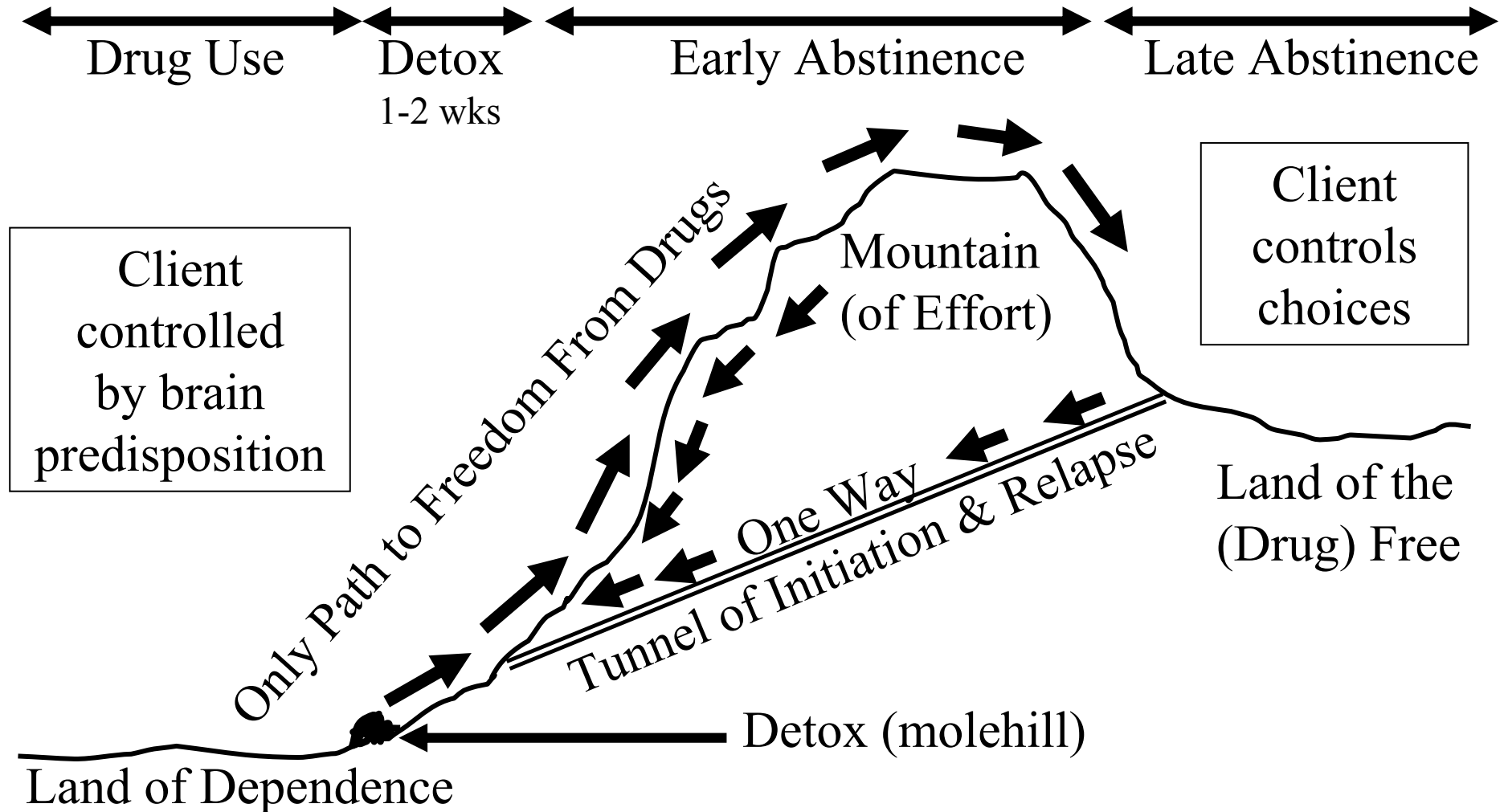
Why is Opiate Aftercare Important?

- Staying off is more difficult than getting off
- Most effort & preparation required for the aftercare phase of treatment
- Rehab may be needed (residential or day care):
 - Residential rehab if deeply ingrained issues or embedded in drug subculture (lifestyle transplant)
 - Needs supporting and embedding in community

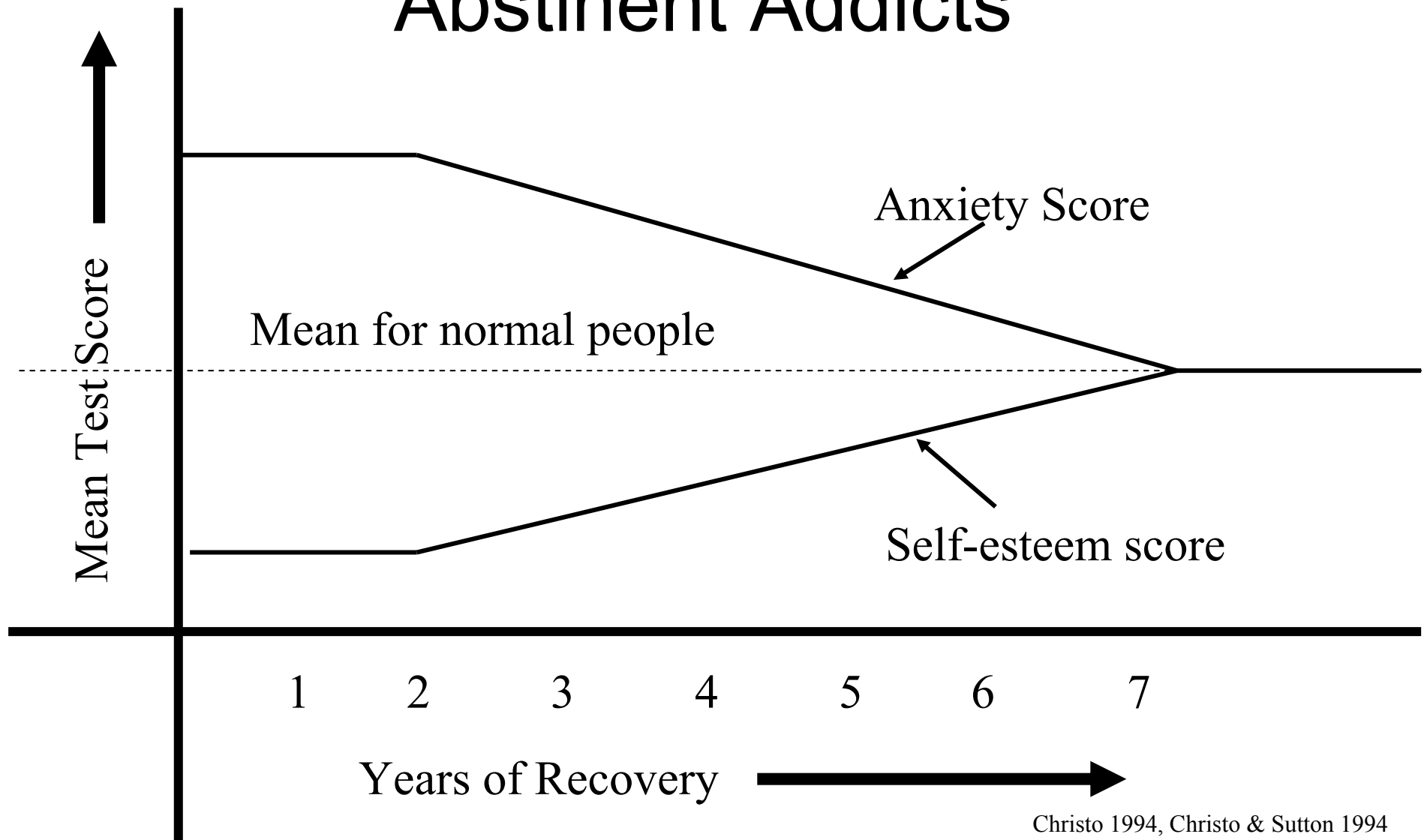
How Clients & Professionals Often Perceive Progress in Addiction Tx



Reality: The Long Hard Road to Abstinence



Recovery of Self-esteem & Normalisation of Anxiety Levels in Abstinent Addicts



Relapse Prevention for Opiates: Consider all 3 Components of Aftercare

- Psychological therapy/support:
 - CBT: Motivational interviewing and Relapse prevention
 - General relaxing therapies: ear acupuncture
- Psychosocial therapy:
 - Promoting support networks, NA etc
- Medication:
 - Naltrexone (Opizone[®] & Nalorex[®])

What is Naltrexone Used For?

- Dependent opiate users who are now abstinent:
 - Prevents impulsive relapse
 - Acts as a safety net
- Combined crack & opiate users:
 - Who are abstinent from opiates, and
 - Who will not use crack if they cannot use heroin for the comedown from the crack
- Dependent alcohol users (out of licence):
 - Reduces “high” & increases negative effects of alcohol, reducing amount drunk
 - Reduces risk of relapse, & length of lapse/relapse

Cost-Effectiveness of Naltrexone

- No formal cost effectiveness studies
- Naltrexone costs £0.85 per tablet per day (one month = £23, three months = £70)
- Average length of time in Tx is 6 weeks to 3 months (av 9 weeks ~ £52)
- Naltrexone drug costs are a very small part of the overall cost of aftercare
- Costs to Tx services, client, society much greater if client relapses to opiate use

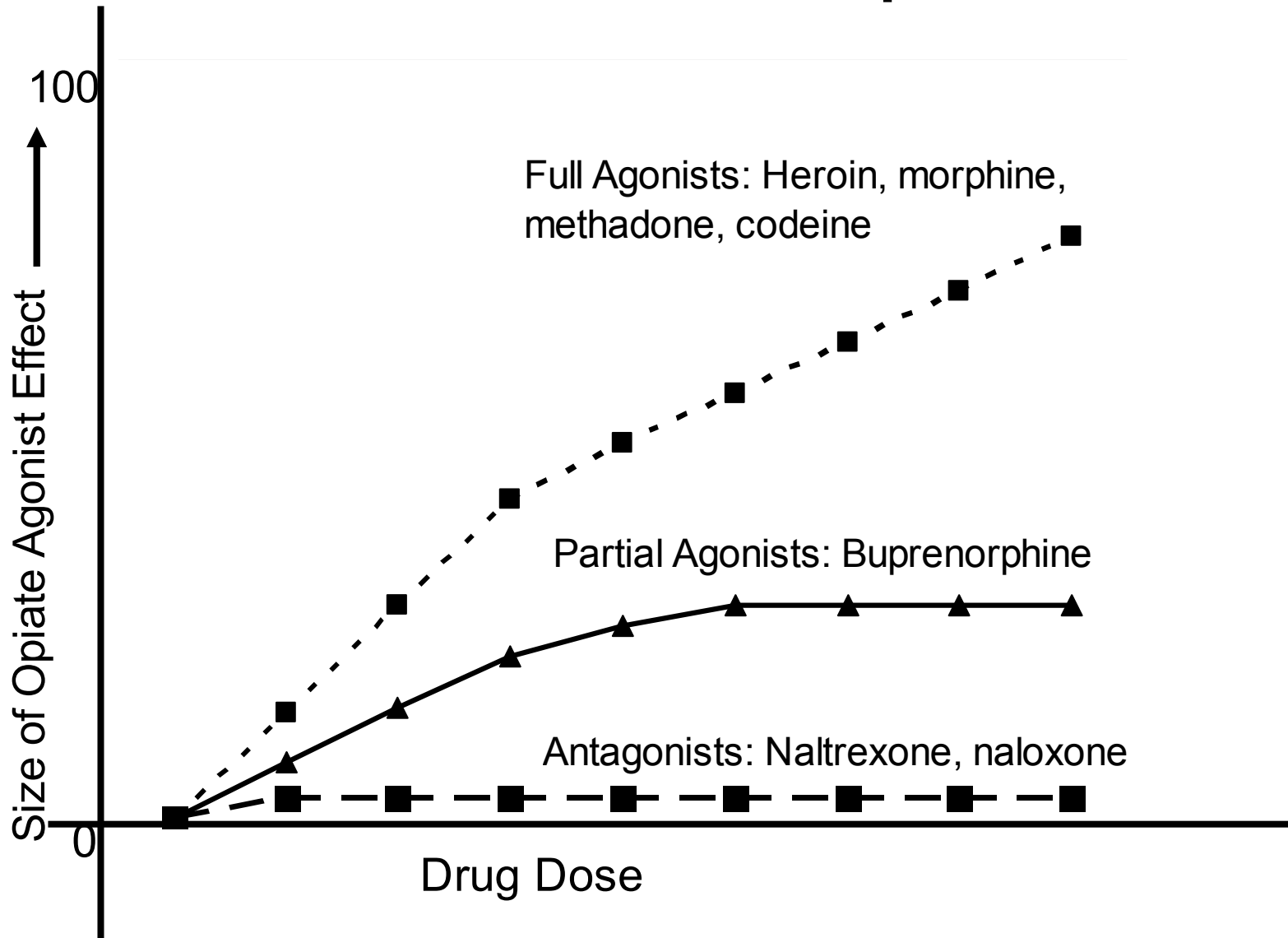
Naltrexone: The Overall Approach

- A crutch – A temporary support to someone who needs help
- Not a cure – The cure is cognitive change
- Only one tool in the tool box for aftercare
- Must be used with psychosocial support
- A bit like a psychological intervention:
 - Enhances abstinence in motivated clients
 - Useless in unmotivated clients (who don't take it)

Naltrexone: The Blocker Drug In Opiate Aftercare

- Opiate blocker (antagonist):
 - Blocks “high” from opiate use completely
 - Blocks opiate receptors so opiates can't act
 - Long-acting blocking heroin for 2-3 days
 - Can't get opiate dependent if taking it

Classification of Opioids



Naltrexone: The Blocker Drug In Opiate Aftercare (cont.)

- Non-addictive
- Very safe with few side-effects
- Take one tablet a day (50mg):
 - or 3x/wk (100mg Mon, 100mg Wed, 150mg Fri)
- Supervised consumption an expectation:
 - Supervision provides additional support (rather than a policing function)
 - Typically by friend or relative (not community pharmacy)
 - Improves outcome
- Dispense 1-2 weeks (later 4 weeks) at a time

How Long to Give Naltrexone For?

- As long as benefits outweigh drawbacks:
 - During initial period following detox 3-12 m
 - During period of continuing vulnerability
 - Until client highly resistant to relapse – note many clients over estimate coping ability
- Restart if cravings develop or enters high risk situations that may lead to relapse
- Need to restart some clients several times:
 - a learning experience for the client

Naltrexone – Opiate Interactions

- 50% clients test the blockade:
 - If use heroin on top – no effect, doesn't make client ill (unlike alcohol & antabuse)
 - If blockade tested (so urine is opiate positive) just continue the naltrexone
- If given to someone on opiates:
 - Causes severe withdrawals for up to 48 hours
 - So only give when urine opiate, methadone & buprenorphine negative (& not used tramadol)

The Advantages of Naltrexone

- Cannot relapse while taking it (“body armour → invincible in the face of attack”)
- Blocks impulsive relapse - Most who relapse do so impulsively:
 - Means client has 2 days to think about it
- Provides a “safety net” for clients during period of highest risk of relapse (60% 1st wk):
 - While symptoms resolve & adapting to life without the support of drugs
 - It really is a crutch, it cures nothing – use it to cover the period of maximum risk
- Proves commitment to abstinence



Naltrexone is your helmet, shield & body armour: It deflects the arrows of the enemy (& any wayward impulses)

Disadvantages of Naltrexone

- Biggest problem with naltrexone is that it doesn't help if it is not being taken!
 - Resolve to take tablets slips at times
 - Client desire to be “completely drug free”
 - It feels like a “wind up” to the client
 - Need to put effort into enhancing compliance
- B&W thinking: An admission of weakness to “depend” on taking a tablet once detoxed
- AA/NA & rehabs opposed to “mind altering chemicals”
- Increased O/D risk:
 - Not when naltrexone being taken
 - When naltrexone stopped (in ambivalent clients)

Disadvantages of Naltrexone (cont.)

- Very safe drug with few side-effects
 - Most clients have no side-effects
 - Withdrawal on induction if opiates present
 - Possible headaches, aches & pains, anxiety, lethargy, tummy pain or upsets, poor sleep, arthralgia, rash, need to stretch
- Most wear off over a few days. If effect sustained, may reduce to ½ tablet
- If side-effects:
 - Review with client whether naltrexone likely cause
 - Help client assess whether for them the benefit of taking naltrexone outweigh its drawbacks
 - Is client looking for an excuse to stop naltrexone?
- Carry warning card in case of accident:
 - Blocks effects of opiates needed if severe injury

Disadvantages of Naltrexone: Liver Function Tests

- Perform LFTs if possible prior to induction :
 - Effects on liver minimal: shown by giving it to alcoholics with severe liver disease
 - LFTs elevated in obese people on high naltrexone doses (200-350mg daily)
- Balance of risks in most clients means do not delay induction if LFTs not done:
 - If LFTs normal, repeated THREE MONTHLY
 - If LFTs <5 x upper limit, MONTHLY LFTs
 - If LFTs >5 x upper limit of normal, WEEKLY LFTs, seen by consultant to do risk-benefit analysis & 25mg dose (½ tablet)

Effects of Naltrexone on Natural Opiates (Endorphins)

- Endorphin suppression causes lethargy & apathy
- Endorphins will have been suppressed in those on daily illicit or prescribed opiates
- Take 3+ months for endorphins to return to normal once opiates stopped, promoted by Naltrexone
- Protracted withdrawal includes lethargy & apathy
- On starting naltrexone:
 - Vast majority of clients notice no endorphin suppression symptoms, presumably as endorphins already suppressed
 - Suggested that endorphins bypass Naltrexone blockade, perhaps as only very low concentration required for effects

Starting Naltrexone

- Assessment
- Personalise it: Identify reasons with the client why it will help them with their problems
- Obtain LFTs
- Check urine for opiates & methadone & buprenorphine. Ask about tramadol. Don't need naloxone challenge test unless uncertain
- Start 5-7 days after Bup/Heroin, 7-10 after Meth
- Give ½ tablet day one, then full tablet thereafter
- Issue certificate as reward & evidence for client

The Evidence – NICE Guidance

- NICE technology appraisal guidance 115: Naltrexone for the management of opioid dependence (Jan 2007)
- Results based on 17 studies of clinical effectiveness (most poor quality & small):
 - Re-incarceration rates: NTX + behaviour Tx better than beh Tx alone on (50% vs 24%)
 - Relapse rates: Naltrexone better
 - Retention: No difference, but problematic as primarily a measure of compliance with Tx

Conclusions of NICE Guidance in Full (NICE §4.3.8)

- “In summary, the [NICE] Committee was convinced of the clinical effectiveness of naltrexone treatment in a selected, highly motivated group of people.
- The Committee concluded that for people
 - Who preferred an abstinence programme,
 - Who were fully informed of the potential adverse effects and benefits of treatment, and
 - Who were highly motivated to remain in treatment,Naltrexone treatment would fall within acceptable cost-effectiveness limits”

BSDAS/BDP Shared Care Policy 1

Referral for Naltrexone Induction (with LFT results)



Rapid Assessment by BSDAS



Agree Aftercare Plan with all parties



Induction of Naltrexone & initial Tx until Stable



GP takes over naltrexone prescribing (max 12 m)

BSDAS/BDP Shared Care Policy 2

- Amber Traffic-lighted:
 - Can be started by Specialists and Specialist Generalists (i.e. GPs or other doctors with a special interest)
 - Continued by any GP or doctor
- Plan to apply for Green traffic-lighting:
 - Point-of-care urine screens now widely used

BSDAS/BDP Shared Care Policy 3

- Following successful induction & transfer of prescribing to GP:
 - BSDAS asks GP to take over naltrexone prescribing
 - Psychosocial care provided by BDP or other community care provider
 - BSDAS asks GP/DLW if like client to be seen for a review appt within 6 weeks of transfer
 - BSDAS continues to provide advice

SUMMARY

- Management of expectations & psychological processes critical to success with naltrexone
- Always combine naltrexone with psychological therapy and psychosocial support
- Naltrexone:
 - Must be given by “supervised” consumption
 - In conjunction with an adequate aftercare plan
 - Block impulsive but not planned relapses
- Shared Care policy available