



SMMGP CLINICAL UPDATE FEBRUARY 2009

Trends in drug misuse recorded in primary care in the UK from 1998 to 2005.

Frischer et al, J Pub health Oct 2008.

Where do the statistics on UK drug misuse come from? The authors point out the problems with trying to derive long-term trends from currently used sources, and present us with a new and highly relevant potential source of UK drug misuse prevalence data – primary care. The study used a subsection of the long-established General Practice Research Database (GPRD) comprising some 900,000 patients from 183 general practices, and searched on 241 diagnostic codes for drug misuse disorders and 12 codes for related prescriptions. Careful analysis was used to avoid duplication errors, and ‘over counting’ of short term patients.

Results: There was a marked decrease in both prevalence and incidence of illicit drug misuse age group (16 – 24 years), from 1998 to 2002 (P 0.01). In older adults (25 – 59 years), the pattern was more variable during the first part of this period, but incidence remained stable from 2002 to 2005.

SMMGP comment: *This paper starts with an excellent resume of currently used data sources and analysis - recommended as a useful reference point. There are a few possible problems with it however: 1) The study validated GPRD data against known secondary care treatment data, whereas it would probably be more helpful to have a data source which also gives us a reliable insight into prevalence of drug misuse in those not in treatment. 2) No account is taken of changes in the ways in which GPs are collecting data in line with policy changes (e.g. QOF) and 3) GPRD data is only collected from surgeries using Vision and is dependant on correct recording of drugs and Read codes.*

Methadone patients in the therapeutic community: A test of equivalency.

Sorensen et al Drug Alcohol Depend 2009 Feb 1; (100(1-2) :100-106

This study compared outcomes at 24 months in a Therapeutic Community (which normally adheres to a drug-free ideology) of 106 drug free clients vs 125 on methadone maintenance treatment (MMT). There were no significant differences in psychiatric history or criminal justice ‘pressure’ between the two groups. Throughout, there were no significant differences in retention in treatment, use of illicit opioids, stimulants or alcohol. There was also no difference in benzodiazepine use until the end of the study, when use in MMT patients was 7% higher. The groups were also equivalent in terms of HIV risk behaviour.

SMMGP comment: *This paper's demonstration that Therapeutic Communities can work just as well for methadone-maintained as for drug free patients, provides important support for the idea of medication assisted recovery. In almost all rehabs in UK one has to enter drug-free or undergo a detoxification in the first weeks which excludes anybody who wants to make changes in other parts of their lives whilst being maintained on medication. It would be helpful if more communities allowed people to enter who were on stable medication.*

The effectiveness of a brief intervention for illicit drugs linked to the Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) in primary healthcare settings. *Humeniuk et al, WHO 2008.*

ASSIST phase III was an international RCT of a brief intervention for illicit drugs (cannabis, cocaine, stimulants and opioids) for 731 moderate-risk patients identified using the ASSIST tool, in Australia, Brazil India and the USA. Half the subjects were randomised to a brief intervention based on motivational interviewing techniques. Both the control and experimental groups showed statistically significant reductions in illicit drug use, apart from opioids, and this finding was confirmed at 3 month follow up. The intervention group showed a marginally better reduction than control, suggesting the effects of simply being screened and recruited to the study were beneficial in their own right. There were marked differences between countries, with India showing an 11/39 point improvement in opiate use, as opposed to no effect in the US. Patients were interviewed by researchers and assured of confidentiality, whereas in routine practice, their doctors would be carrying out the intervention.

SMMGP comment: *On the face of it, this paper appears to support the notion of carrying out brief interventions for all kinds of illicit drug use in primary care. However, benefits were small, and it is not clear to what extent results can be transferred to a UK setting.*

A Study of methadone maintenance for male prisoners - month post-release outcomes *Kinlock et al Crim Justice Behav 2008 ;35(1): 34-47*

This US study randomised 197 heroin dependent new-intake prisoners with sentences exceeding 3 months to 3 groups: a) group counselling only, b) counselling with opportunity for methadone maintenance treatment (MMT) on release, and c) counselling and MMT in prison. Group counselling took the form of 12 weekly sessions addressing relapse prevention and other re-entry issues, and all participants were given an appointment to meet individually with the counsellor immediately prior to release to draw up a comprehensive care plan for their future in the community. At 3 months post-release, 96% were followed up. Group c) participants were significantly more likely to enter treatment ($p=0.001$), to avoid reincarceration ($p=0.019$). Groups (b) and (c) were significantly less likely ($p=0.05$) to report heroin or cocaine use, or criminal involvement.

SMMGP comment: *MMT treatment in prison is rare in the US, particularly amongst longer term inmates, but US inmates are less likely to have access to heroin whilst in prison than in other countries. This study provides some support for the notion of 'retoxification' prior to release. However it is noteworthy that half the original sample were excluded as they did not wish to have methadone treatment, and that over a fifth of patients in group a) remained abstinent post release.*

Predictors for Non-Relapsing Status in Methadone-maintained Heroin Addicts. A Long-Term Perspective Study, *Maremmi Heroin Addict Relat Clin Probl 2008; 10(4): 19-28*

This Italian paper looked at 129 consecutive patients referred to the Pisa MMT programme over a 6-year period, with at least a 2-year history of heroin dependence, and attempted to establish the pre-treatment characteristics predicting good response. Over 50% had a psychiatric diagnosis, including anxiety and phobias, depression, bipolar disorder, and schizophrenia. Patients were titrated until defined as stable, most requiring more than 120mg of methadone.

Results: Age, sex, education, marital status, some social adjustment areas (leisure-time, social and legal issues), the substance use at baseline (alcohol, stimulants, cannabinoids, amphetamines, inhalant and hallucinogenic) showed no significant impact on relapsing risk. The most important predictors of non-relapsing were time spent in treatment (especially if greater than 3 years) and the presence of a psychiatric comorbidity. The authors hypothesised that methadone may have had the effect of stabilising psychiatric conditions, and also that such patients would benefit more from the structure that participation in the MMT programme requires.

SMMGP comment: *The programme described uses an interesting definition of stabilisation (no more than one positive urine test for opiates in the preceding 60 days). This paper supports the notion that some patients may arrive at heroin dependency through self-medication for mental illness.*

Scientific Evidence and Practical Experience with Methadone- Assisted Withdrawal of Heroin-Dependent Pregnant Patients *Hendra Jones, Heroin Addict Relat Clin Probl 2008; 10(4): 33-38*

This US paper retrospectively compared outcomes in mother and baby in 175 patients between groups who received a 3 or 7 day methadone assisted withdrawal programme against those receiving MMT. All programmes were delivered in a residential setting. Some patients who initially had methadone-assisted withdrawal later received MMT, and this was taken into account during data analysis.

Results: Maternal retention in treatment, and attendance for antenatal care was superior in the MMT group. No statistically significant differences were noted on the toxicology testing for illicit drug use, neonatal outcome measures of birth weight, APGAR scores, requirement for medication to treat neonatal abstinence syndrome, length of hospital stay or estimated gestational age at delivery. Patients who initially opted for methadone assisted withdrawal and later received MMT showed comparable outcomes to MMT-only patients.

SMMGP comment: *A weakness in the study is that patients were not randomized to the different treatment arms, rather treatment type was determined by maternal choice. Nonetheless, as the author suggests, there are potential longer term effects of maternal loss to treatment, such as loss of benefits of a holistic care package, or reduced engagement in child health programmes. This paper suggests that MMT should be considered as the first line approach for maternal opioid use.*

Home Office Cannabis potency study 2008, Hardwick et al. 2008 Home Office (HO)

In 2006, the Advisory Council on the Misuse of Drugs (ACMD) called for research into the potency of cannabis, and this is the HO's response. 23 police forces from England and Wales submitted 2921 confiscated samples for analysis. There was a significant rise in the proportion of herbal cannabis as opposed to cannabis resin (from 30 % in 2002 to 55% in 2005). A random selection of samples of sufficient size were submitted for microscopic analysis to differentiate intensively cultivated ('home-grown') herbal cannabis from imported. Biochemical analysis was used to determine the level of the main psychoactive ingredient in cannabis, 9-delta-tetrahydrocannabinol (THC) and another constituent, cannabidiol (CBD) which appears to show antipsychotic properties. The paper contains interesting graphs on regional variations in cannabis types.

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Results: Over 97% of the herbal cannabis had been grown by intensive methods. The mean THC concentration in intensively grown herbal cannabis was 16.2%, whilst in traditional imported herbal cannabis it was 8.4%, and in resin, 5.9%. Cannabis resin had a mean CBD concentration of 3.5%, but CBD was less than 0.1% in all herbal samples.

SMMGP comment: *The introduction of facts into the cannabis debate is very welcome, and debunks some of the wilder assertions being made by some newspapers, but the 'new cannabis' is probably between 03-05 times stronger. Also the fact that the strongest form is now the most commonly found is a concern, particularly as it contains only negligible amounts of the (possibly) psychoprotective CBD.*

The impact of worker values on client outcomes within a drug treatment service. *International Journal of Drug Policy: Volume 19, Issue 1, February 2008, Pages33-41. Rosie Phillips and Humphrey Bourne.*

Little attention has been paid to understanding the impact of values, attitudes and characteristics of drug workers on therapeutic relationships and treatment outcomes. This study investigates the impact of drug workers' personal values on client outcomes within a drug treatment service. Eight drug workers and 58 clients were recruited from a service working with socially excluded drug users

Results: Drug workers prioritising stimulation, self-direction and hedonism value types experienced more positive client outcomes compared with those prioritising security, conformity, benevolence, tradition and universalism types, concluding that drug workers personal values have a significant impact upon client outcomes in the treatment of substance misuse. Reasons for this are explored, as are limitations of this study and suggestions for future research.

SMMGP comment: *Although this is not copper-bottomed research and published nearly a year ago, the ratings from which the outcomes were derived were dependent partly on the worker's own judgment of how well their client was doing, so might have been influenced by those same personality characteristics but we still find it interesting. One could deduce from this that perhaps, the more like their clients workers were, the better the outcomes. There is also a good body of research which does confirm the notion of therapeutic alliance, which is not the same as this, but could be used more in practice. SMMGP have long suspected that but have only anecdotal evidence to support it that also the more we like our patients the better the outcomes?! Anybody fancy a study to confirm this, dare we say using a validated objective outcome scoring tool?!*