SMMGP CLINICAL UPDATE DECEMBER 2008

Shooting up Infections among injecting drug users in the UK 2007 *Update October 2008 HPA*
Detailed data on injecting behaviour, bacterial and viral infections are presented. Key messages include some good news, with a marked increase in hepatitis B vaccination in IVDUs (now at two-thirds) and a small decline in sharing (but with a quarter of injectors continuing to share). The bad news is there is an increase in risky groin and crack injecting and a fifth of new injectors will contract hepatitis C and one in a hundred, HIV, within the first three years of starting to inject. Overall hepatitis C prevalence amongst injectors continues to rise and is now at almost 50%.

SMMGP comment: *We agree with the HPA recommendation that there is still a need for more services to tackle injecting related harms, and support those who wish to stop injecting. There is a serious need to increase treatment capacity for hepatitis C, with at least 6,000 new infections per year in England and yet only 3,000 people being treated the potential health impact of this epidemic is alarming!*

Reducing drug users' risk of overdose, *Rome et al (Scottish government) http://www.scotland.gov.uk/Publications/2008/10/30132711/0*
Scotland's drug-related deaths have been consistently higher than those in the rest of the United Kingdom (almost three times higher than England and Wales in 2005). The researchers interviewed drug users, witnesses, and emergency staff with personal experience of overdose. Amongst the recommendations is one for regular primary care screening, including regular medical examinations and liver function tests, for risk factors such as harmful drinking and depression.

SMMGP comment: *The interview transcripts are fascinating, and although the recommendations are for Scotland, other UK countries should consider adopting primary care DRD-risk screening, as we know overdose risk is higher in medium to long term users.*

Overdose training and take-home naloxone for opiate users: prospective cohort study impact on knowledge and attitudes and subsequent management of overdoses, *Strang J et al Addiction volume 103. Number 10 October 20081648-1657*
The impact that training in overdose management and naloxone provision was having was measured by assessing the knowledge and confidence of current opiate users. Significant improvements were seen in the knowledge about the risks of overdose, the appropriate actions that needed to be taken and in the use

of naloxone and the study concluded that users can be trained to take the appropriate action to reverse potential fatal overdose.

SMMGP comment: *There is a lot of overdose training around the country, much of it is being done by current users. If users aren't trained in your area, this research reinforces the fact that we should be making it available in all areas.*

The normalisation of binge drinking? An historical and cross cultural investigation with implications for action, *Berridge et al*
http://www.aerc.org.uk/documents/pdfs/finalReports/AERC_FinalReport_0037.pdf
This paper demonstrates that binge drinking is not a new phenomenon, but there has been a shift in definition from description of a type of clinical picture to a description of a type of drinking episode. Even within the new definition there is poor consensus on the amount of alcohol or the speed or context of drinking that constitutes a 'binge'.

SMMGP comment: *Binge drinking is defined as consuming twice the DOH sensible daily drinking limits, or more, in a limited period of time (this is usually defined as 1-3 hours or 'an evening'). This means drinking 6 units or above for a woman and 8 units or above for a man. The term binge drinking is normally used to refer to a pattern of drinking which leads to a rapid rise in blood alcohol concentration, and therefore, drunkenness. Alcohol Concern (2003) have stated that in the UK, binge drinking accounts for 40% of all drinking occasions amongst men and 22% by women. Binge drinking is more prevalent in the 16-24 age group although this pattern of consumption does continue into middle age with 33% of men and 20% of women drinking twice the daily limits at least once a week. The immediate consequences of binge drinking are largely behavioural and include accidents, violence, poor social behaviour, self harm, unsafe sex and risky drug taking. Immediate physical effects include hypothermia, hypoglycaemia, cardiac arrhythmia, stroke, respiratory or circulatory failure and inhalation of vomit, any of which can be fatal. Binge drinking is particularly harmful to the foetus compared to drinking the same amount over a longer period.*

National and regional estimates of the prevalence of opiate use and/or crack cocaine use 2006/7: a summary of key findings *Gordon Hay et al*
This home office report is the third and final sweep of a study estimating the prevalence of Problem Drug Use using sophisticated statistical methods on multiple sources of existing data to gain a more accurate estimate than that determined by self-report alone. The data shows London, Northwest and Yorks and the Humber regions had the highest estimated prevalence, and that whilst prevalence overall has remained stable over the three years of the study, there has been a decrease in injecting.

SMMGP comment: *news of a decrease in injecting is welcome. Interestingly, regional variations in drug use prevalence mirror those of alcohol*

Extended vs. Short-term Buprenorphine-Naloxone for Treatment of Opioid-Addicted Youth, *Woody, GE, et al, JAMA. 2008; 300(17):2003-2011.*
Usual recommendations on drug treatment for young people emphasise detoxification in preference to maintenance treatments, but according to this paper, there has been only 1 controlled trial of pharmacotherapy for opioid-addicted youth. In this US multicentre trial, 152 opiate dependent 15-21 year olds were commenced on combined buprenorphine/naloxone sublingual tablets (Suboxone) and randomized to either 9 weeks of maintenance therapy (max dose 24mg) followed by a 3 week tapering of dose, or a detoxification programme, tapering the dose to zero in 2 weeks (from max dose 14mg). Results in the first 12 weeks strongly favoured patients in the maintenance group. They had much less use of opioids, cocaine, and marijuana; much better treatment retention; and much less injecting and need for additional treatment while on medication. However the differences in opioid use and injecting were fading by week 12, and lost at 6, 9 and 12 months.

SMMGP comment: *Whilst NTA publication on pharmacological intervention in Young Persons' treatment is awaited, in their draft **Young People's Specialist Substance Misuse Treatment: Exploring the Evidence, at** http://www.nta.nhs.uk/news_events/newsarticle.aspx?NewsarticleID=78 they say: "Extensive guidance on undertaking pharmacological interventions with young people will be published shortly by the NTA"). This study suggests that pharmacological treatment for this group may not be that different to that for adults. It is a shame that the number of under-18s was too small for statistical analysis. There is a need for similar research in the UK.*
Traditionally working with young people is carried out by specialist young people's teams and drug users under 18 years old are excluded from having drug treatment in general practice, but this evidence suggests this approach may be outdated. The NTA Young Persons Team have recently been reviewing the treatment needs of the under 18s with substance misuse problems. They are also reviewing the need to develop training for primary care practitioners who work with this group. .Watch this space!

Computer-Assisted Delivery of Cognitive-Behavioral Therapy for Addiction: A Randomized Trial of CBT4CBT: *Carroll, KM, et al, Am J Psych July 2008 Vol. 165, Iss. 7; p881.*

In this US trial, 77 individuals seeking treatment for substance dependence at an outpatient community setting were randomly assigned to standard treatment or standard treatment with biweekly access to computer-based training in CBT (CBT4CBT) skills across six 40-minute modules: (covering patterns of use and functional analysis; coping with craving; refusing offers; problem solving; addressing cognitions; decision making) with a homework assignment at the end of each module. Participants assigned to CBT4CBT submitted significantly more urine specimens that were negative for any type of drugs, (this was most marked

for cocaine), tended to have longer continuous periods of abstinence during treatment, and evaluated the CBT4CBT program positively. There was a significant positive relationship between the number of CBT4CBT homework assignments completed and substance use outcomes.

SMMGP comment: *NICE has validated CBT, including computerised CBT, in drug treatment for treatment of co-morbid depression and anxiety but states CBT 'should not be routinely offered' for substance dependency per se. However, there is a dearth of research evaluating computer-assisted treatment specifically for substance use disorders – this study suggests computerisation could make CBT cost-effective for substance misuse too.*

High prevalence of hepatitis C virus infection among non-injecting drug users: association with sharing the inhalation implements of crack *Liver International, July 2008, vol./is. 28/6(781-6), 1478-3231 Macias, J et al*

The prevalence of HCV infection in non-injecting drug users (NIDU) is higher than in general population, and there has been speculation that causes include sharing of crack pipes. This Spanish study looked at factors associated with HCV infection among (NIDU). 182 NIDU underwent standardised interviews to establish blood-borne virus (BBV) risk factors followed by testing for hepatitis C. HCV infection was detected in 23 (12.6%) participants. Sharing crack cocaine inhalation tubes, presence of tattoos and age >or=34 years were independently associated with HCV infection.

SMMGP comment: *RCGP guidelines have targeted BBV prevention messages at crack smokers for some time now. It is very useful to have these recommendations underpinned with research, and converts our approach from a 'should do' to a 'must do'.*

Parental drug use, early adversities, later childhood problems and children's use of tobacco and alcohol at age 10: birth cohort study *Addiction October volume 103 p 1731-1743 Macleod J et al*

Looking at a total of 6895 children aged 10 it was found that parental social disadvantage (measured by Family Adversity Index which is constructed with questions about maternal age, housing problems, parental education, social networks, maternal emotional strain and crime) was the strongest predictor of children's smoking and it also predicted children's alcohol use. Parental smoking and paternal alcohol use had little independent influence on offspring drug use. They concluded that strategies to prevent early initiation of tobacco and alcohol use should focus upon the reduction of childhood social disadvantage and the behavioural and cognitive problems associated with this.

SMMGP comment: *Reconfirms how important it is to attack poverty and social disadvantage.*