Relapse prevention, peer support and recovery resources for opioid users

Date: 27 October 2021

Presentation slot: 14:35-14:50

Via Zoom

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North Staffordshire Combined Healthcare NHS Trust

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Dr Derrett Watts; Edward Myers Unit

<u>Declarations</u>;

- Some consultancy work for Lundbeck in past
- Areas of Work – North Staffordshire Combined Healthcare NHS Trust

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Plan & Purpose for Talk

PLAN FOR TALK

- Relapse Happens
- Relapse Matters
- Relapse Can Be Prevented
  - Naltrexone
  - Relapse Prevention Plan
  - Peer Support
  - Recovery Resources

PURPOSE OF TALK

- To emphasise that improved outcomes can occur with better planning for abstinence, alongside involvement of peer support and the use of naltrexone.

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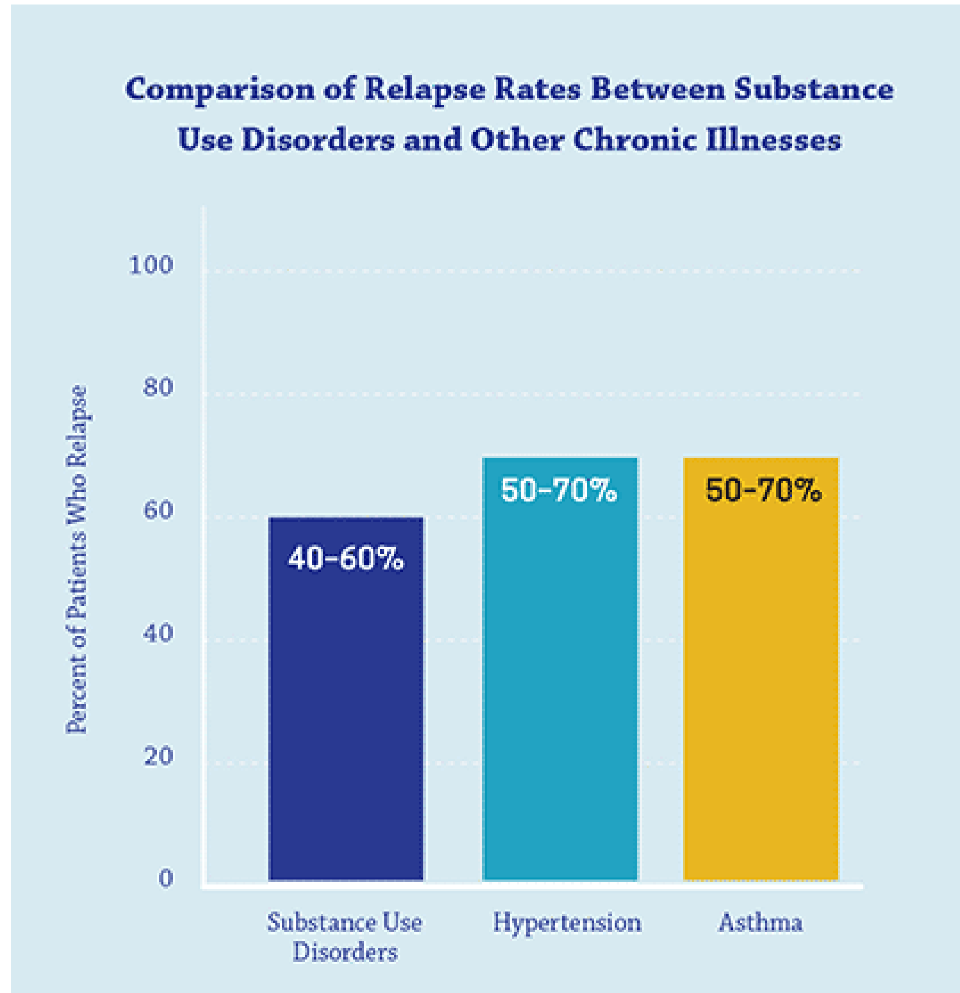
Relapse Happens .....



- *JAMA, 284:1689-1695, 2000.*

- Relapse is common across medicine – and this includes Substance Use
- Relapse rates for people treated for substance use disorders are similar to those for people treated for high blood pressure and asthma.
- Substance use disorders should be treated like any other chronic illness. Relapse serves as a sign for resumed, modified, or new treatment.

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Relapse Matters ……

- Impact on family
- Impact on individual
  - *“**Recovery** is a lifelong lifestyle. It’s frightening and terrifying but, if you’re like me, there is no other choice ….. My **relapse** actually started long before I began taking drugs again. A relapse occurs when you stop following your programme, which includes going to NA meetings ……. When you physically start using the drugs again, its actually the end of your relapse and the start of active addiction. An addict doesn’t just casually pick up where he left off; an addict continues as if he never stopped. The addiction and dependence become progressively quicker after each relapse, and are far more damaging.”* (Hykie Berg, “Ultimate Survivor”, Lux Verbi, 2018)

Relapse can be prevented …..

- Need Good management of withdrawal

  + on-going management plan

(preferably devised before detoxification)

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Characteristics of a Relapse Prevention Plan

- A lot of similarities to a suicide/self-harm prevention.
- **Recognizing personal risk factors;**
  - Personal – mood, anxiety, boredom, etc.
  - Places - which have been associated with drug use
  - People – who are likely to promote your drug use
- **Knowing how to respond to these risk factors**
  - Work out strategies for each of the above – some may be long-term (deleting some people from contact list) and some may be
- **Involvement in individual or group support**
  - May involve Professionals and Peers
- **Having an effective recovery plan**
  - Moving life away from avoiding drug use to living a fulfilled, purposeful life, where drug use does not fit in. Need to be an holistic approach.

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Relapse can be prevented .....

- Need Good management of withdrawal + on-going management plan
- Naltrexone should be part of that
- **Addressing unmet needs in opiate dependence: supporting detoxification and advances in relapse prevention** –

Published online by Cambridge University Press:

20 January 2021 Katherine Herlinger and Anne Lingford-Hughes

- “Despite the fact that opiate dependence is an enduring disorder characterised by periods of relapse, **there are few abstinence aids or relapse prevention medications available**. Naltrexone is a long-acting non-selective opioid antagonist and is currently the only licensed medication in the UK for relapse prevention, although it is rarely taken”

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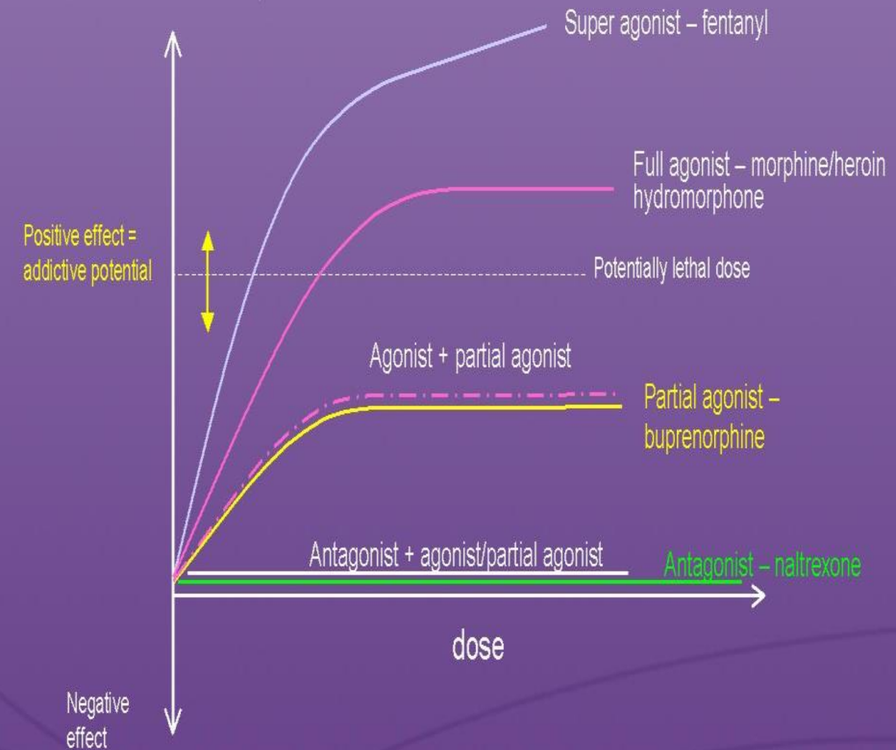
Opiate receptor pharmacology

- Three receptor subtypes

mu – μ	kappa – κ	delta – δ
analgesia	analgesia	?analgesia
euphoria	dysphoria	?addiction
respiratory depression	diuresis	
pupillary constriction		

mu efficacy and opiate addiction



NICE guidelines: Naltrexone for the management of opiate dependence (NICE Technology Appraisal 115):

- *"Naltrexone is recommended as a treatment option for people who have been opioid dependent but who have stopped using opioids, and who are highly motivated to stay free from the drugs in an abstinence programme.*
- *It should only be given to people who have been told about the problems associated with treatment, and with proper supervision. Treatment with naltrexone should be given as part of a support programme to help the person manage their opioid dependence.*
- *Healthcare professionals should regularly review how well naltrexone is working to help people stay off opioids. If there is evidence that the person has been using the drugs again then healthcare professionals should consider stopping naltrexone treatment."*
- *"naltrexone is a clinical effective treatment in a selected, highly motivated group of people"*

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Naltrexone

- Naltrexone is a long acting competitive opiate antagonist.
- Effective in alcohol treatment as well - acts by blocking the effects of opiates released following alcohol consumption, preventing the enhanced dopamine release in the mesolimbic system.
- Naltrexone is metabolised by the liver and excreted by the kidney

- Mu antagonist; No intrinsic opioid activity
- No risk of dependence
- Give in conjunction with PSI
- High drop-out rates
- Precipitates withdrawal if commenced too soon – either challenge test or wait
- In an emergency requiring opioid analgesia an increased dose of opioid may be required to control pain. The patient should be closely monitored for evidence of respiratory depression or other adverse symptoms and signs.
  - No opiate prescriptions including pain killers
  - Difficulties if needing surgery (warning cards)

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Initiation + Continuation

- Ensure Opiate free status
  - At least 2 oral fluid tests, or negative urine screenings for opioids should be obtained prior to administration of naltrexone.
  - Be aware what opioids are detected in your tests and advise patients of the risk of precipitated withdrawal with all opioids (i.e. Tramadol)
  - If unsure about opiate free status can undertake Naloxone Challenge
  - Started only after 7-10 days of abstinence from opiates (10 days after last methadone dose).
- Day 1 - 25 mgs (1/2 tablet)
- Day 2 and onwards - 50 mgs daily
  - Ideally to be supervised by a family member, concerned other, professional
  - Alternative dosage to improve adherence and supervision: Monday 100 mgs, Wednesday 100 mgs, and Friday 150 mgs, not to exceed 350 mgs weekly.
- Continue for at least 3 months

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Contraindications / Warning

- Be aware of **contraindications** especially:
  - Patients currently dependent on opiates (causes acute withdrawal)
  - Acute hepatitis
  - Acute liver failure/Severe hepatic impairment (ALTx2)
  - Severe renal failure
  - Hypersensitivity to Naltrexone HCl

- Patients should be **warned;**
  - Attempting to overcome the blockade of opioid receptors whilst taking naltrexone could result in acute opioid intoxication, overdose and death
  - The patient’s motivation will be critical in the success of treatment. Prescribers should continue to assess this risk during treatment and advise accordingly

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Side Effects

Frequency	Side effect	What to do
Common >10%	Headache, sleep disorders, restlessness, nervousness, abdominal pain and cramps, nausea, weakness and joint/muscle	Generally mild & self limiting, if analgesia is required use non-opiates. If **continuous & severe may require cessation.**
Common 1-10%	diarrhoea, constipation, increased thirst, increased energy, feeling down, irritability, dizziness, skin rash, delayed ejaculation, decreased potency, chills, chest pain, increased sweating and increased lacrimation.	Generally mild and self limiting. If continuous and severe **may require cessation.**
Rare <0.1%	Liver abnormalities	monitor LFT’s if continued elevation of ALT to >3X normal limit then **stop medication.**
Rare <0.1%	Depression, suicidal ideation and self harm; Euphoria hallucinations	Seek advice from psychiatric services and **stop medication**
	Spontaneous bruising, excessive bleeding	Seek advice from haematologist **Stop naltrexone**

Not used enough ……….

- **Addressing unmet needs in opiate dependence: supporting detoxification and advances in relapse prevention** – Published online by Cambridge University Press: 20 January 2021 Katherine Herlinger and Anne Lingford-Hughes.
- People stay engaged when on OST (In England, 94% of opiate dependent individuals engage with services for at least 12 weeks)
- This is better than all other addictions but in contrast Opiate dependence has lowest rate of successful exits
- Currently it appears that most detoxifications in England occur in the community;
    - 8059 individuals completed treatment for opiate dependence in community v only 1427 in-patient detoxifications reported (2019-2020).
    - Given that 140 599 individuals were recorded as receiving treatment for opiate dependence over that period, suggests **only 5.73%** overcame their dependence (Public Health England 2020b).
- Despite the availability of naltrexone for relapse prevention;
    - Poor adherence is commonplace, with most dependent opiate users returning to their drug use
    - Naltrexone is also often not offered in clinical practice.

Peer Support …. Works!

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- **Peer-Delivered Recovery Support Services for Addictions in the United States: A Systematic Review**; Ellen L Bassuk, Justine Hanson, R Neil Greene, Molly Richard , Alexandre Laudet; J Subst Abuse Treat; . 2016 Apr;63:1-9. doi: 10.1016/j.jsat.2016.01.003. Epub 2016 Jan 13.
- Systematic review identifies, appraises, and summarizes the evidence on the effectiveness of peer-delivered recovery support services for people in recovery from alcohol and drug addiction.
- Despite significant methodological limitations found in the included studies, **the body of evidence suggests beneficial effects** on participants and is associated with improvements in a range of substance use and recovery outcomes..
- **Benefits of peer support groups in the treatment of addiction; Substance Abuse and Rehabilitation' Kathlene Tracy, Samantha P Wallace, 29/09/16.**
- Peer support groups included in addiction treatment shows much promise with studies demonstrating associated benefits in the following areas:
- 1) substance use,
- 2) treatment engagement,
- 3) human immunodeficiency virus/hepatitis C virus risk behaviors,
- 4) secondary substance-related behaviors such as craving and self-efficacy

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Peer Support ……. Why it works

Recovery, peer support and confrontation in services for people with mental illness and/or substance use disorder; Patrick W Corrigan, Jonathon E Larson, David Smelson, Michelle Andra ; Br J Psychiatry; 2019 Mar;214(3):130-132. doi: 10.1192/bjp.2018.242

- "…. peer support yielded benefits for individual with substance use disorder"
- What is distinctive about it? Ethical guidelines included;
  - Voluntary, Hopeful, Open-minded, Equally shared-power
  - e.g. "peer supporters do not force or coerce others to participate in peer support services or any services".

Recovery Resources – Need Localised Approach

(Heroin addiction: get help - NHS (www.nhs.uk))

- **Self-help;** e.g. Narcotics Anonymous helpful.
- **Reducing harm;** Staff at your local drug service will help reduce the risks associated with your drug-taking. For example, you may be offered testing and treatment for hepatitis or HIV.
- Other types of help and support you may be offered while you come off heroin include:
- **Talking therapies** – you may be offered a talking therapy like CBT if you need help with anxiety or depression while you're detoxing
- **Support groups** – your key worker will give you details of local self-help groups, such as Narcotics Anonymous or SMART Recovery
- **Support for family and carers** – your key worker can organise support for people close to you who are affected by your addiction (see advice for families of drug users)
- **Help to stay healthy** – this could be anything from advice on healthy eating to tests for infections such as HIV
- **Incentives** – you may be offered rewards, such as vouchers or doses of methadone to take at home, for sticking with your treatment and staying off heroin
- 'A fellowship of abstinent friends' to be created in University campus addiction recovery programme (birmingham.ac.uk)
- Ex-Footballer Paul Walsh Shares His Experience of Being a Peer Supporter | Manor Clinic Southampton (themanorclinic.com)