NALTREXONE APPRAISAL CONTRIBUTION

Naltrexone is an opioid antagonist. As I understand it, it occupies the opiod receptor sites in the brain, spinal column and other sites in the body where the agonists – heroin and morphine operate and displaces them. Thus a sufficient dose stops the action of the opiates. This forms a path to a drug free life.

I first became aware of the existence of Naltrexone when it was given to my loved one, after a detox from heroin at a private clinic. He had become suicidal after several years of heroin abuse & the waiting list at the local treatment centre was one year plus. Despite all family commitments we made funds available. I remember assembling along with other carers for a meeting to plan discharge treatment. I felt nervous, vulnerable and, like all the others, thinking/hoping this is IT at last! A male nurse advised each client with carers. We were given Naltrexone and its function as a blocker or opiate antagonist explained. The impression taken away by all us desperate people was that one dose a day would keep our loved one safe because it would stop heroin or other opiates from having any effect.

Naltrexone can be given 7 – 10 days after last opiate dose (if opiates are not completely out of the system, it causes instant withdrawal symptoms) and must be prescribed. Naltrexone blocks the opioid receptors of the brain to the effects of heroin and other opiates. Whilst taking Naltrexone, using heroin will no longer produce a 'high'. Therefore funds spent on heroin would be wasted. One specific carer was to administer the Naltrexone tablet daily at the same time and watch the patient swallow it. The tablet could be crushed on a spoon to ensure that it had been administered. To my mind, once this became necessary we were on the road back to chaotic behaviour. All were made aware that a user would become very ill if they indulged their dependence at the same time. It would be best to take the Naltrexone for one year to establish a new lifestyle.

The fact is that a user is at great risk of overdose after stopping Naltrexone. Studies have shown, as I too found that many do not remain on Naltrexone and do return using.

Substance abuse is a difficult treatment area but as in all areas, as proved by hospital allocation of a 'Named Nurse' to a patient, continuity of care by a member of staff involved with both patient and carers achieves retention in treatment and reduction of use, all of which impact on the family, community and levels of crime and anti-social behaviour. I felt that with paid treatment on a detox

- We were let down by this lack of continuity.
- We were not made aware of the limitations in that Nalraxone would not reduce craving.
- Naltrexone seems to be more useful to people well motivated to stay off opiates and we were completely unaware that it was highly possible that he would lapse as lapse and relapse are part of the course. More devious behaviour to keep off the Naltrexone in order to use was not offered as a possibility as it would detract from the quality of the product we had bought.
- We were unaware of how difficult it would be to obtain Naltrexone. Our G.P., who referred at our request, had advised that he could not be involved in the treatment as neither he nor any other Doctor in the practice was trained in Drug Abuse Treatment. We desperately entered into the treatment to help our

- loved one but did not find out about the continued 'treatment' on Naltrexone until the discharge after detox. As we lived at a distance from the private treatment centre, in another town, the Naltrexone was prescribed at discharge but then not under any supervision by a doctor specialised in that medication and we could not enlist the help of our G.P.
- We were very lucky that our local Treatment centre eventually agreed to prescribe. For the remainder of the year following the detox the private company sent 'concerned' update forms on their patient's progress but we felt exposed to an opportunity for business as the availability of scripts through the private company was constantly offered and was the main impact of the contact. I felt vulnerable and exposed to a trap if we had not been rescued from our new 'need' by the local centre.
- Each patient is an individual with individual needs and responses but common trends appear. My loved one felt that 'choice' had been removed by Naltrexone. This is not an unknown feeling and indeed can be paralleled to elderly patients in Residential homes who can be just as devious in not taking drugs which they feel are to sedate them so that they are less trouble to look after. Their choice has been similarly removed.
- No counselling or assistance with Cognitive Behaviour Therapy, which is very supportive and helpful to progress were offered. Some private centres offer Psychiatric and counselling support but at great extra cost and certainly beyond the means of ordinary folk. What about those with no carers?!!
- My loved one, despite being a chaotic user, generally felt that Naltrexone was a 'strong' drug and could not use it. The situation of home treatment proved to be inappropriate and we were not qualified independent staff. He resorted to devious behaviour to avoid swallowing the tablet. Though familiar with this behaviour amongst residential geriatrics who did not want to spend life sedated. I was too emotionally involved to deal with it in this instance. Resorting to crushing the tablet on a spoon was equivalent to me to forcing treatment on someone against their will. I felt that we had already lost the battle and were back on the road to using. Frank discussions years later showed that motivation had indeed been lost and this technology was not the patient's choice. Therefore education and information are important for both user and carer to empower them to decide on the treatment that suits them and to cope with the outcome. This technology appraisal and the guidelines it will produce are of paramount importance to those who prescribe, treatment providers, users and carers. We cannot force the patient to use a particular technology or engage in treatment. They must feel that 'It is right for them' with support help and guidance to choose for themselves.
- Naltrexone is licensed to be prescribed for relapse prevention and I am aware that there is great disparity in availability not only geographically but between health care on the NHS, private treatment for users, and in prison whether in some old fashioned Her Majesty's Prisons or modern private prisons of which I think there were 5 in Doncaster where I used to live. Also in prison is it seen as part of an exit programme and available post release? I know in some that it is but at least the prisoner is always released with an appointment for assessment for Naltrexone to be prescribed and thus the patient is retained in treatment. Furthermore, as the tolerance of opiates by users, serving a prison

- sentence, is lost due to limited supply, they are at risk of overdose on release if treatment is not followed through in some way. Post release treatment arrangements are essential. I do not know if Naltrexone is available for prisoners in treatment in a drug free wing. I do not know the answer to these questions but the aim of this appraisal must be to bring equality of opportunity for retention in treatment and positive progress for all with every assistance that the technology can bring.

General positive points:

- Naltrexone is very useful for people who are well motivated
- Users never know what may act as a 'trigger' to use again so Naltrexone will help them feel safe and strong as they get their life back on track.
- Carers/partners can administer the daily tablet so that there is feeling of belonging, team effort and sense of progress developed. This must be positive as part of the problem for users is the isolation from society. For the patients who used Naltrexone successfully the impact of the feeling of protection would give their carers an essential, well earned break, both practical and emotional, from the stress of using with all its impacts on relationships, finances etc. For the patient, Naltrexone could give a period of time in which to adjust physically and psychologically and start to develop themselves and their lives. This kind of 'bridge' must never be under estimated as starting a new life after detox is a very big step for the patient; little things we take for granted like seeing a beautiful tree in the garden, stroking a pet after spending much time not even being able to bear being touched all have a big new impact. Support from psychosocial interventions and the world at large will all contribute to the achievement of the technology.
- You cannot become physically dependent on Naltrexone; we were advised to use it for at least on year and it seems that two years is a useful period to help the patient to bridge the change of lifestyle. This drug seems a good support mechanism for those who feel able to use it and have the required motivation to give up their dependency. I have no evidence regarding implants.
- Naltrexone has been found to reduce the craving for alcohol. This will in turn reduce consumption with positive effects on carers, family, friends, finances and the community.

Possible negative points

- Naltrexone does not suit everyone; when my loved one described it as a strong drug and chose not to use it, he could not or did not want to explain his reasons except to say it seemed a strong drug. It is said to cause dysphoria or a feeling of being ill at ease. This seems reasonable as there is a strong belief that some drug users are trying to escape the pain of their lives and 'chase' the euphoria produced by drugs or alcohol. Logically, Naltrexone would seem to take them back to square one of having a 'need of escape' as opposed to the desired feeling of protection from relapse. There have also been reports of Naltrexone's causing anxiety and sleeplessness. This hardship of sleeplessness in drug withdrawal has to be experienced to know the full misery. Imagine lying through long night after long night unable to 'switch off your brain'. Counting sheep etc is a total waste of time and frighteningly ineffective. The patient is unable to feel any positive results from the opiate withdrawal. In fact the very opposite is the case. I have heard innumerable medical staff and treatment workers unfeelingly declare that nobody ever died from lack of

- sleep. Coping with any feelings of anxiety will be hard as part of the reason for drug abuse was to escape feelings of inadequacy, anxiety pain.
- There are negative issues around prescribing of Naltrexone. G.Ps. generally are reluctant to be involved so Naltrexone is often only available from treatment centres. When I lived in South Yorkshire we were victims of private supply clinics. In my home area of Swindon, there are issues around London doctors issuing prescriptions. As in our experience, prescribing at a distance involves lack of trained advice, help and supervision. Many drug abusers have little money let alone funding for private prescriptions.