Bristol Drugs Project

bdp

Pharmacist Event – 24 July 2013

By the end of the evening you should:

- better understand the local 'picture' with regards substance misuse
- develop your ideas of how to get the whole pharmacy team engaged in service provision
- be better able to provide harm reduction advice to clients
- have improved understanding of the drug using client's experience of pharmacy use

Agenda

- Opiate prescribing services
  - What makes a good experience?
  - Arrangements / Pharmacy Role
  - Alcohol use
  - Safeguarding issues
- Needle exchange and harm reduction approaches:
  - Steroids & other PIEDs
  - Pharmacist role
- Service user experience and feedback:

Opiate Prescribing – service user experience of pharmacies

Questions:

- “What makes for a good pharmacy experience for opiate programme service users?”

- “What do you need to take into account?”

Pharmacist Role (1)

- To supervise consumption of substitute medication in a discreet way which does not embarrass the service user.
- To check the legality of the prescription and that the quantities and patient's details are correct.
- To register the service user on the patient Medication Record.

Pharmacist Role (2)

- To agree a convenient time for the service user to collect the substitute medication.
- To explain that missed doses cannot be collected at a later date.
- To explain that the substitute medication will not be dispensed if the service user has missed three or more instalments.

Service User Responsibilities

- To sign an agreement to participate in the scheme under the scheme's presiding conditions.
- To collect their prescription from the pharmacist at an arranged time.
- To keep arranged appointments with the prescriber and the drug worker.
- Once stabilised, only to take the prescribed medication and to provide a urine sample for analysis when requested.

Prescribing Considerations & Arrangements

Issues to be considered when assessing patients for unsupervised consumption

Current protocol:-

Prescriptions initially always dispensed by supervised consumption unless patient is transferring with an existing Care Plan that allows unsupervised, when discretion can be allowed. Flexibility around supervision should be considered as part of the Care Plan after around 3 months stabilisation if the patient is not using other opiates on top, and not using other drugs harmfully.

Urine Testing protocol:-

Random urine testing will be carried out during treatment, and results recorded. Evidence supports that urine testing be done unobserved, and without punitive sanctions being applied. Testing can give positive feedback to the patient about current drug use. Some “on-top” use of opioids may continue in patients who are otherwise making considerable progress in achieving gains based on social or health determinants. Careful judgement may indicate that continuing treatment, increased psychosocial intervention, or increased doses of substitute medicines be justified.

Supervised or un-supervised?

Q. What factors should be considered when decisions are made regarding whether somebody's medication is dispensed on a supervised consumption basis or otherwise?

Basic Principles / issues to be considered

1. Environmental considerations:	1	2	3	4	5
Patient's dependants (young children?)					
Drug using partner (on supervised consumption)					
Associates (on supervised consumption)					
Drug dealing history					
Housing arrangements					
Patient in employment					
Patient in full/part time education					

2. Medical considerations:	1	2	3	4	5
Maximum safe dose					
Alcohol use					
Other drug use					
Other medical conditions					

3. Other factors:

	1	2	3	4	5
History of compliance					
Frequency of contact with GP/DLW					
Opinion of pharmacist					
Opinion of drug liaison worker					
Opinion of GP					

***(low score is positive, high score needs careful consideration)**

Scenario

Susan, who has been collecting her methadone twice weekly from your pharmacy for many weeks, presents to collect today (Friday) and you notice that she appears quite drunk. She has her young son with her, which is not an everyday occurrence but she has brought him before.

<u>Question</u> – What should your response to this situation be? What issues are raised? What communication should this situation provoke?

Alcohol Services

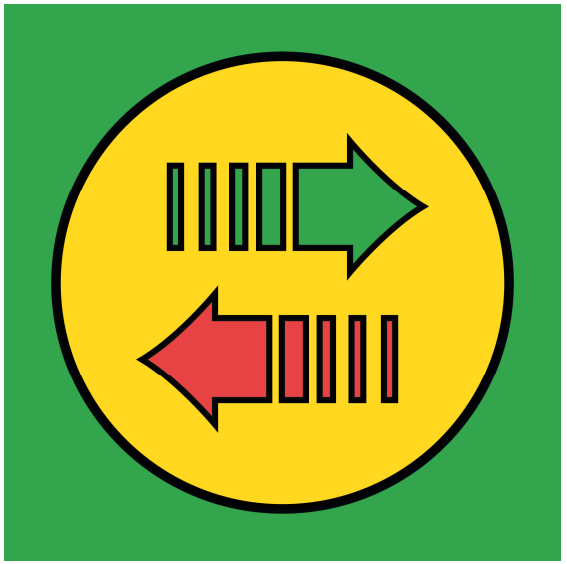
Primary care – This is the main access point for alcohol service users. Screening for problematic alcohol use should be undertaken in primary care. Compelling evidence on efficacy of brief interventions around alcohol use in this setting.

Specialised alcohol misuse services – referral usually from GP or other professional service provider (e.g. in B&NES - New Highway and DHI). Those with complex needs (e.g. criminal justice requirement or severe mental health problems), will be seen by specialist NHS services (SDAS in B&NES)

Self-help / mutual aid –

- Alcoholics Anonymous (17 meetings weekly in B&NES)
  0845 769 7555
- SMART Recovery UK
  0845 603 9830

Needle exchange and harm reduction approaches




Needle Exchange - an opportunity to talk about change

Hierarchy of Goals

Reduce extreme risk activities

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Inject with sterile equipment every time

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Safer injecting practices

↓

Switch to maintenance therapy

↓

Switch to reducing doses (detox)

↓

Sustained abstinence

Harm Reduction

- Is pragmatic
- Prioritises goals
- Has humanist values
- Focuses on risks and harms
- Does not focus on abstinence
- Seeks to maximise interventions


NICE Guidelines:
- Static exchange
- MHRS
- Pharmacy NSP
HRS
Harm Reduction Servic

Needle Exchange works by:

- Providing the **means** for injecting drug users (IDUs) to reduce their risky behaviours for transmission of blood borne viruses
- Providing **strategies** for IDUs to reduce their risk
- Providing **Information** to limit “injecting injuries”
- Providing a **gateway to treatment** and other services
- Enabling **safe disposal** of used needles and syringes

Permitted paraphernalia & Pharmacy packs

Not *currently available in Bristol*

X

X

Harm Reduction Issues

hep C

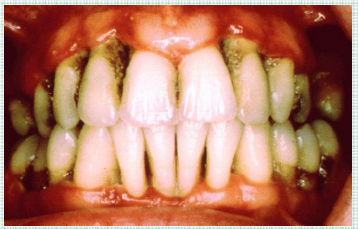
HIV

hep B

Other harm reduction advice

As a provider of a needle and syringe service you should also provide:

- Assessment of injection sites for infection
- Encouragement to swap from injecting to smoking
- Health promotion advice
  - Dental health
  - Sexual health
  - Tobacco and alcohol



Safer injecting of PIEDs

- Differing needs
- Exchange packs not suitable
- Specialist clinics in some areas
- Literature available
- Drug services are experts in injecting advice not necessarily steroid use but have some useful knowledge and experience

Steroid users – key differences

- Growing proportion of NSP users
- Pattern of use very different (occasional – related to cycles of use)
- Inject IM (or Sub-Cut) rather than IV so need different equipment
- Often appear uncomfortable in drug service surrounds
- Crossover between this group and users of other drugs
- Similar HR issues apply

Public Health England

Image and Performance Enhancing Drug (IPED) Injecting

IPEDs are used to change physical appearance **or** improve performance / strength.

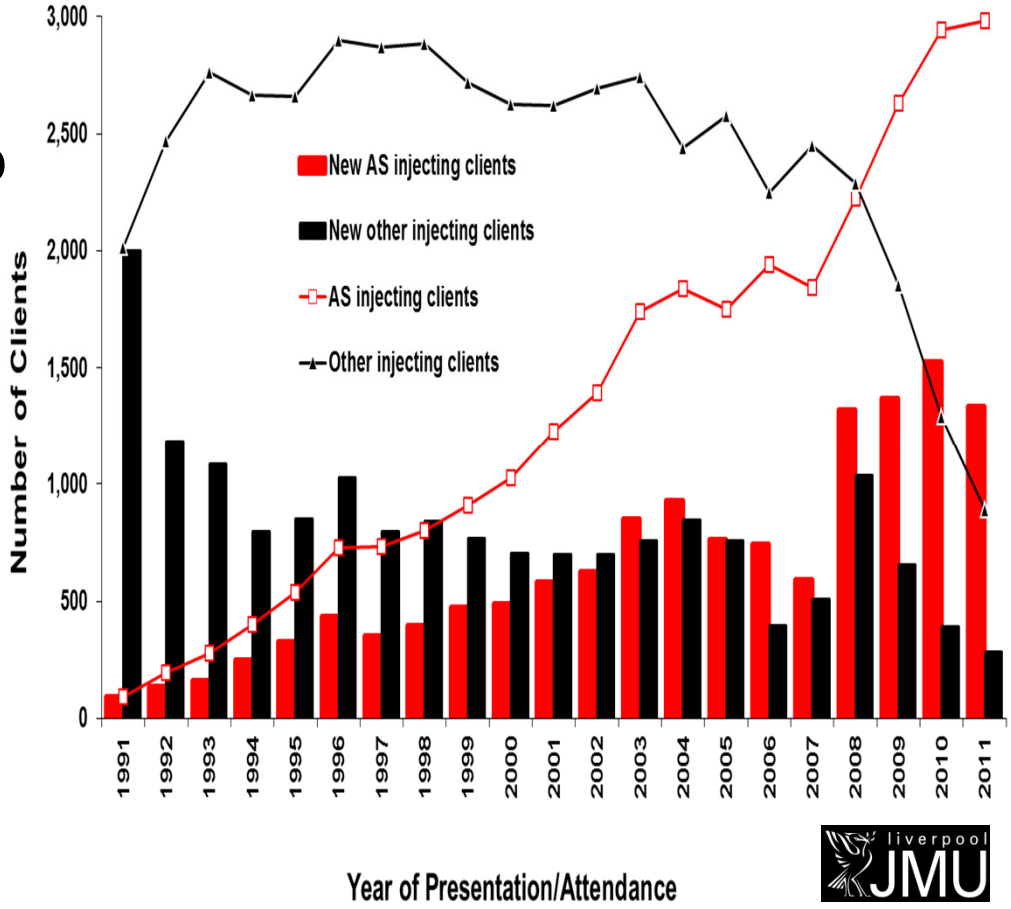
This sub-group of people who inject drugs (PWID) is rarely studied.

Anabolic steroids (AS) are probably the most commonly used type of IPED.

Drug (2011/12)	Last year	Ever
Anabolic steroids	**70,000**	228,000
Heroin	**47,000**	255,000

British Crime Survey, 2012

'All' & 'new' clients attending agency based Needle and Syringe Programmes (NSPs) in Cheshire & Merseyside: 1991-2011.



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IPED injection and risk

A wide range IPED are used and injected. The Anabolic Steroids are the mostly commonly used and injected, but there is a wide range of others.

A recent study of 395 male IPED injectors (undertake by PHE with LJMU & Public Health Wales) found:-

IPEDs injected:

Anabolic steroids (86%); growth hormone (32%); hCG (16%); Insulin (6%); Melanotan I/II (9%).

IPED taken orally:

Anabolic steroids (57%); Anti–oestrogens (23%); Clenbuterol (15%); Ephedrine (20%); Phosphodiesterase type 5 inhibitors ("Viagra /Cialis", 7%).

Overall, 9% had ever shared injecting equipment.

High levels of sexual activity, condom use poor; 3% had sex with a man in the past year.

High levels of non-injecting psychoactive drug use in past year: 46% cocaine, 12% amphetamine. 5% had ever injected a psychoactive drug.

Hope *et al.* Forthcoming

Pharmacy services for drug users

Service users' perspective

Questions & Feedback

Please complete a feedback form before leaving - thank you