



**RCGP 11TH NATIONAL CONFERENCE:
MANAGEMENT OF DRUG USERS IN PRIMARY
CARE
MANCHESTER – 27TH & 28TH APRIL 2006**

**ARE WE DELIVERING EFFECTIVE CARE IN
GENERAL PRACTICE?**

HOW WOULD WE KNOW?

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EXPANSION IN GP PRESCRIBING FOR DRUG USERS (NTA FIGURES 2005-2006)

- GP prescribing now available in 95% of areas
- 30% of community prescribing done by GPs
- Average wait for GP prescribing 1.7 weeks (2001 figure: 5.6 weeks)
- Models of Care 2006 target 35% GPs, 40% practices involved (2004-5: 32% GPs, 34% practices were involved)
- NES/LES contracts and RCGP training now available



IS ANYONE GETTING BETTER OUT THERE?

What are we trying to achieve?

“With this medication, and a comprehensive programme of rehabilitation, patients have shown marked improvement; they have returned to school, obtained jobs, and have become reconciled with their families.” (Dole and Nyswander, JAMA 1965) (1)

The evidence base is for in-treatment harm reduction outcomes

HOW DO WE MEASURE EFFECTIVENESS?

Gold standard: measure actual outcomes through peer-reviewed research

Outcomes which have been measured:

- Reduction in illicit drug use
- Reduction in risk taking behaviour
- Improvements in mental and physical health
- Improvements in social functioning
- Reductions in drug-related deaths

HAS THIS BEEN DONE IN UK PRIMARY CARE SETTINGS?

Sheffield cluster (2000-2003):

- Heroin use reduced by 92.7% ($p < 0.001$)
- Mean convictions and cautions reduced by 62% ($p < 0.001$)
- Significant improvements in HIV risk taking behaviour, social functioning, physical and mental health (2)
- Drug related deaths fell, no increase in methadone deaths (3)
- Significantly less time spent in prison (4)

NTORS:

- Treatment outcomes in primary care are equivalent to those in specialist settings (and problems at intake were comparable) (5)
- Significant improvements in drug use, health and social functioning

Glasgow Study (1997-2000):

- Significant reductions in injecting, overdose and criminal activity (6,7)

Review papers:

- Simeons 2005, Weinrick 2000 confirm safety and effectiveness of GP prescribing (8,9)

Descriptive studies:

- Edinburgh (10), London (11,12), Isle of Wight (13)

PROXY MEASURES FOR OUTCOMES

Proxy measures with a known direct relationship to positive outcomes in drug users:

- **Adequate dosages (14,15,16,17)**
- **Long term harm reduction philosophy (1,18,19)**
- **Retention in treatment (18,19,20)**

Which is itself related to other proxy measures:

- **take home doses (1,21)**
- **accessibility and convenience**
- **availability of ancillary services**
- **optional counselling, especially in early stages**

Other factors known to be related to good outcomes (1,14,18,19,20,21):

- **Reducing barriers to entry**
- **High quality medical and psychosocial services**
- **Orientation towards social rehabilitation**
- **Detoxification only of willing stable patients with established abstinence**

PROXY OUTCOMES IN PRIMARY CARE STUDIES

Retention in treatment:

- NTORS (5) 66% retained at 6 months (60% in specialist clinics)
- Sheffield (2) 70.8% retained at 1 year
- Glasgow (7) 51.5% retained at 1 year

“High quality medical services”:

- GP attitudes towards treating drug users are probably improving (22,23,24)

Accessibility:

- Patient surveys suggest that drug users prefer GP treatment to specialist services (accessibility is a reason) (25,26,27)

Long term philosophy:

- Patients report a more ‘holistic’ approach by GPs (25)

BUT:DO NO HARM!

GP survey and analysis of prescribing data– Strang 2003 and 2005 (28)

- 40% no take-home doses
- 40% once a week pick ups
- 9% of GP prescriptions were for dihydrocodeine (unlicensed)
- **2001** mean daily dose prescribed by GPs was 36.9 mg methadone - 90% of doses were <60 mg (“too low to constitute optimal maintenance”)
- BUT methadone mixture 95% of methadone scripts in 2001, injectables/tablets reduced by 50% over 12 years

Risks of not prescribing

- GP prescribing almost certainly reduces deaths (3,29)
- Many GPs won't prescribe (27)
- Some prefer to prescribe for detox
 - high death rate in recently detoxed patients (30)
 - maintenance a good route to abstinence (31)

PRIMARY CARE MEASURES WHICH WE COULD USE

- Hep B vaccination rates
- Blood borne virus testing and referral rates
- Family planning advice rates
- Quality of care for other conditions
- Quality of pregnancy care
- Quality of care to children and families of drug users

More difficult:

- Long term approach
- Harm reduction not abstinence based
- Holistic attitude

CONCLUSIONS

- The published evidence suggests that we are doing a good job
- We perform well even on measures designed for use in secondary care

1st principles of primary care:

- Natural environment for harm reduction
- Natural environment for treatment of long term chronic relapsing condition
- Natural environment for comprehensive treatment

BUT why so little research using true primary care outcome measures?

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