SMMGP News and Updates

SMMGP news and updates for members, including Policy and Clinical updates.

SMMGP Policy Update

How can opioid substitution therapy be optimised to maximise recovery outcomes for service users? *Advisory Council on the Misuse of Drugs Recovery Committee, October 2015* **http://tinyurl.com/ACMD-report**

A new report published by the Advisory Council on the Misuse of Drugs (ACMD) says high quality drug treatment for heroin users is cost-effective and benefits both individuals and society, and that that everyone with heroin dependency should have access to high quality drug treatment.

The ACMD found that the current quality of drug treatment in England varies significantly and is *being compromised by frequent re-procurement and shrinking resources*.

The report calls for investment in drug treatment to be protected and a national quality improvement programme to be implemented. The report was written for the Inter-Ministerial Group on Drugs, which asked the ACMD's Recovery Committee to examine how opioid substitution therapy could be improved to get better results for those suffering heroin addiction.

The report has drawn comment from various sources, with a blog post by Russell Webster entitled *It's Official - Heroin Treatment Under Threat* producing a helpful summary of its conclusions. **http://www.russellwebster.com/its-official-heroin-treatment-under-threat/**

In the light of the findings of the report Steve Brinksman, SMMGP's Clinical Lead comments: "We will continue to champion the treatment of drug dependence in primary care as the best place for *the provision of quality, constant and compassionate care as for all patients with complex conditions*".

Public Health England surveys of NSP providers in England

PHE Alcohol and Drugs Directorate have extended their **online surveys of providers and commissioners of needle and syringe programmes** – both surveys will now close on **Friday 13 November**. **Please respond to these important surveys if you are involved in NSP and have not already done so**. There were some technical problems with the surveys initially, which have now been resolved, so if you were frustrated at a previous attempt, please try again. Responses to this survey will be used to show the value of investment in interventions that reduce drug-related health harms.

A survey for **providers** is available here:
https://surveys.phe.org.uk/TakeSurvey.aspx?SurveyID=NSPProv2015

A survey for **commissioners** is available here:
https://surveys.phe.org.uk/TakeSurvey.aspx?SurveyID=NSPComm2015
The survey should be completed only once by each local commissioning area or each NSP site, whichever is applicable.

Answers will remain confidential and any published findings will be anonymised.

SMMGP Clinical Update

The SMMGP Clinical Update is compiled by Euan Lawson. This issue includes:

- Hepatitis C prevention and convenience: why do people who inject drugs in sexual partnerships 'run out' of sterile equipment?
- QTc prolongation in veterans with heroin dependence on methadone maintenance treatment.
- Heroin on trial: systematic review and meta-analysis of randomised trials of diamorphine-prescribing as treatment for refractory heroin addiction.
- The paradox of control: An ethnographic analysis of opiate maintenance treatment in a Norwegian prison.

Hepatitis C prevention and convenience: why do people who inject drugs in sexual partnerships 'run out' of sterile equipment? *Fraser S, Rance J, Treloar C. Critical Public Health 2015, Apr 29.*

This article is an analysis based on 80 in-depth qualitative interviews conducted with individuals in heterosexual relationships where injecting drug use had been involved. They were recruited between 2012 and 2013 from Australia in the state of New South Wales, Victoria. Purposive recruitment was used to reach couples where both partners were identified as people who inject drugs. The same researcher interviewed both members of the partnership separately.

The authors treated people who are injecting drugs like consumers and used this market framework and perspective to analyse and inform their findings. When asked about sharing injecting equipment many participants reported that they had "run out". Even though they had good knowledge of the risks of shared equipment, in particular around hepatitis C, they ran out in much the same way as any consumer will run out of goods from time to time. One of the other themes discussed in the findings was convenience. All of the users recognised that running out of equipment wasn't a good thing and some of them chose to pick up boxes of 100 needle syringes from the exchanges to improve convenience. Much of this convenience was determined by opening hours and public holidays in the same way as any other consumers.

Users in sexual partnerships also described their use of injecting equipment in various contexts. For instance, taking care with injecting and letting the HCV positive partner go first was an expression of love and trust. For one male, letting his partner go first was the 'gentlemanly' way to behave.

Commentary: The underlying premise of this research is an important one – although the responsibility for safe injecting is placed on the individual people live (and therefore) inject in the context of their relationships and sexual partnerships. It's easy to forget that people,

including those who inject drugs, tend to behave rationally. This means we can be savvy about how we get people to engage with organisations such as needle syringe exchanges. Providing adequate coverage in a reasonable geographical area remains an important part of harm reduction services and providing adequate quantities of equipment will also help reduce sharing practices, even in stable partnerships. Exploring injecting within relationships should be an important part of an injecting history and ongoing management.

The authors state:
"We begin by noting the value of treating people who inject drugs like other consumers of goods and services, as knowledgeable and reasonable members of the community whose desires and priorities cannot simply be dismissed as dysfunctional or disordered."

That's not a bad principle to adopt when exploring any behaviour.

QTc prolongation in veterans with heroin dependence on methadone maintenance treatment. *Hassamal S, Fernandez A, Moradi Rekabdarkolaee H, Pandurangi A. Int J High Risk Behav Addict 2015, Jun 20;4(2).*

This paper reports on a study of 59 veterans in the USA who were on a stable dosage of methadone to treat their heroin dependence. They obtained ECG data by using 12 lead electrocardiograms both pre-methadone and while they are on methadone. They then retrospectively collected data on risk factors from the medical records.

The mean QTc at baseline (pre-methadone) was 426 +/-34ms and after being on methadone for an average of 8.7 years this had increased to 450ms. There was no significant relationship between QTc prolongation and risk factors except for serum calcium levels. Those veterans who had a rise of more than the average of 24ms were on higher doses of methadone. None of the veterans experienced cardiac arrhythmias.

Commentary: This study had more men who were older and the average age was just under 57. Age is an independent risk factor for QTc prolongation and four of the veterans in this study had a QTc of >500ms and had continued with methadone without any cardiac toxicity. It could be that the numbers are just too small in this study but that seems to be a recurring theme in evidence around QTc prolongation - case reports are highlighted but epidemiological evidence doesn’t back up concerns about arrhythmias.

I’ve certainly seen methadone prescriptions being limited in individuals whose QTc interval has remained comfortably within what most people would regard as safe limits. There doesn't seem to be a lot of doubt that methadone increases the QTc interval - I don't think many people are going to argue about that.

However, it's worth bearing in mind that the review by the Cochrane Group in 2013 found insufficient evidence to support the use of routine ECGs to prevent arrhythmias in people on methadone.

Heroin on trial: systematic review and meta-analysis of randomised trials of diamorphine-prescribing as treatment for refractory heroin addiction. *Strang J, Groshkova T, Uchtenhagen A, van den Brink W, Haasen C, Schechter MT, et al. Br J Psychiatry 2015, Jul;207(1):5-14.*

This systematic review found six RCTs that met the inclusion criteria for analysis. Supervised injectable heroin (SIH) treatment improved outcomes across all the trials. Generally there was a reduction in the use of illicit street heroin compared with the control groups, which were quite often receiving oral methadone maintenance treatment. The six studies are outlined below.

Switzerland 1998. This was a small study with just 51 participants and was the very first randomised trial of SIH. They compared injectable diamorphine and methadone maintenance treatment over a six-month period. The two groups had equivalent retention but the group receiving SIH had greater reductions in illicit heroin use and in crime at the six month point.

Netherlands 2003. There were two Dutch randomised trials and these had much bigger samples (n=594) with a robust study design. They found a better retention rate from methadone maintenance treatment at 12 months compared with SIH but the heroin prescribed group were much better “responders”. They also found it was cost-effective.

Spain 2006. This small randomised trial with 62 participants found equivalent retention and significantly greater reduction in self-reported illicit heroin use in the diamorphine group at the nine month follow-up point.

Germany 2007. This was a large multisite trial with over 1000 participants and they found higher retention in the SIH group compared with the methadone group. It was also the first trial to include objective laboratory test results. They found greater proportions of the SIH group reporting reduced heroin use. This study was also very careful to ensure those receiving oral methadone were appropriately dosed.

Canada 2009. This was the NAOMI (North American Opiate Medication Initiative) trial, which was based at two sites and had 226 participants. They found significantly higher rates of retention in the SIH group as well as better clinical response scores.

England 2010. Our own RIOTT (Randomised Injectable Opioid Injectable Treatment Trial) was the first trial that used laboratory illicit opioid test results as the pre-declared primary outcome measure. Good retention was achieved in all groups and they found that at months 4 to 6 the SIH group were significantly more likely to provide urines that were negative for illicit heroin.

Commentary: In many ways I find this a somewhat depressing topic as it apparently remains, at least in our corner of the UK, an almost entirely theoretical discussion despite the evidence of benefit (in carefully selected groups of patients). As the authors do, it is worth drawing attention to the Cochrane reviews of 2005 and 2011 that looked at injectable heroin. The initial Cochrane review felt that no definitive conclusions about the overall

effectiveness of heroin prescription could be made. However, in 2011 the Cochrane group went on to conclude that heroin prescription should be provided in clinical settings for those who currently or previously had failed maintenance treatment. The authors describe a number of potential reasons why SIH has not been implemented. These include: issues such as “diamorphophobia” where there is anxiety about using heroin as a medicine – while the UK has used diamorphine for decades many countries associate heroin entirely with its illicit use; concerns about security and public safety; and the financial costs of providing the care. Some of these need further study but, if nothing else, one can be clear that what was once an important barrier, the evidence on clinical effectiveness, has been hurdled.

The paradox of control: An ethnographic analysis of opiate maintenance treatment in a Norwegian prison. *Mjåland K. Int J Drug Policy 2015, Aug;26(8):781-9.*

This was a report of the author’s ethnographic research as he spent eight months in a Norwegian prison observing participants. As part of this work he interviewed 23 prisoners and 12 prison staff. Halfway through his research the prison authorities, in response to concerns about security and diversion of buprenorphine, introduced a separate unit for prisoners on the opiate maintenance treatment programme providing a natural experiment that could be studied.

His research found that there was a strict and repressive control system in place to control the diversion of buprenorphine. He also noted that diversion of buprenorphine *increased* with the establishment of a new unit where the repression was even stricter. This was perceived as illegitimate and unfair by the prisoners and, in myriad ways, the prisoners protested by confronting and subverting the programme.

Commentary: Human behaviours are complex and while they are often predictable they are not necessarily the straightforward responses one might be tempted to assume. Mjåland’s research seems to be a good example: increasing supervision created an atmosphere and culture of subversion as the prisoners pushed back against the regime. These lessons are almost certainly transferable to community settings as well. Punitive and degrading control measures are likely to result in similar examples where those in the system subvert and resist. This is the “paradox of control”.