



SMMGP CLINICAL UPDATE - APRIL 2009

The Leeds Evaluation of Efficacy of Detoxification Study (LEEDS) prisons project: a randomised controlled trial comparing dihydrocodeine and buprenorphine for opiate detoxification. *Sheard et al. Substance Abuse Treatment, Prevention, and Policy 2009, 4:1*

Detoxification is a popular option for many new prisoners, but due to the lack of evidence base a wide variety of agents for opiate detoxification have previously been prescribed (e.g. methadone, dihydrocodeine, buprenorphine, lofexidine and clonidine). In this recent UK trial, 90 adult male prisoners requesting an opiate detoxification were randomised to receive either daily sublingual buprenorphine or daily oral dihydrocodeine, within a standard reducing regimen of not more than 20 days. 63 men (70%) gave a urine sample to assess the primary outcome of abstinence from illicit opiates five days post-detoxification.

Results : A higher proportion of people allocated to buprenorphine provided a urine sample negative for opiates (abstinent) compared with those who received dihydrocodeine (57% vs 35%, RR 1.61 CI 1.02–2.56, $z = 2.065$, $p = 0.04$). Although it showed superior efficacy over dihydrocodeine for detoxification, buprenorphine is highly amenable to diversion in prisons, and recruitment is currently underway for a 3-centre trial comparing methadone vs buprenorphine as prison detoxification agents.

SMMGP comment : Study supports the use of buprenorphine rather than dihydrocodeine for detox as long as measures against diversion are taken but it was unfortunate that a high proportion of subjects were lost to longer term follow up attempts, contributing to lack of statistical significance in outcomes at 1, 3 and 6 months. As the authors point out, 43% of subjects continued to use opiates during or immediately after detoxification, suggesting that a goal of abstinence is not realistic for many prisoners.

Curbing problem drinking with personalized-feedback interventions: a meta-analysis. *Riper H., van Straten A., Keuken M. et al. Request reprint American Journal of Preventive Medicine: 2009, 36(3), p 247–255.*

Primary care is always on the hunt for the ultra-brief, single shot screening tool or intervention and here is a meta-analysis evaluating one of the briefest; it examines the overall effectiveness of *comparing the individual's drinking to population norms* in a single session. This so-called 'personalised feedback', contextualising a patient's own behaviours, risks or test results, (as opposed to a more generalised description of a 'typical' case) is a key technique in motivational interviewing. The authors succeeded in finding 14 RCTs which focused solely on single session personalised feedback without any attempt at therapeutic intervention.

Results : On average studies showed a small to moderately statistically significant reduction in reported alcohol consumption, with a NNT (number needed to treat) of 8.06, on a par with brief interventions for smoking cessation.

SMMGP comment: An effective intervention that is realistic during a 10 minute GP appointment is very welcome. It also fits very well with the supporting literature for the alcohol DES – see the ‘what is everyone else like?’ section in the level 1 simple brief intervention at: <http://www.ncl.ac.uk/ihs/news/item/?brief-interventions-alcohol-and-health-improvement> (N.B. : this is a timely reminder that we may only have 1 more year of the alcohol DES – make sure your PCT is spending its money as intended!).

Plus - take a look at the [DH Alcohol site](#) which has a useful e-learning section and is packed with practical aids such as an easy unit calculator, how to do brief interventions and lots more.

NICE public health guidance 18: Needle and syringe programmes: providing people who inject drugs with injecting equipment. (NICE Feb 2009)

This public health intervention guidance is primarily aimed at commissioners and could almost be seen as a ‘Models of Care’ for needle exchange, in its requirement for a full range of needle exchange provision in every locality, and a general improvement in quality (e.g. 24 hour needle exchange). There are some new clinical implications too: specialised services should now be offering (or helping people to access): opioid substitution; treatment of injection site infections; vaccinations for hepatitis A and B and tetanus; testing and associated counselling for hepatitis B and C and HIV; psychosocial interventions; primary care services (including condoms and general sexual health services, dental care and general health promotion advice); secondary care services (for example, treatment for hepatitis C and HIV); welfare and advocacy services (e.g. advice on housing and legal issues).

SMMGP comment: Until now few specialist needle exchange services have offered tetanus vaccination, or testing for hepatitis B or HIV, or treatment for injection site infections. Commissioners may need to involve primary care if they are going to succeed in delivering these sorts of requirements. (See also SMMGP Mar 2009 Policy Update).

Coping skills training and contingency management (CM) treatments for marijuana dependence: exploring mechanisms of behavior change.

Litt M.D., Kadden R.M., Kabela-Cormier E. et al. Addiction: 2008, 103(4), p. 638–648.

This study attempts to examine how contingency management works for cannabis. 240 dependent adult cannabis smokers were randomly assigned to one of four nine-week treatment conditions:

1. Supportive case management, the control condition used as a benchmark for the other treatments;
2. Motivational enhancement therapy plus cognitive–behavioural coping skills training;
3. Standalone contingency management procedures rewarding cannabis abstinence with vouchers for retail goods or services, with no other therapeutic inputs;
4. A combination of contingency management with the motivational and cognitive–behavioural therapies.

The main outcome measure was total abstinence over the past 90 days with follow up every 90 days for the 12 months after treatment ended. Standalone contingency management led to the highest in-treatment abstinence rate, but as soon as treatment stopped, the effect faded, until by 8 months post treatment, abstinence was no better

than case management alone. Group 2 psychological therapies show moderate improvement during treatment which was partially sustained post-treatment. However, if it was enhanced by other psychological therapies, (as in group 4) the effect continued to grow over the whole follow up period to 14 months.

SMMGP comment: This study shows how CM can be made to fit best into an effective treatment programme, by harnessing the power of CM to induce change and the effectiveness of psychological therapies to sustain it. The study also suggested that CM, used wrongly, can actually erode motivation, and reduce a person's self-efficacy (belief in their ability to change). There is a fascinating discussion on the more effective use of CM as an empowering, rather than a controlling factor in managing behaviours.

NTA launches new mapping tool to promote behaviour change in drug dependent clients. http://www.nta.nhs.uk/areas/workforce/psychosocial_tools.aspx

The NTA and the British Psychological Society have jointly launched a long-awaited toolkit describing a range of psychological therapies to support drug users to overcome addiction. It is aimed at staff (practitioners, service managers and commissioners) and outlines core therapeutic skills needed to increase users' chances of recovery and reintegration. Incorporating techniques used in mental health treatment, the toolkit follows the government's Improving Access to Psychological Therapies (IAPT) programme and supports the view that a wide variety of interventions (including talking therapies) should be built in to treatment to accommodate clients with complex needs.

The toolkit is accompanied by a psychosocial interventions resource library (PIRL) to help practitioners improve the quality of psychosocial treatment available to their clients - [see PIRL website here](#). The tools include the International Treatment Effectiveness Project (ITEP) and Birmingham Treatment Effectiveness Initiative (BTEI) which comprise of a system of manuals. The manuals employ a series of 'maps' which help to structure psychosocial interventions, through a technique known as 'node-link mapping'. The full suite of documents is available on the NTA website.

SMMGP comment: We welcome the introduction of this toolkit on the NTA website and believe it is likely to have a positive influence on service provision. Whilst the BTEI appears to offer some valuable tools for providing psychosocial interventions, the implementation of the manual based approach could cause problems for services, if not done flexibly. For instance, if it was deemed essential to fill in a mapping sheet at the end of each session this could increase unnecessary paperwork for clinicians. It should be remembered too that not every client will respond favourably to a paper based approach to keywork. The node-linked mapping approach of BTEI is based largely upon American research. There is no published UK research into treatment outcomes of this intervention and it should be remembered that it was not included in the recent NICE psychosocial guidelines. There is some (as yet unpublished) indication that client engagement and satisfaction is improved and there are beneficial effects to the organization itself. It would be interesting to see more UK-based research regarding this intervention before it is widely implemented throughout the UK.

Relating counselor attributes to client engagement in England. *Simpson D., Rowan-Szal G.A., Joe G.W. et al. Journal of Substance Abuse Treatment: 2009, 36, p. 313–320.*
This summary is from an abstract published in 'Findings' April 09 and available as download from their excellent website at <http://findings.org.uk/index.php>

Effectively, this study seeks to relate the health of an organisation as perceived by its staff to how deeply its clients engage with its services. The study aimed to compare data from 44 voluntary and statutory agencies across England with similar data from the USA to test relationships held across different populations and treatment systems, in order to profile the 'organisational health' and resources of addiction services and the motivation and psychosocial functioning of their clients. Both these influences were then further analysed to establish how far clients reported actively engaging in their treatments and experienced a positive relationship with their counsellors or key workers – variables which have been found in other studies to in turn be related to better treatment outcomes.

Replies were from services for alcohol and drug clients and included day care programmes, outreach services, community drug teams, and Drug Intervention Programme teams in and around Manchester, Birmingham, or Wolverhampton. Each provided a 'snapshot' of clients and service profiles during the same fortnight in 2006. 1539 clients completed CEST (Client Evaluation of Self and Treatment) forms and 439 counsellors completed ORC (Organisational Readiness for Change) forms.

The analysis centred on two dimensions from the CEST form which reflected the client's engagement with treatment - **participation** in treatment was measured against compliance with treatment requirements, active engagement, and making therapeutic progress. Greater participation was significantly related to other items on the forms reflecting the client's motivation, including a greater desire for help with substance use problems, readiness to be helped through treatment, feeling that more intense treatment was needed to overcome substance use problems through treatment; and clients' psychosocial functioning. Greater participation was also related to greater self-esteem, a feeling of having good decision making skills, being in control and able to solve problems, and pro-social attitudes. Lower participation was related to anxiety, depression, hostility and a tendency to take risks. Similar relationships were found with the degree to which clients felt **rapport** with their counsellors - an amalgam of feeling understood, respected, supported and helped.

Averaged across all the clients at an agency, these same two dimensions were also related to that agency's functioning. Some significant relationships emerged, notably between client treatment participation and rapport with their counsellor, and how far the agency's staff felt that opportunities for professional development were provided and to what degree they took up those opportunities. The participation dimension was also related to staff's feelings that they had the skills to do their jobs, but were also willing to try new things and adapt, and to their perceptions that the agency had a clear mission and programme and that staff were not unduly pressured.

To narrow in on a more homogenous set of treatment services, another analysis confined itself to 22 agencies in the Birmingham region with 142 counsellors and 858 clients. Importantly, these clients could be individually linked (unlike in the broader sample and also unlike in the corresponding US studies) to their counsellors, meaning the client's engagement with treatment could be related to their *own* counsellor's perceptions of themselves and the service they worked for. At this level, client

participation was greater in services where premises were suited to counselling and which had gone further in developing electronic (computerised) systems for client assessments and records.

Apart from these concrete features, participation was also greater in services characterised by team working and mutual trust among staff, and which encouraged discussion and implementation of new ideas and procedures – attributes also related to greater client rapport with their counsellor. In addition, rapport was greater when staff felt services had adequate guidance on providing an effective service, were better resourced in terms of staff, training, and equipment, had a clear mission and programme, fostered open communication, and were receptive to staff suggestions, ideas and concerns.

Given the Birmingham findings, the analysts concluded that relationships between organisational functioning and quality of services were rooted in the personal interactions between clients and counsellors. The implications were that engagement might be improved by starting treatment with interventions (if needed) to rectify clients' low motivation, poor mental health, and anger-related problems, and by developing well resourced organisations which foster communication, participation and trust among staff, have a clear mission, but are open to new ideas and working practices.

SMMGP comment: Although this study was not done across general practice it is an interesting and wide-ranging investigation of the organisational health of services and how it impacts on people. Despite their complexity, there is coherence to the findings with the role of openness to change being the most striking. Staff working in an atmosphere of support and respect for their views, and concern for their development, tended to have clients who also felt understood, respected, supported and helped.

Drinking Patterns, dependency and life-time drinking history in alcohol-related liver disease. *Jennifer Hatton et al Addiction April 2009 volume 104 number 4 page 587- 592*

This paper examines one theory behind the astronomical rise in UK death rates from liver disease (400% in the last 40 years, with more than 80% a direct result of alcohol) by testing the hypothesis that it is due to a rise in episodic or binge drinking as opposed to regular harmful drinking.

A prospective survey of 234 consecutive patients attending a UK liver unit was carried out using face to face interviews, validated alcohol use, dependency questionnaires and liver assessment. In 106 patients, liver disease was attributable to alcohol. Over three-quarters (71%) drank on a daily basis, whilst those few who drank less than 4 days a week had largely adopted this pattern recently against a background of drinking more frequently for most of their lives. Indeed only one patient with alcoholic liver disease (ALD) had consistently drunk infrequently (3 days per week for fifteen years). In addition the majority of patients were drinking more than they had in their youth. The paper concludes that increases in UK liver deaths are a result of daily or near daily heavy drinking - not episodic or binge drinking - and this regular drinking pattern is often discernable at an early age.

SMMGP comment : A very striking histogram in this paper demonstrates clearly the strong association between daily drinking and severe ALD. Whilst binge drinking brings its own problems, we should not ignore our young patients who consistently drink daily – according to this paper they are at high risk of ALD in later life.