

# Audit of longitudinal opiate substitution therapy prescribing 2009

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## INTRODUCTION

Much effort has been put into finding doses of methadone that will be effective in reducing consumption of street heroin by opiate addicts.

However, there is less data about what happens over the next few months during and after stabilisation to prescribing regimes. Data from the National Drug Treatment Monitoring Service record that 153,000 people were receiving prescribing services in 2009-10 and that 15,000 (9.8%, if all were receiving prescribing) completed treatment drug-free (NDTMS 2010). Similar figures from the previous year (NDTMS 2009) have been incorporated into proposed Government policy in the recent Green Paper *Criminal Justice and Addiction* that may form the basis of the new Government's strategy for addiction treatment, with emphasis on getting people dependent on heroin off all opiates and into recovery (CSJ 2010).

With the recovery agenda in mind we felt we needed to examine client's progress towards reduction and abstinence in substitute prescribing. We therefore undertook an audit of people started on opiate substitution therapy in our service to see the patterns of progress that occurred in the subsequent few months up to 1 year. We report here the findings of this pilot study.

## METHOD

Health Link is a statutory Tier 3 alcohol and drug treatment service for residents of Bedfordshire (excluding Luton) that includes Bedford, Leighton Buzzard and Dunstable, and other small towns in Bedfordshire, a mixed urban and rural area around 50 miles north of the outskirts of London. It is run by a South Essex Partnership Foundation NHS Trust (a combination of a Mental Health provider and Social Services). As part of a complex network of services that combine to form the drug treatment system for the area, the majority of people seeking treatment for opiate addiction go to the Bedford Shared Care Service, a Tier 2-3 service run by primary care physicians. Patients with complex needs, including heavy alcohol and opiate use, or dual diagnosis of an addictive disorder and a severe and enduring mental illness, come to Health Link.

Patients who were started on opiate substitution therapy in 2009 were identified. Prescriptions for methadone and buprenorphine are generated using a proprietary electronic system (BOMIC). The system retains records of all prescriptions generated, permitting review of changes over time. Patient records were followed up to 1 year from starting.

## RESULTS

In the calendar year 2009, 23 patients were started on Opiate Substitution Therapy. 14 (61%) were male. Average age 35.1 years (range 24.8 – 48.1 years)

9 had not completed a year in treatment by the time of the audit, 3 had not completed 9 months.

### Prescriptions

	Number	Starting daily dose (mg)
Methadone	20	Mean 50.8, range 20 - 100
Buprenorphine	3	

## Patterns

We identified three detoxification patterns, three stabilisation patterns and one relapse pattern (Figure 1)

- At 3 months, 16 patients (70%) were exhibiting a stabilisation pattern; at 12 months 13 patients (57%)
- People who had an 'r' pattern had a lower initial dose than those with a 'line pattern'
- At 3 months, 4 patients (17%) were exhibiting a detoxification pattern; at 12 months 5 patients (22%)
- People exhibiting detoxification patterns did not have a higher starting dose than those exhibiting stabilisation patterns
- At 3 months, 1 patient (4%) was exhibiting a relapse pattern; at 12 months 3 patients (13%)

In respect of change of dose,

- The majority of patients did not change their dose.
- For those patients for whom the dose was changed, the average rate of change was 1-2mg per month reduction, with the highest monthly change being a reduction of 16.67 (i.e. 4mg per week)
- The pattern of increasing dose was highest in the first three months, but after this, 60-70% did not reduce
- There is an increase in the number of patients reducing their doses after 6 months.

## DISCUSSION

This is a very small pilot study, looking at the longitudinal changes in prescribing patterns in the first year of opiate substitution therapy. We found that the most common pattern for patients in the first year of treatment is to stabilise, but that after 6 months, more people start to detoxify. However, detoxification dose reduction rates are extremely slow and none of our patients completed detoxification in the year's time frame.

There are few studies analysing the progress of methadone maintenance in such detail. Calsyn *et al* (2006) in a study of 30 patients on methadone maintenance having their dose slowly reduced in a taper fashion found that none of them achieved abstinence. Milby (1988) conducted a metanalysis combining several different studies over three five year periods to see how many patients on methadone maintenance reached abstinence. He found that detoxification completion rates were 39.7% (1970-75), 54.9% (1976-80) and 76.3% (1981-5). His findings suggested that the increase in detoxification completion was related to introduction of brief detoxification with  $\alpha$ 2-adrenergic agonists such as clonidine. O'Connor *et al* (1997) found in a study of 162 heroin-dependent patients that 65% of patients receiving clonidine, 81% of those receiving a clonidine-naltrexone

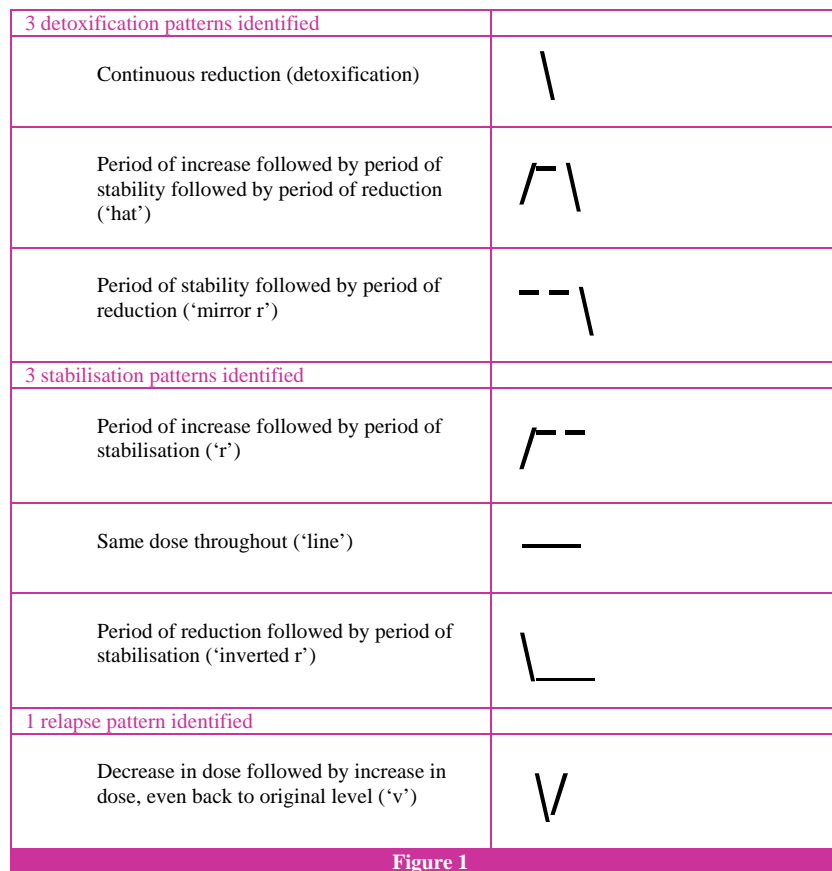


Figure 1

combination and 81% of those receiving buprenorphine completed detoxification over 8 days. Kornør and Waal (2005) in a review of detoxification studies from methadone maintenance found an abstinence rate of 22-86% (mean 33%), though the period of abstinence ranged from 1 to 103 months. Patients reached 0mg in 7 weeks to 7 months. The patients had been on methadone maintenance from 1-48 months before starting detoxification.

This small study needs repeating on a larger scale. The data needs to be related to the clinical status of the patients, including the extent of their use on top.

Until such data are available, our findings and the limited data from the literature suggest that there should be extreme caution in exerting undue pressure on patients to detoxify, and stabilisation in the first year should be seen as an acceptable clinical goal.

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