THE UK SCENE
Do we need Suboxone ?

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THE UK SCENE

Methadone predominates :

Currently said to be:
105,000 patients receiving Methadone
19,000 patients receiving Buprenorphine
1,100 Patients receiving suboxone

Historically substitution therapies not supervised
Concern around Methadone deaths led to introduction of local schemes in 1990's

No central legislation just recommendation in national guidelines to supervise for first three months

Now : 36% of Methadone supervised
26% of Buprenorphine supervised

(Prof J. Strang et Al submitted for publication)

DIVERSION

Is it a problem ?

Of the **197** UK Methadone related deaths in 2003 over half involved diverted Methadone

(Ghodse et Al 2003,2004)

But what about Buprenorphine ?

Fewer Drug Related Deaths observed with buprenorphine than with methadone

	Treatment episodes	Deaths*	Deaths per 1,000 treatment episodes
Methadone	102,615	258	2.7
Buprenorphine	49,948	1	0.02

* Where drug in question is mentioned as a cause of death in coronial or autopsy document, or where a fatal opioid overdose occurs during treatment or within two weeks of cessation of treatment with the drug in question

19. Gibson AE et al. Drug Alcohol Review 2007;26:405-410

IS BUPRENORPHINE DIVERTED ?

7 Boroughs Buprenorphine Study

182 patients in London
24.3% had used diverted Buprenorphine
(Prof J. Strang personal communication)

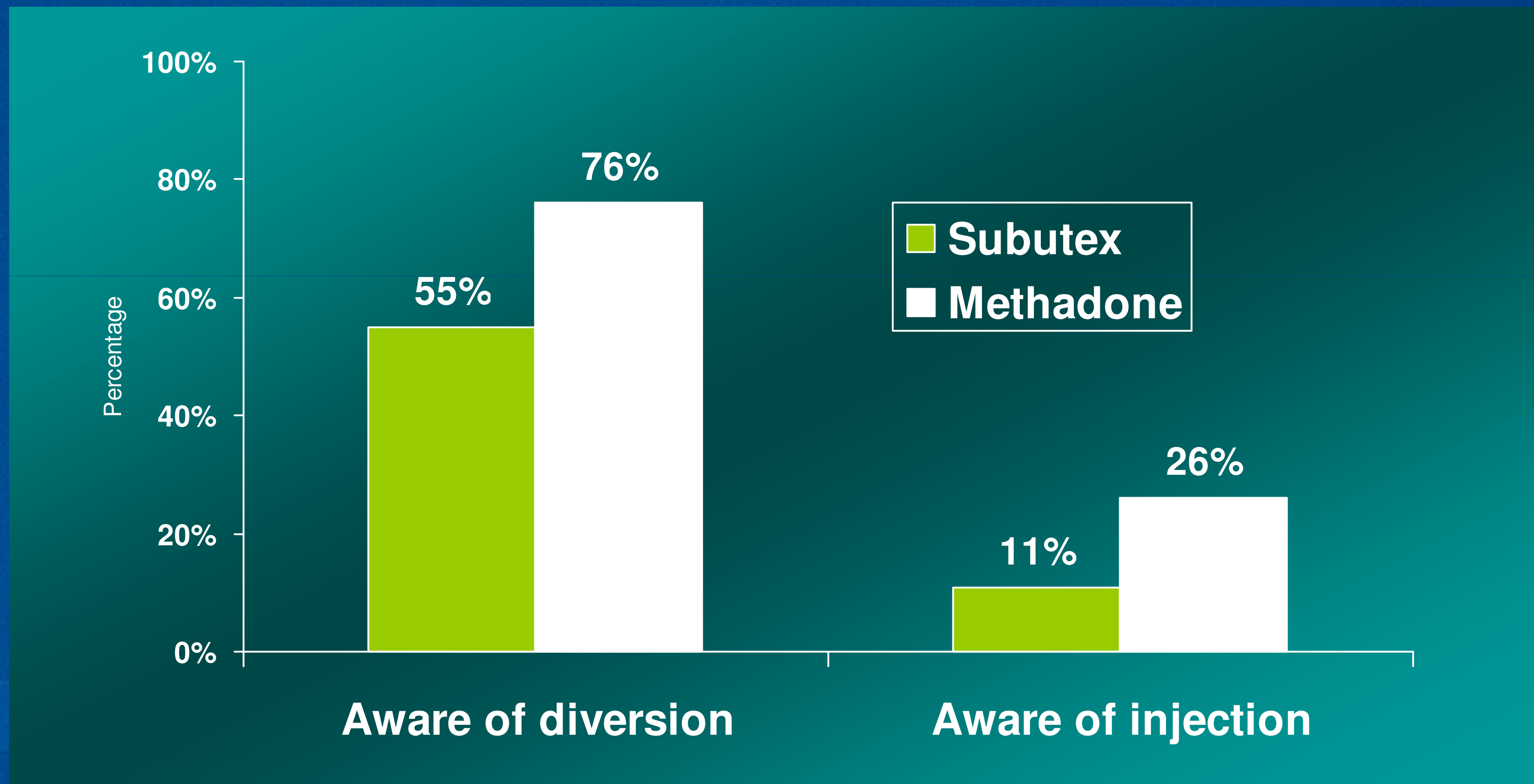
2 market research studies commissioned
by Schering-Plough
each **100** patients from around UK.

1st 39% used diverted Buprenorphine

2nd 37% had been offered diverted Buprenorphine
28% admitted diverting their own.

Market research has indicated the presence of diversion and misuse in the UK1

Patients reporting awareness of substitution therapy diversion and injection



Data on file. n=100 drug substitution users.

1. Data on file, Silver Fern Research for Schering-Plough 2006.

MISUSE OF OPIATE SUBSTITUTES IS A REAL PROBLEM

In a French study surveying opioid-dependent patients on buprenorphine maintenance therapy, **46%** reported having **injected buprenorphine** at least once[1]

In a survey of injecting drug users, **30%** reported having **injected buprenorphine** in Victoria (Austrialia)[2]

1. Vidal-Trecan G *et al. Drug Alcohol Depend* 2003; **69**:175-181.
2. Breen C *et al. NDARC Monograph No. 50* 2003.

PROBLEMS FROM DIVERSION

1) Individual Health

If Buprenorphine is so safe why worry ?

Injecting harms

- BBV's
- Septicaemia/SBE
- DVT's
- Microvascular damage
- Reduced venous access for healthcare

2) Wider 'Image' of the Agent

- Families/carers
- Police
- Users perceptions drug of misuse not recovery
- Daily Mail readers – the reactionary public element

SO WHY NOT ALWAYS SUPERVISE ?

Cost

Daily dispensing and supervision – €4.5 – €7.5 Euros per day

Practicalities

- Evasion
- Rural Areas
- Patient Power in NHS

Therapeutic problems

- Stigma
- Mixing with other users
- Engagement/retention

Interference with rehabilitation

- Training
- Employment
- Childcare

If diversion's a problem

And supervision has drawbacks ……..

To square the circle we need a substitute with a lower street value which is therefore less likely to be diverted.

SUBOXONE?

SWITCHING FROM SUBUTEX TO SUBOXONE

One services method and experience :

Southampton & New Forest
United Kingdom

HAMPSHIRE PARTNERSHIP NHS TRUST SUBSTANCE MISUSE SERVICE

Pre May 2007

- **Were using subutex frequently**
- **Had an agreed protocol for its use**
- **Frequently used supervised consumption of subutex**
- **Had many concerns about the quality of supervision offered by pharmacists**
- **As outlined in the previous slide, were paying a large amount of money to have subutex supervised**

With the arrival of suboxone it was agreed that there were many advantages to this new product and the decision was taken to introduce it in place of subutex

WHY CHANGE TO SUBOXONE ?

1. We had anecdotal evidence from those attending clinic that other users were injecting
2. Some patients did admit that they were injecting their subutex (they were then switched to supervised consumption)
3. Strong reports from the local mobile needle exchange service that patients were reporting to them that they were injecting their subutex
4. We were of course aware that subutex was illicitly available and being sold in Southampton

Cost £5 or approximately €7 for an 8mg tablet

PROBLEMS WITH SUPERVISION

The problems with supervising subutex :

1. **It takes 8 to 10 minutes to dissolve**
2. **Pharmacists are frequently distracted by other activities in their shops and unable to properly supervise the tablet remained in the patients mouth and properly dissolved**
3. **Some patients simply refuse to stay**
4. **No real way to check if the tablets were properly being taken i.e. chemists not really in a position to check in peoples mouths**
5. **We were aware of the use of either tooth paste or small bottle tops in patients mouths to catch the tablet and prevent it being absorbed**
6. **We were aware through our own staff observations that some pharmacists were simply not bothering to supervise at all**

ADVANTAGES OF SUBOXONE WERE PERCEIVED AS :

1. It promoted harm minimisation by decreasing the likelihood of injection
2. We thought that there would be reduced diversion because of the consequences of intravenous use
3. Because of this it was felt we could relax in all but the occasional cases the requirement for supervised consumption
4. This would allow considerable financial savings

INITIAL STEPS :

A new protocol for suboxone based on the current subutex protocol was written and approved by the local Medicines Management Committee

We designed new patient information leaflets

Without this further progress would not have been possible

There then followed 3 principle steps :

1. There was an arrangement to meet service users
2. A universal letter was written to all local prescribing pharmacies
3. Staff education

MEETING WITH SERVICE USERS

This was conducted face to face at their user base.

They were given information on :

1. **Why we wanted to make the change**
2. **Harm minimisation outlining:**
   A) consequences of injection
   B) Risk of overdose if further opiates are used on top
3. **Advised that we would remove the expectation of supervised consumption as the norm**
4. **Advised of our intention of starting all new patients from a specific date and then transferring all patients on subutex to suboxone over the next 3 months following consultation with key workers**
5. **Further advice that subutex would only be available for pregnancy and treatment choice would be suboxone or methadone**

LETTER WAS WRITTEN TO ALL LOCAL PRESCRIBING PHARMACIES

A letter was written to all the local pharmacies from all the consultants in the service and the service manager informing them of :

1. The date of the expected change (8th May 2007)
2. Informing them that all new patients would be started on suboxone after that time
3. All current patients on subutex would be transferred to suboxone over the following 3 months
4. Informed them that we viewed this as a harm minimisation action
5. That we wanted to inform those who may have significant stocks of subutex of our intention to change to suboxone

USE OF METHADONE AND SUBOXONE IN SOUTHAMPTON AND NEW FOREST AREA :

	Methadone	Suboxone
Southampton: New Road Centre	152	64
Bridge (Rapid Prescribing)	39	16
Sub Total	180	80
New Forest	56	18
Total	236	98

STAFF EDUCATION

1. This was done by presentations to the team by Schering-Plough

2. The distribution of formal literature regarding suboxone

3. Adhoc discussions with the staff by myself

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