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Innovation in drug treatment commissioning

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Innovation in drug treatment commissioning

Overcoming the challenges of designing and delivering drug treatment services.

It has never been more urgent to improve access to drug treatment services; rates of drug-related deaths have increased by over 60 per cent since 2010[1] at a time when funding for drug treatment services has been declining.[2]

Despite these difficult circumstances, commissioners and treatment providers across the country have sought to tackle this challenge by developing innovative ways to commission and deliver services to improve outcomes for people in their areas and reduce drug-related harm and deaths.

The Government's new 10-year Drug Strategy, From Harm to Hope[3], makes a long-term commitment to tackling drug use as a national policy priority.

This includes welcome funding commitments for local areas in most need. It creates a new national commissioning quality standard to ensure consistency, promote effective joint-working, and align drug treatment services with target outcomes, including reduced drug-related harm and death. As such, all areas will potentially need to consider new and innovative approaches to commissioning as part of this system-wide reform.

As a biopharmaceutical company working to improve outcomes in opioid dependence treatment, Camurus sought to identify examples of existing best practice in the commissioning and delivery of drug treatment services and share them with the wider sector. Our aim is to help other areas identify innovative approaches that may help them better serve their local populations at this critical time.

60%

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Key learnings

Partner collaboration

Collaboration with external partners is critical for identifying people at risk of harm and meeting their needs.

Holistic approach

A multi-disciplinary, holistic approach to meeting all of a service user's needs is vital to achieving positive outcomes.

Effective voices

Service users' and their families' voices must be part of effective service development and planning.

Variety of service models

Treatments like Buvidal® (buprenorphine prolonged-release solution) can add to the range of treatments available and can be used successfully within a variety of different service models.

Case studies: Blackpool

Expanding innovative approaches to reduce drug-related harm

Blackpool has had the highest rate of drug-related deaths of any local authority in England and Wales since 2009.[4] To address this, in 2019, the local public health team and the Lancashire Constabulary implemented the Drug-Related Death and Non-Fatal Overdose Review Panel to tackle drug-related harm.

Attended by stakeholders from across local services, individuals at highest risk are identified by key workers and panel members who discuss services that may benefit them, enabling tailored support to be provided quickly.

This approach by the public health team and constabulary has been highly successful in bringing partners together from across the system to share information and coordinate action, with individuals experiencing a significant reduction in their risk of a drug-related death following Panel outreach. This success has contributed to Blackpool securing funding from Project ADDER to expand its approach and support even more vulnerable drug users.

The council has commissioned a Lived Experience Team (LET) to help locate and engage patients with the most complex needs. The team, who are already trusted within the community due to their own lived experience, have visible presence on the streets of Blackpool and offer a person-centred approach which means people are more likely to engage with treatment and support.

The LET is part of a wider multi-disciplinary adult outreach team which includes nurses, mental health leads, housing support and intensive employment support with direct involvement from the public health and commissioning team at Blackpool Council. All parties are co-located in the same building and this accessible and holistic approach means vulnerable people access comprehensive support from the day they are referred. This has removed the usual time lapse in between referral and service provision.

Camurus has worked with the commissioning team and drug treatment provider Delphi Medical to enable Buvidal® to be made available as a treatment option for all suitable patients in Blackpool. This is seen by the Blackpool public health team as a positive step, particularly for helping long-term drug users to engage in treatment and move into recovery.

The adult outreach team is also in regular contact with the police who may identify individuals who would benefit from treatment. This collaborative approach has been very successful to date, with 42 people whom otherwise may not have presented for treatment, being directly referred to support.

Redbridge

Using Buvidal® to support positive patient outcomes

The Redbridge Council commissioning team was seeking innovative interventions that were both clinically and cost effective for opioid users, recognising that they often present with highly complex needs and have a limited range of treatment options.

In March 2019, Redbridge Substance Misuse Commissioners engaged with Camurus to pilot the introduction of Buvidal® as a treatment option for people with opioid dependence in the borough, convening local stakeholders in a Buvidal® Working Group.

The Group created an operating model, a clinical protocol and established patient selection criteria for the treatment. As part of this approach, Camurus provided comprehensive training for staff so they felt confident introducing Buvidal® to the treatment pathway, as well as providing ongoing support once patients began their treatment.

The introduction of Buvidal® has enabled patients to move away from daily supervised consumption which the council had recognised as an obstacle to engaging in Education, Training and Employment (ETE). Redbridge's response to the Government's Rough Sleeping Programme, which has sought to transition homeless people away from rough sleeping, has also successfully incorporated the use of Buvidal®. This positive progress has been further supported by training local pharmacists to administer Buvidal®, therefore increasing patient choice in terms of where Buvidal® is accessed.

Redbridge Commissioners have recognised the importance of shared decision-making between patients and clinicians. Buvidal® is offered as a mainstream treatment option alongside other forms of opioid substitution therapy (OST). The additional option of a long-acting treatment may help address barriers that contribute to limited engagement amongst some groups.

Worcestershire

Creating a shared care network to improve service access

Worcestershire traditionally had drug treatment services based in urban areas. As a large county with widely dispersed communities, this presented significant access challenges for people seeking drug treatment services, particularly those with more complex needs or in rural areas.

In response, service provider Cranstoun worked with GP surgeries across the county to establish a shared care model for substance misuse treatment, enabling users to access support via their GP in addition to community-based treatment.

Through the shared care system, service users have medical reviews and psychosocial intervention sessions at the GP surgery. This ensures pharmacological and psychosocial treatment are delivered collaboratively between the GP and Cranstoun recovery team, meaning drug and alcohol recovery goals are managed in conjunction with service users' physical and mental health needs.

This approach has enabled the creation of a treatment network with consistent clinical standards and governance, including specific shared care guidelines, annual training events, clinical and shared care lead support, and annual surgery reviews and audits.

Service users have welcomed the confidentiality this approach offers as well as easier access to support. The shared approach provided a responsive and resilient service that was well equipped to swiftly reset delivery when the pandemic lockdown measures were relieved.

Recently this has allowed the shared care network to introduce a pilot for the use of Buvidal®, the first with a model of this kind. The collaborative model has enabled standard operating procedures to be developed in partnership with GPs and for the Cranstoun team to have a full understanding of which patients are eligible for this treatment. Early feedback is positive and the pilot will continue to evolve ahead of what is hoped will be a wider rollout after 12 months.

Newcastle

Using data and supporting families to address drug -related harm

Newcastle City Council has undertaken concerted efforts to reduce drug-related deaths and harm, following an increase in drug-related deaths in 2013/14.[5] Critical to this work has been strategic buy-in, alongside strong relationships with key groups such as local police, recovery groups, the community and voluntary sector and NHS leaders.

This has led to funding being protected for vital services such as harm reduction provision, bespoke family support, residential rehabilitation and community support programmes. It has supported the development of an annual drug intelligence snapshot to inform delivery priorities for treatment and support services.

This data has proved crucial in helping to review and assess service delivery and outcomes linked to drug and alcohol treatment. It not only seeks to measure direct client impact, but also value for money to ensure funding is spent where it is most effective. This analysis has also included other impacts – families, carers, safeguarding and social care as well as broader community impacts and substance related offending; taking a whole system approach.

Critically, the Newcastle team also recognised the important role families and loved ones play in an individual's treatment journey. It ensures their voices are heard and provides intervention support to help families manage an indiviudal's drug use.

Key principles include intervening early, supporting whole family recovery and extending resources and support to develop 'community recovery hubs'.

Through the Newcastle User Carer Forum users and families provide suggestions for how services can operate more efficiently and better meet client needs. Forum members are involved in all stages of service development, including procurement/tendering and evaluation processes to ensure their experiences are genuinely at the heart of provision. This approach continued virtually during the pandemic to ensure carers and service users could input on service changes during this critical period.

In recognition of current challenges, and in response to the Dame Carol Black independent review of drug policy, Newcastle (as a regional centre with associated levels of drug related deaths and drug related offending) has received funding through the second phase of Project ADDER. It includes specific funding for enhanced criminal justice provision, a dedicated physical health team, extension to recovery communities and dedicated support for families affected by substance misuse. This funding is also supporting the establishment of an analyst hub between Northumbria Police and the local authority which will include the development of a Drug Market Profile and revised drug related death and near miss processes.

Please note
Camurus has not been involved in the work set out in this case study. It is included as a good example of utilising data to support the analysis of service outcomes and to demonstrate how community stakeholders and families can be incorporated into service planning.

Hertfordshire

Taking a holistic approach to addressing drug use

Hertfordshire had experienced a stark increase in the number of children entering care. The children's services team needed a new approach to support families to address issues like drug use so children could remain safely in their own homes.

The Family Safeguarding model was designed to keep more children who are likely to or have suffered abuse and neglect safely with their families by identifying and meeting needs early. These children are often living in homes where drug use, domestic abuse and mental health issues are present. Instead of seeking to escalate cases, resulting in children being removed from their parents, the Family Safeguarding Team work collaboratively to support parents to overcome these barriers.

The team use techniques which provide more tailored support for families, engaging with them positively through motivational interviewing to reduce the fear of having children taken into care and demonstrate that help is available: parents are "worked with and not done to".[6, 7]

In households where substance misuse is present, drug treatment services work alongside social workers, visiting homes to improve access and ensuring that parents have the right support to move away from drug dependency. With looked after children at greater risk of substance misuse,[8] this investment is also viewed as a means of reducing the longer term likelihood of children becoming drug dependent themselves.

During the trial period for this model in 2015/16, there was an estimated 53 per cent reduction in emergency hospital admissions for adults.[9] On substance misuse specifically, initial findings showed a reduction in alcohol and drug use during treatment.[10] By year 12 the cumulative cost of setting up and running the model is projected to be £15.9 million, but it is expected to have generated cumulative cost reduction/avoidance of £281 million.[11]

Please note
Camurus has not been involved in the work set out in this case study. It is included as a good example of how broader psychosocial interventions can be used as part of a robust approach to substance misuse and can achieve positive outcomes beyond helping drug users move into recovery.

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About Camurus

Camurus is a biopharmaceutical company working to improve outcomes for people with opioid dependence. Camurus is proud to partner with drug treatment services across the UK to support healthy communities.

If you would like further information or to discuss the details in this briefing please contact Samantha Nickerson at **samantha.nickerson@camurus.com**

References

[1] **Office or National Statistics, Dataset - Deaths related to drug poisoning by local authority, England and Wales, Table 3, 3 August 2021.** Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/datasets/drugmisusedeathsbylocalauthority [Last accessed November 2021]

[2] **Dame Carol Black Review of Drugs, Executive Summary, February 2020.** Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/897786/2SummaryPhaseOne+foreword200219.pdf [Last accessed September 2021].

[3] **From Harm to Hope, December 2021.** Available at: https://www.gov.uk/government/publications/from-harm-to-hope-a-10-year-drugs-plan-to-cut-crime-and-save-lives [Accessed December 2021].

[4] **Office or National Statistics, Dataset - Deaths related to drug poisoning by local authority, England and Wales, Table 3, 3 August 2021.** Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/datasets/drugmisusedeathsbylocalauthority [Last accessed September 2021].

[5] **Public Health England, Responding to drug-related deaths in Newcastle, 1 March 2017.** Available at: https://www.gov.uk/government/case-studies/responding-to-drug-related-deaths-in-newcastle [Last accessed September 2021].

[6] **Department for Education, Family Safeguarding, Evaluation Report, 2020.** Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/932367/Hertfordshire_Family_Safeguarding.pdf [Last accessed September 2021].

[7] **Department for Education, Family Safeguarding Hertfordshire, Evaluation Report, 2017.** Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/625400/Family_Safeguarding_Hertfordshire.pdf [Last accessed October 2021].

[8] **Alderson, H., Brown, R., Copello, A. et al.** The key therapeutic factors needed to deliver behavioural change interventions to decrease risky substance use (drug and alcohol) for looked after children and care leavers: a qualitative exploration with young people, carers and front line workers. BMC Med Res Methodol 19, 38 (2019). Available at: https://doi.org/10.1186/s12874-019-0674-3.

[9] **Department for Education, Family Safeguarding Hertfordshire, Evaluation Report, 2017.** Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/625400/Family_Safeguarding_Hertfordshire.pdf [Last accessed October 2021].

[10] **Department for Education, Family Safeguarding Hertfordshire, Evaluation Report, 2017.** Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/625400/Family_Safeguarding_Hertfordshire.pdf [Last accessed October 2021].

[11] **Department for Education, Family Safeguarding, Evaluation Report, 2020.** Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/932367/Hertfordshire_Family_Safeguarding.pdf [Last accessed September 2021].

Prescribing Information for Buvidal® (buprenorphine prolonged-release solution for injection)

Please refer to the Summary of Product Characteristics (SmPC) before prescribing

Active ingredient: Buprenorphine. Prolonged-release solution for injection in pre-filled syringes. Weekly injection (8 mg, 16 mg, 24 mg, 32 mg) or monthly injection (64 mg, 96 mg, 128 mg, 160 mg).

Indication: Treatment of opioid dependence within a framework of medical, social and psychological treatment. Treatment is intended for use in adults and adolescents aged 16 years or over.

Dosage: To avoid precipitated withdrawal, initiate when objective and clear signs of mild to moderate withdrawal are evident, considering the duration of action of the opioid, time since last dose and degree of opioid dependence. Do not start until ≥6 hours after last heroin or short-acting opioid. Reduce methadone to ≤30 mg/day and start Buvidal® ≥24 hours after the last methadone dose. Buvidal® may trigger withdrawal symptoms in methadone-dependent patients. *Initiation in patients not already receiving buprenorphine:* Patients not previously exposed to buprenorphine, administer 4 mg sublingual buprenorphine and observe for an hour to confirm tolerability. Recommended starting dose of Buvidal® is 16 mg, with one or two additional 8 mg doses at least 1 day apart (target dose of 24 mg or 32 mg during the first week). The dose for the second week is the total dose administered during the first week. May transfer to monthly Buvidal® after four weeks and once stabilised. *Switching from sublingual buprenorphine:* Switch directly to weekly or monthly Buvidal®, starting on the day after the last sublingual buprenorphine dose. See SmPC for dose recommendations. *Maintenance:* Weekly or monthly as needed. One supplemental Buvidal® 8 mg dose may be administered between regular weekly or monthly doses (except 160 mg). The maximum dose is 32 mg weekly, with an additional 8 mg dose, or 160 mg monthly. Weekly doses may be administered up to 2 days before or after the weekly time point, and monthly doses may be administered up to 1 week before or after the monthly time point. If a dose is missed, administer the next dose as soon as practical. *Termination:* Consider prolonged-release characteristics and any withdrawal symptoms. If switching to sublingual buprenorphine, do so one week after the last weekly dose or one month after the last monthly dose of Buvidal®. *Elderly:* No dosing recommendations over 65 years. Consider renal and hepatic function.

Administration: Administration of Buvidal® is restricted to healthcare professionals only. For subcutaneous administration only. Inject slowly and completely into sufficient subcutaneous tissue of the buttock, thigh, abdomen, or upper arm area. Do not re-inject the same injection site for at least 8 weeks (each area can have multiple injection sites).

Contraindications: Hypersensitivity to buprenorphine or excipients. Severe respiratory insufficiency. Severe hepatic impairment. Acute alcoholism or *delirium tremens*.

Special warnings and precautions for use: Must not be administered intravenously, intramuscularly or intradermally. Monitor for any attempts to remove the depot. Some precautions associated with buprenorphine class. *Prolonged-release properties* of the product should be considered during treatment. Patients with concomitant medicines and/or co-morbidities should be monitored for signs and symptoms of toxicity, overdose or withdrawal. *Respiratory depression:* Deaths reported with buprenorphine. Care in respiratory insufficiency. *CNS depression:* Buprenorphine may cause drowsiness. *Dependence:* Chronic administration of buprenorphine can produce opioid dependence. *Serotonin syndrome:* Concomitant serotonergic agents (e.g. monoamine oxidase inhibitors, selective serotonin re-uptake inhibitors, serotonin and noradrenaline re-uptake inhibitors or tricyclic antidepressants) may result in serotonin syndrome, a potentially life-threatening condition - if clinically warranted, observe carefully, particularly during initiation and dose increases and consider reducing or discontinuing therapy if serotonin syndrome is suspected. *Hepatitis, hepatic events and hepatic impairment:* Recording of baseline liver function tests and viral hepatitis status recommended. Hepatic injury reported with buprenorphine. Caution with buprenorphine in moderate hepatic impairment – monitor for signs and symptoms of opioid withdrawal, toxicity and overdose. Monitor hepatic function regularly. *Drug withdrawal syndrome (GB):* Before starting any opioids, discuss withdrawal strategy with the patient. Dose tapering over weeks or months may be required. Risk of neonatal withdrawal syndrome following use in pregnancy. *Precipitation of opioid withdrawal syndrome:* Buprenorphine products have precipitated withdrawal symptoms in opioid-dependent patients when administered before the agonist effects from recent opioid use or misuse have subsided. *Renal impairment:* Caution in severe renal impairment. *QT-prolongation:* Caution with other medicines that prolong the QT interval and in patients with a history of long QT syndrome or other risk factors for QT prolongation. *Acute pain management:* A combination of opioids with high mu-opioid receptor affinity, non-opioid analgesics and regional anaesthesia might be necessary. Monitor and titrate, considering potential risk of overdose and/or death. *Sleep-related breathing disorders:* Opioids can cause sleep-related breathing disorders. *Opioid class effects:* See SmPC for details. *Interactions:* See SmPC for buprenorphine interactions. *Pregnancy and lactation:* Caution – see SmPC for details. *Driving and operating machines:* Minor to moderate influence, including drowsiness, dizziness or impaired thinking – likely to be pronounced by alcohol or CNS depressants. See SmPC for details of what individual patients should be told by the prescriber.

Undesirable effects: *Very common:* insomnia, headache, nausea, hyperhidrosis, drug withdrawal syndrome, pain. *Common:* infection, influenza, pharyngitis, rhinitis, lymphadenopathy, hypersensitivity, decreased appetite, anxiety, agitation, depression, hostility, nervousness, abnormal thinking, paranoia, medical dependence, somnolence, dizziness, migraine, paraesthesia, syncope, tremor, hypertonia, speech disorders, lacrimal disorder, mydriasis, miosis, palpitations, vasodilation, hypotension, cough, dyspnoea, yawning, asthma, bronchitis, constipation, vomiting, abdominal pain, flatulence, dyspepsia, dry mouth, diarrhoea, gastrointestinal disorder, rash, pruritus, urticaria, arthralgia, back pain, myalgia, muscle spasms, neck pain, bone pain, dysmenorrhea, injection site reactions (pain, pruritus, erythema, swelling, reaction, induration, mass), peripheral oedema, asthenia, malaise, pyrexia, chills, neonatal withdrawal syndrome, chest pain, abnormal liver function tests. *Other:* urinary retention, injection site reactions (abscess, ulceration and necrosis). See SmPC for further details.

Overdose: Apply general supportive measures, closely monitoring and treating respiratory and cardiac status. Consider long duration of action of buprenorphine and prolonged release from the depot.

Package quantities and UK net price: 1 pre-filled syringe per pack. Weekly injection (8 mg (0.16 ml), 16 mg (0.32 ml), 24 mg (0.48 ml), 32 mg (0.64 ml)): £55.93. Monthly injection (64 mg (0.18 ml), 96 mg (0.27 ml), 128 mg (0.36 ml), 160 mg (0.45 ml)): £239.70. **Marketing authorisation numbers:** *GB:* PLGB 42800/0001, PLGB 42800/0003-9. **ROI and NI:** EU/1/18/1336/001-7, EU/1/18/1336/009. **Legal category:** POM. **Marketing authorisation holder:** Camurus AB, Ideon Science Park, SE-223 70 Lund, Sweden. Email: Camurus.uk@camurus.com Additional information available on request.

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Adverse events should be reported. Reporting forms and information can be found at www.mhra.gov.uk/yellowcard (or search for MHRA Yellow Card in the Google Play or Apple App Store) for the UK and http://www.hpra.ie/homepage/about-us/report-an-issue for Ireland. Adverse events should also be reported to Camurus AB via email: safety@camurus.com

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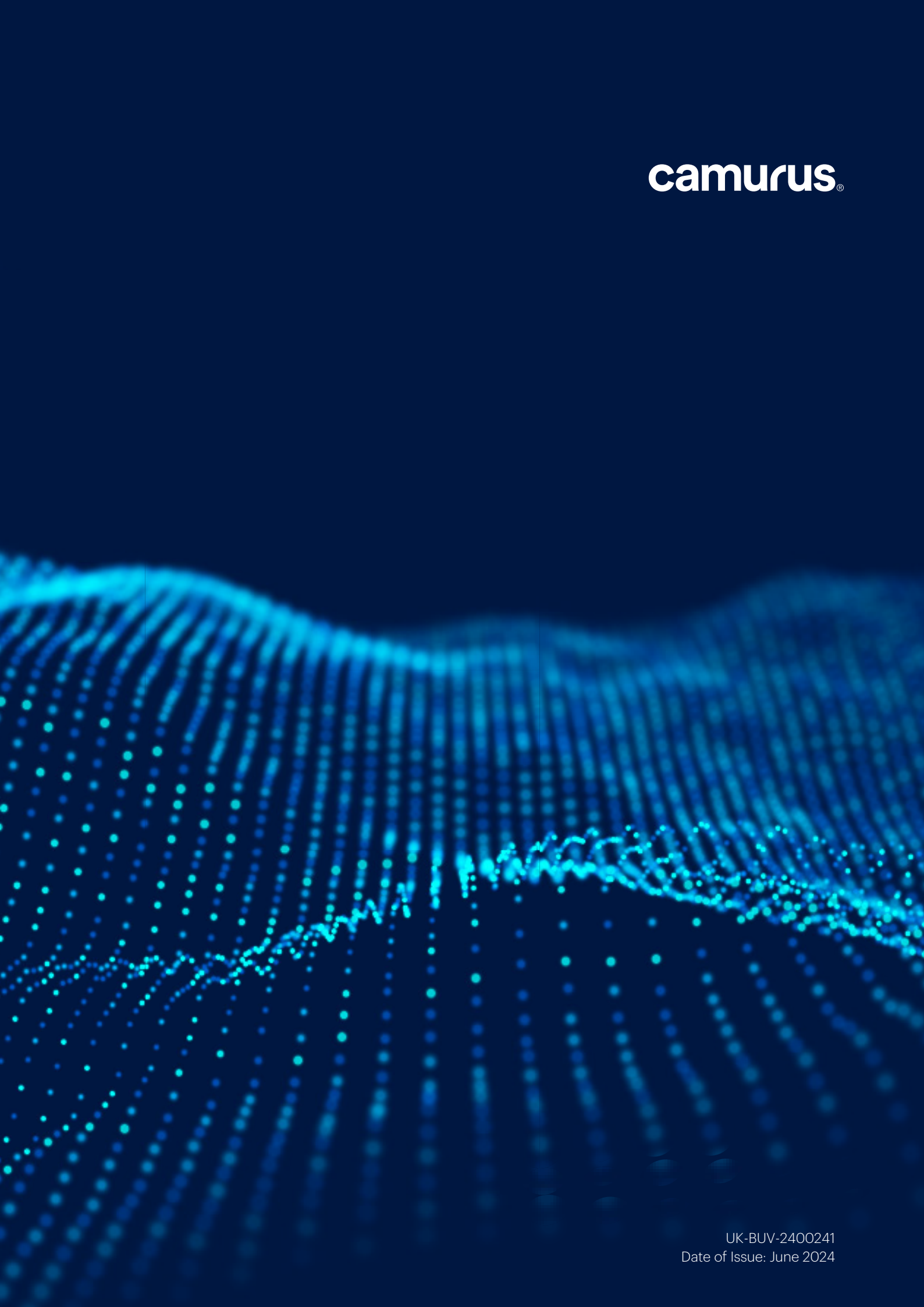

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