Gateshead Clinical Commissioning Group

Guidelines for Prescribing of Methadone, Benzodiazepines and Buprenorphine in Substance Misuse

Implementation Date: August 2013

Review Date: August 2015

This drug protocol has been prepared and approved for use within Gateshead in consultation with Gateshead CCG and Secondary Care Trusts

Approved by:

Committee	Date
Gateshead Medicines Management Committee	14.8.2013

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Guidelines for Prescribing of Methadone Diazepam and Buprenorphine in Substance Misuse:

Introduction

The Shared Care Monitoring Group is a multidisciplinary team working to improve the quality of service to people with substance misuse related problems in Gateshead. There is significant disparity in Gateshead with prescribing of methadone, benzodiazepines and buprenorphine for substance misuse. This information is monitored for all practices on a quarterly basis. In the last few years there have been relatively high numbers of drug related deaths in Gateshead but the number of deaths reduced dramatically in 2012 and so far the numbers appear to following a lower trend for 2013. These deaths occur in patients both in treatment and not in treatment. Drug related deaths are more common in patients who are polysubstance using. Diversion of methadone, buprenorphine, benzodiazepines and other medications is prevalent in Gateshead. Diverted methadone has been responsible for a number of local drug related deaths. Therefore there is a need to bring all prescribing more closely into line with national recommendations. This will improve the appropriateness, safety and quality of care that we deliver to people with substance misuse related problems and to the wider community that we all work.

Plans are in place to share all the information for prescribing of methadone, diazepam and buprenorphine by practices as is done for other prescribing indicators that we receive on a quarterly basis.

The guidelines are meant to be a pragmatic evidence based guidance to appropriate and safe prescribing. The guidelines do not replace the guidance in the Drug Misuse and Dependence: UK Guidelines on Clinical Management 2010 (known as the "Orange Book") nor the guidance in the BNF.

The guidance will be split into methadone (including methadone concentrate) benzodiazepine (namely diazepam) in substitution prescribing and also benzodiazepine prescribing in other clinical needs and buprenorphine.

Methadone Prescribing

There are 2 main preparations of methadone recommended. Methadone mixture 1mg/1ml and methadone mixture 10mg/1ml (which will be dealt with later). Please remember that there is no proven benefit on dental caries with prescribing the sugar free preparations. Dental caries is a result of the actions of opioids on saliva production and general poor oral hygiene. However a prescriber may wish to choose a sugar free preparation based upon patient preference and tolerance or for patients with diabetes. Opioid dependency **must** be established (supported by at least 2 consecutive urines showing opioids) before entering into and agreement to prescribe.

1. All but in a few exceptions, methadone should be prescribed supervised and always initially on an FP10 MDA (blue) prescription. The frequency of supervision is a decision reached between the prescriber and the patient, depending upon stability and progress. We would however recommend at least a once weekly supervised dose even in the most stable patients. (in some very stable patients on small doses we recognise it may be appropriate to relax this to once a fortnight).

2. Supervision arrangements should be re evaluated if patients are continuing to use heroin, benzodiazepines or other substances whilst on methadone. We recommend in these circumstances at least 5 day supervision. Please remember though that 7 day supervision is always an option.

3. All non supervised doses of methadone should be prescribed and dispensed as daily doses or instalments. Large doses and bottles of non supervised methadone covering more than one instalment **must** not be prescribed.

4. Single doses of methadone whether to be supervised or dispensed should be prescribed on an FP10 MDA script.

5. There is no place for any routine or otherwise prescribing of methadone tablets or other preparations of methadone. Methadone 5mg tablets have previously been used for those patients travelling abroad. However we no longer advocate this. We therefore recommend daily instalment bottles of methadone for travel in the UK and abroad. We strongly recommend proof of holiday before changing prescribing arrangements for holidays. We would encourage prescribers to resist

demands for sudden unscheduled holiday's demands without clear proof. Please remember that safety of prescribing is paramount.

6. Methadone concentrate 10mg/1ml may be considered in patients who are finding it difficult to consume large quantities of the 1mg/1ml preparation. A decision regarding this must only be made after due careful discussion with the patient, the caseworker and the dispensing pharmacist. We do not recommend the use of concentrate in doses less than 100mg. We recommend that patients on concentrate 10mg/1ml methadone should be considered for **5** day supervision. Allowances may need to be made for Bank Holiday weeks depending upon the stability of the patient. We recommend that if less supervised arrangements have been in place that patients are considered for increased supervision. If patients are not happy with increased supervision they can be considered to change to normal concentrate 1mg/1ml methadone to retain their current arrangements. As always these need to be clinical decisions between the doctor and the patient. Again safety of prescribing is paramount. Methadone concentrate 10mg/1ml can only be prescribed as sugar free (SF).

7. Please note we do not advocate split dosing of methadone. For example some consumed in the pharmacy with the rest to take home unsupervised. This we have found to be a common method of diversion. One however may consider split dosing of methadone in pregnancy as methadone can be metabolised faster in pregnancy and in the early stages hyper emesis maybe a problem.

Benzodiazepine Prescribing

We hope that the general principles documented here will be used for all benzodiazepine prescribing in both primary and secondary care. We advise all prescribers to follow the Committee of Safety of Medicines advice as detailed in the BNF.

There is no evidence that maintenance prescribing of benzodiazepines reduces any harm. Benzodiazepines are not licensed for long term use or maintenance prescribing. Long term benzodiazepine prescribing may cause harm especially with regards to cognition and memory. Benzodiazepines are often implicated in drug related deaths (14 of the 17 deaths in Gateshead between January 2008 and June 2009), however, ongoing work to reduce drug related deaths in Gateshead, which included introduction of

version 1 of this guideline, has been very successful with only 1 death in 2012 involving benzodiazepines. Benzodiazepines are very addictive and notoriously very difficult to withdraw from.

Therefore there needs to be a very good and explicit reason why a benzodiazepine script is started.

If a prescription is to be commenced:

1. We recommend diazepam 2mg tablets in all prescribing.

2. All benzodiazepines should be converted to diazepam (please see BNF for conversion chart). There is no place for dual prescribing for example temazepam and diazepam or zopiclone and diazepam.

3. In substance misuse prescribing there needs to be clear evidence of dependence including consistently positive drug tests for benzodiazepines.

4. We recommend a maximum dose of 30mg (the dose which will prevent any withdrawal seizure). 30mg is also the maximum licensed dose.

5. All substance misuse prescribing should be on an FP10 MDA prescription for instalment dispensing. The frequency of instalment dispensing again is a decision reached between the prescriber and the patient. If prescribing both diazepam and methadone one should consider initially 5 day supervision of methadone and 5 day instalment dispensing of diazepam, even if less frequent supervision arrangements were formally in place. Supervision and dispensing arrangements can be reviewed as treatment progresses but it is often appropriate to continue daily dispensing until the reducing regime is complete and drug tests are clear of benzodiazepines. Again we would recommend at least once weekly dispensing. Supervised consumption of diazepam in the pharmacy is not available in Gateshead.

6. In substance misuse related prescribing we recommend that clear goals and boundaries regarding stabilization and withdrawal should be set out and adhered to. We recommend a continuous reduction of 2mg fortnightly in the majority of cases.

7. In other cases of prescribing of benzodiazepines we recommend that no more than 28 days' supply is given at any one time.

Buprenorphine Prescribing

Buprenorphine can be used as an alternative to methadone for the treatment of opioid dependency. Like with methadone, opioid dependency **must** be established (see above) prior to entering into an agreement to prescribe. Preparations that are available for prescribing in substance misuse are 0.4mg, 2mg and 8mg tablets which are all for sublingual administration. We do not advocate prescribing buprenorphine above methadone but there will be circumstances where it maybe more appropriate. Patients may express a preference based upon previous experience or information. Buprenorphine appears safer in overdose than methadone and may have an easier withdrawal. Buprenorphine is less affected by interactions with hepatic enzyme inducers/inhibitors (anticonvulsants, rifampicin, ribavirin) and is less sedating than methadone (this maybe a positive or negative for different patients).

1. Buprenorphine is a partial opioid agonist with a high affinity for opioid receptors. Therefore it will displace other opioids (i.e. heroin and methadone) from receptors. Having less opioid activity (partial agonist) and displacing other opioids that have been recently used this may cause a precipitated withdrawal. Although not dangerous this may discourage patients from continuing with treatment. We therefore recommend that buprenorphine is only commenced when patients are already starting to feel opioid withdrawal (at least 8 hours after last heroin use and at least 24 hours after methadone use).

2. Buprenorphine is easily water soluble therefore there is a risk it can be dissolved and injected. Supervised consumption is recommended. All pharmacies involved in the Shared Care Scheme are happy to supervise buprenorphine. We recommend that prescriptions should state that buprenorphine is crushed and supervised in the pharmacy, whole tablets to be taken home at weekends or other non supervised days.

3. Initiation of treatment should be commenced with a dose of 4mg. The dose can be increased by between 2mg and 8mg daily, usually 4mg until the patient is stabilized, up to a maximum dose of 32mg/day. A common effective dose is between 12 -24 mg, though higher or lower doses maybe appropriate. This will

necessitate regular clinical review during the induction phase and early stabilisation of maintenance.

4. All prescriptions of buprenorphine for substance misuse treatment must be written on a FP10 MDA (blue) prescription. Single doses whether supervised or dispensed likewise should be written on FP10 MDA prescription.

5. Buprenorphine, like methadone is licensed for maintenance treatment. Supervision arrangements need to be decided between the clinician and the patient. Daily supervised administration is recommended for those patients who are continuing to use heroin, benzodiazepines, cocaine and have dangerous patterns of alcohol consumption.

6. In methadone detoxification we do not advocate switching to buprenorphine when patients reach doses of 30mg of methadone. We normally encourage patients to continue on methadone. Switching can be problematic and has the potential to precipitate relapse. If a patient is very keen to switch we suggest seeking advice from the Central Prescribing Service

7. A gradual dose reduction in buprenorphine detoxification can be considered as follows, daily doses above 16mg then reduce by 4mg every 1-2 weeks, daily doses of 8-16mg reduce by 2-4mg every 2 weeks, daily does 2-8mg reduce by 2mg every 1-2 weeks, below 2mg reduce by 0.4-0.8mg every 1-2 weeks. Patients will often need to reduce much more gradually than this.

8. Please note that buprenorphine is not routinely tested for on standard “drugs of abuse screen” on ICE and must be specifically requested alongside the above.