

Opiate misuse

Data Focussed Commentary

Illicit drug use in the UK

A report to the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) contains useful information about the use of illicit drugs in the UK up to 2007.¹ It states that:

- 35% of adults had used one or more illicit drugs in their lifetime
- in young adults, 24% had used illicit drugs in the previous year
- men are significantly more likely to use drugs than women
- cannabis is the most commonly used drug
- in the 16–59 age group, 30% had used cannabis in their lifetime
- 10 people per 1000 population aged 15–64 years are estimated to be using drugs in a chronic, potentially damaging way.

In 2005, there were 1,827 drug-related deaths in the UK.¹ Other problems related to illicit drug use include:

- HIV
- hepatitis B and C
- crime
- truancy
- injection site infections.

Prescribing data (PACT)^{*}

The following PACT data is from the Prescription Pricing Division. Figure 1 shows the number of prescription items of methadone dispensed in general practice in England. Figure 2 shows expenditure on methadone in general practice in England (see footnote):

^{*} Prescribing trend charts in this document refer only to data derived from prescriptions written in primary care settings. However a significant proportion of prescribing for substance misuse takes place via FP10HP prescribing within community-based substance misuse teams hosted by secondary care organisations. Therefore some of the changes in prescribing patterns seen here may reflect changes in the configuration and organisation of services rather than changes in the overall patterns of use of these drugs.

Figure 1: Trends in the prescribing volume of methadone in general practice in England, 2002 – 2007.

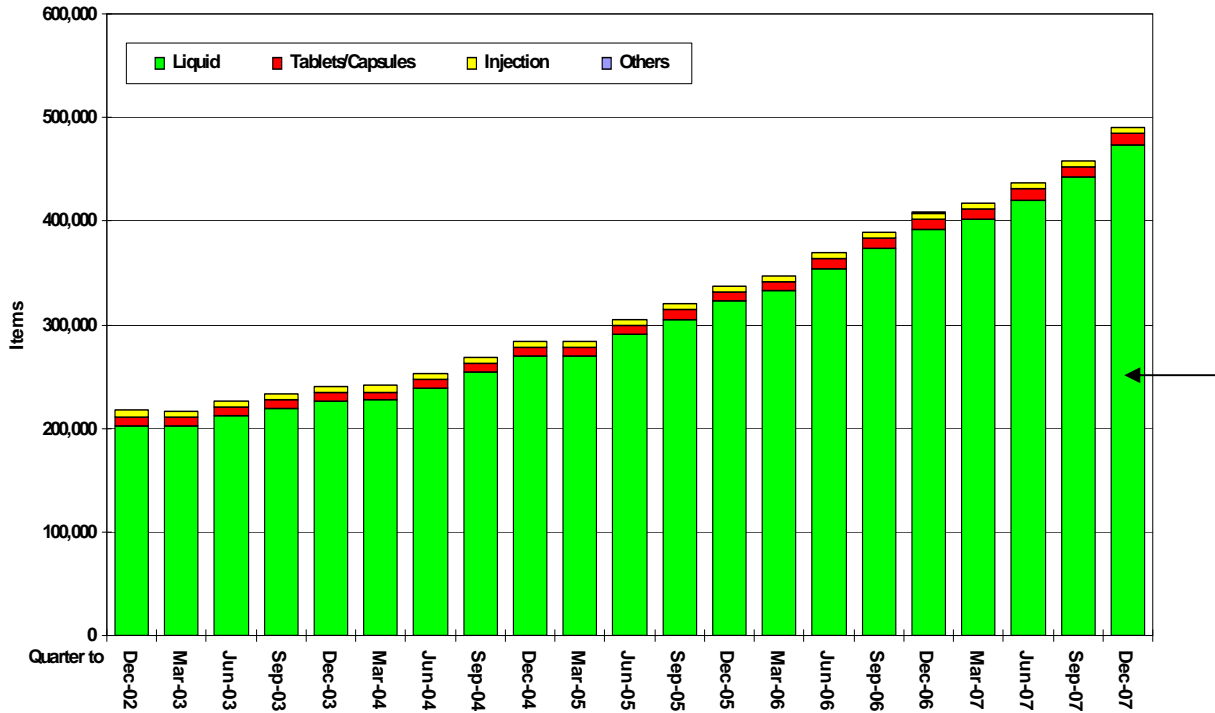
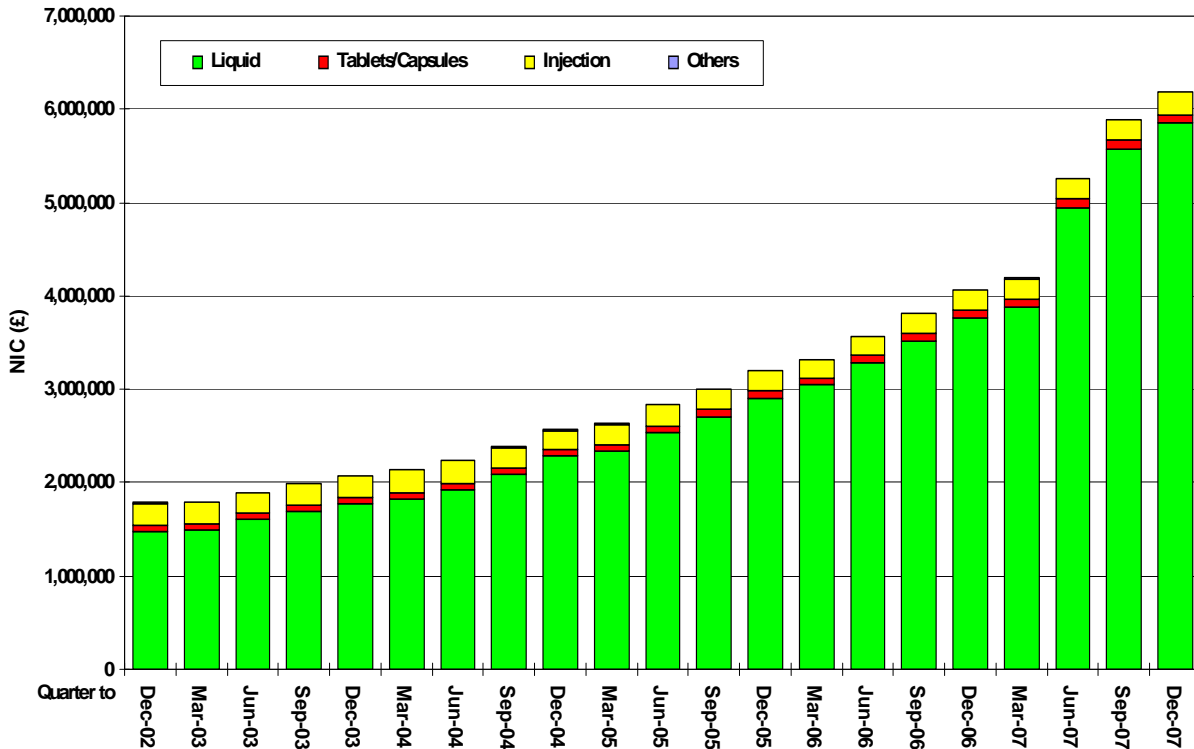


Figure 2: Trends in expenditure on methadone in general practice in England, 2002 – 2007.



Between 1990 and 2001, NHS prescriptions for methadone dispensed in England tripled from 425,400 to 1,318,100 annually.² The above graphs show that this trend is continuing. Based on these data projected annual prescribing volume in 2008 is set to increase to around 2 million items.

However, it is not possible to tell from these data alone whether these data reflect an overall increase in methadone prescribing, increases in the proportion of methadone prescribing accounted for by installment prescriptions, more people undergoing treatment, changes in acquisition cost of drugs for substance misuse, shifts in prescribing patterns between primary care and specialist services settings, or a combination of these factors.



How would you gather information on trends in methadone prescribing in your area?



What are local and national drivers for methadone prescribing?

Primary care



Do methadone maintenance treatment programmes work in primary care settings?

Research conducted in general practice settings by Keen et al³ points to benefits arising from the provision of methadone maintenance treatment services based on the 1999 version of UK national clinical guidelines ('Orange Book').

Does MMT based on 'the orange book' work in primary care?

Keen J, et al. Br J Gen Pract 2003;53:461-7

- The first 96 eligible consenting patients entering treatment were recruited; 65 completed the study
- The intervention consisted of a methadone maintenance treatment provided by GPs with prescribing protocols based on the 1999 national guidelines
- **Frequency of heroin use (confirmed by urinalysis) was reduced** from a mean of 3.02 episodes per day (SD = 1.73) to a mean of 0.22 episodes per day (SD = 0.54). $P < 0.001$
- **Mean numbers of convictions and cautions were reduced** by 62% ($P < 0.001$) for all crime
- HIV risk-taking behaviour, social functioning, and physical and psychological well being all showed significantly positive improvement



(SD stands for standard deviation and is a measure of the spread of the results.)

The P-value gives a measure of the likelihood that a result in a study is a real effect rather than one due to chance. By an arbitrary convention, if the P-value is ≤ 0.05 the effects of 2 interventions are said to be statistically significantly different. A P-value of < 0.05 means that this result would have arisen by chance on less than one occasion in 20.

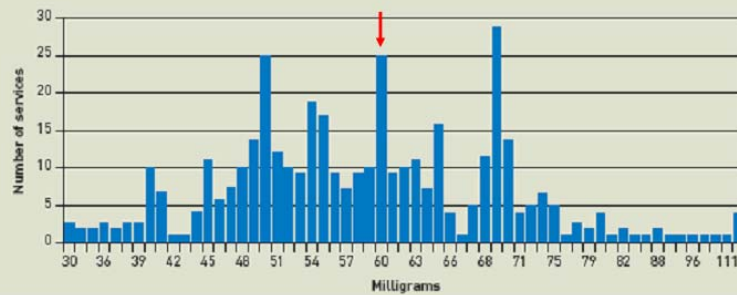
However further research^{4,5} has shown that prescribed doses of methadone are generally below those recommended in national clinical guidelines (60 –120mg/day).⁶

Methadone doses are still low

Healthcare Commission & NTA improvement review. 2006

- The mean methadone dose nationally was **57mg**
- Only 30% of services had a mean dose above 60 mg

Figure 8: Average doses of methadone for maintenance prescribed by local drug partnerships



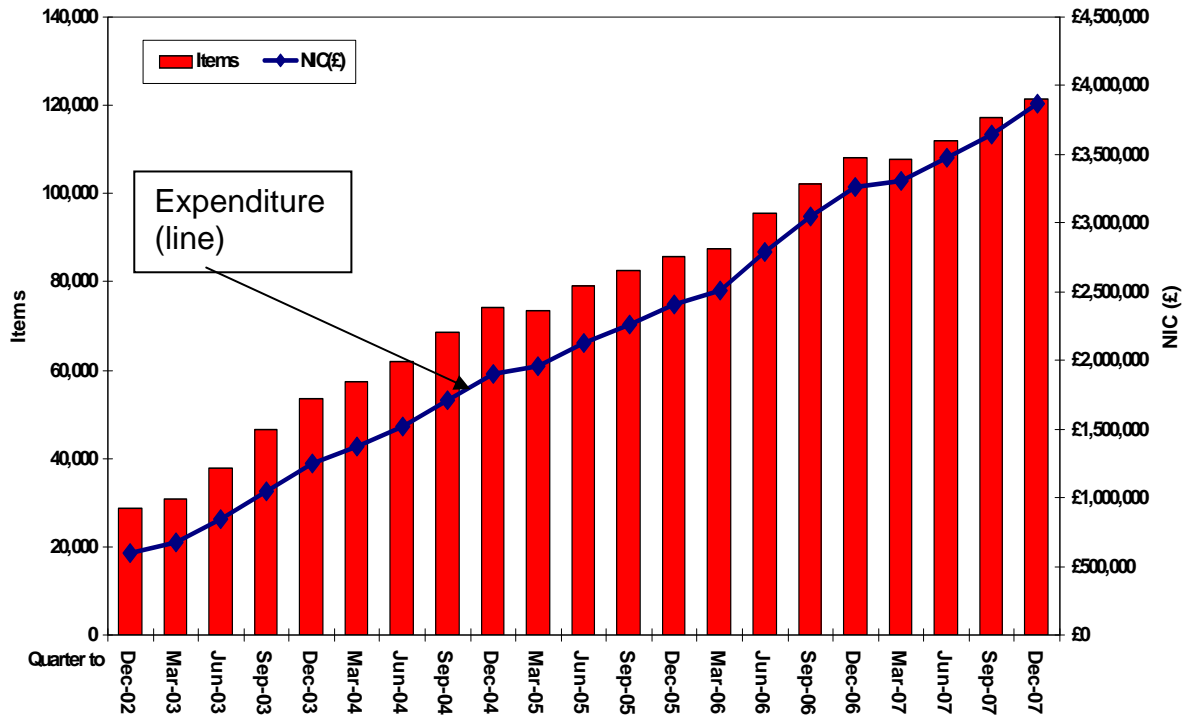
What about buprenorphine prescribing?

Recent years have also seen increases in prescribing rates of buprenorphine, although the prescription volume is lower than methadone.



Why are prescribing rates of buprenorphine increasing?

Figure 3: Trends in the prescribing volume and cost of buprenorphine and buprenorphine/naloxone for opioid dependence in general practice in England, 2002 - 2007.



In its Technology Appraisal of methadone and buprenorphine for the management of opioid misuse, NICE said that either of these options could be offered as first-line treatment in opioid detoxification. When deciding between them, healthcare professionals should take into account:

- the decision about which drug to use should be made on a case by case basis, taking into account a number of factors, including the person’s history of opioid dependence, their commitment to a particular long-term management strategy, and an estimate of the risks and benefits of each treatment made by the responsible clinician in consultation with the person
- the preference of the patient.

Overall, NICE said that if both drugs are equally suitable, methadone should be the first choice treatment for managing opioid dependence. Therefore we would expect buprenorphine rates to be below those of methadone, and indeed this is currently the case.



Some further points for reflection:

- In your own area, do prescribing data show a difference in the rates of prescribing for buprenorphine and methadone?
- What are the mean daily doses of methadone used in your area? Are they high enough? (Higher doses are associated with higher levels of retention in treatment programmes).
- Are primary care healthcare professionals in your area fully engaged with the provision of substance misuse treatment services? What are the barriers that prevent more people getting involved?

Clinical guidance

A number of guidance documents have been issued in recent years to try to improve the care of patients who misuse drugs, and opiates in particular. These include:

- Drug Misuse and Dependence—Guidelines on Clinical Management (better known as the “Orange Book”)⁶
- NICE clinical guideline on opioid detoxification⁷
- Guidance from the Royal College of General Practitioners (RCGP)^{8,9}
- Healthcare Commission/National Treatment Agency review of treatment services for substance misusers⁵
- Guidance on pharmaceutical services for drug misusers¹⁰

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