Northumberland
County Council

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HEALTH AND WELLBEING OVERVIEW AND SCRUTINY COMMITTEE

15th May 2018

SPECIALIST COMMUNITY SUBSTANCE MISUSE SERVICES IN NORTHUMBERLAND

Joint Report of: The Director of Public Health, Northumberland County Council and Deputy Chief Operating Officer, Northumberland Tyne and Wear, NHS Foundation Trust

Cabinet Member: Cllr Veronica Jones, Adult Wellbeing and Health

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Purpose of report

The Cabinet Member for Adult Wellbeing and Health undertook at the Full Council meeting on 3 January 2018 to report further to this Committee about issues relating to methadone prescription which had been raised in a Member question. The specific questions concerned:

- The average length of time people were kept on methadone;
- Whether methadone has been linked to suicide;
- The commercial interests of companies by continuing to have people kept on methadone.

The report also provides more information regarding the evidence relating to opiate substitution therapy (OST) and clinical guidance about this; the approach taken to this therapy; and the wider treatment and recovery support and benefits provided by the specialist substance misuse service in Northumberland.

Recommendations

The Committee is recommended to note the content of the report and provide comments.

Key issues

- Drug misuse treatment is often characterised by a number of treatment episodes throughout a lifetime; during this time, the dosage will fluctuate as patients stabilise or risk changes. This makes it difficult to gather data on the length of time any one person has prescribed methadone and is less useful as a measure of progress or success.
- OST is effective in reducing the risk of a range of drug related harms including injecting, the spread of blood borne viruses in the community such as hepatitis B and C as well as the use of illicit substances. There is no significant evidence of an association between methadone use and suicide.
- Methadone and buprenorphine, both of which are used in OST are effective in treating illicit opiate use such as heroin. Reductions in the use of illicit substances therefore reduces the likelihood of engaging in acquisitive crime to fund drug use which has a positive impact on our communities. It is the strong evidence for this approach which is based on clinical studies; the evaluation of substance misuse programmes globally; and the consensus of experts in the field, promulgated via national guidelines that encourages the prescribing of OST rather than commercial interests.
- OST should be delivered as part of a wider treatment and recovery system which also provides psychosocial and recovery support. Current General Medical Council guidance on Good Medical Practice, the multi-disciplinary approach to managing service users and the governance mechanisms in relation to the operation of the pharmaceutical industry will preclude patients from being maintained for longer than is clinically necessary.

Background

Opiates have been used to treat pain for centuries. Over the same period of time, the medicinal use of this class of drugs has had to be balanced with the euphoric effects that have induced its misuse and abuse. In England, recommendations around the supportive prescribing of addictive drugs in a controlled manner date back to the 1926 Rolleston report. Although the nature of substance misuse continues to change and the focus of substance misuse interventions has reoriented on harm minimisation and recovery oriented programmes, substitution therapies such as methadone remain a key intervention.

Introduction

The effectiveness of well-delivered, evidence-based treatment for drug misuse is well established. UK and international evidence consistently show that drug treatment, covering different types of drug problems, using different treatment interventions, and in different treatment settings impacts positively on levels of drug use, offending, overdose risk and the spread of blood-borne viruses. For a significant proportion of those entering treatment, drug treatment results in long-term sustained abstinence[1].

Why OST is recommended in the treatment of substance misuse disorders

Pharmacological approaches remain extremely important and have clearly demonstrated efficacy (that they work in controlled or ideal circumstances) and effectiveness (that they work in 'real world' conditions) for those with problems related to the use of heroin or other opiates. Methadone and buprenorphine are prescribed drugs used in OST and are effective medicines for the treatment of opiate dependence. Their use is recommended by the National Institute of Health and Care Excellence (NICE) whose role is to improve outcomes for people using the NHS and other public health and social care services by producing evidence-based guidance and advice for health, public health and social care practitioners. Access to OST is also recommended by the Drug Misuse and Dependence UK Guidelines on Clinical Management (2017) as a pharmacological intervention within a wider treatment and recovery plan including psychosocial interventions (non-medical interventions used to change a person's behaviours towards a more healthy interaction with society) and recovery support.

There is strong international evidence that OST can lead to a reduction in the use of heroin, and the harmful behaviours which are characterised by heroin use. The evidence is clear that OST:

- Reduces the likelihood of injecting heroin intravenously; the sharing of needles and syringes; and the risk of vein damage and transmission of blood borne viruses such as HIV and hepatitis;
- Reduces the likelihood of engaging in acquisitive crime to fund heroin use;
- Reduces mortality – the risk of drug related death increases for those not in effective OST treatment;
- Reduces hospital admissions; and
- Reduces the likelihood of misusing other illicit substances.

The research, the international track record and clinical experience indicates that not everyone who comes into treatment will overcome their dependence; it is not possible or ethical to predict which individuals will or will not fall into this category. For this reason, the

[1] Drug misuse and dependence UK guidelines on clinical management, Department of Health (2017)

treatment programme makes every effort to provide the right package of support to maximise every individual's chances of recovery.

Well-delivered OST provides a platform of stability and safety that protects people and creates the time and space for them to move forward in their personal recovery journey[2]. It is not acceptable practice to impose time limits on treatment that take no account of individual history, needs and circumstances, or the benefits of continued treatment. Treatment must be supportive and aspirational; realistic and protective. Arbitrary or premature curtailment of an individual's OST will not help them sustain their recovery and is not in the interests of the family and carer circle or the wider community. Time-limiting OST would be prejudicial to those with drug problems and is contrary to the international scientific evidence base.

Whilst every pharmaceutical manufacturer has a commercial interest in promoting its products, there are controls in place to regulate the relationships between healthcare staff and manufacturers. The Association of British Pharmaceutical Industries has its own code of practice which includes this element of activity and through which sanctions can be applied. As previously highlighted it is the extensive evidence of effectiveness and cost effectiveness which incentivises healthcare professionals to prescribe OST currently. It should be noted that methadone is a relatively inexpensive medication so in the context of the total cost of OST, the drug itself remains one of the smallest elements, with the costs of pharmacy supervision, NHS Business Services Authority dispensing and professional fees being the larger element.

The benefits of OST as part of a wider treatment and recovery system

Implementing the treatment process involves comprehensive assessment, active engagement, and collaborative teamwork across local health, social care, family services, education and employment services, utilising the broad range of evidence-based interventions for substance use/misuse and for comorbid conditions, and active follow up. Coordinated, well-led interventions should mobilise resources of local communities, including safeguarding, education, training, mental health and resilience building.

Since 2013, the Northumberland Recovery Partnership (NRP) has delivered specialist substance misuse services led by Northumberland Tyne and Wear NHS Foundation Trust (NTW) with Changing Lives and Turning Point completing the partnership. This partnership delivers the range of interventions recommended by NICE and other national guidance and provides a mix of interventions ranging from clinical services, harm reduction interventions, structured day programs, psychosocial support, structured and informal

[2] Medications in Recovery, re-orientating drug dependence treatment, National Treatment Agency (2012)

groups, recovery support for employment, training and housing and the support and coordination of a wider network of volunteers and peers who provide access to mutual aid.

Drug misuse is a chronic relapsing condition. Patients may make several attempts over several years to become stable and ultimately 'drug free'. Relapse should not be considered as a failure of the programme. From our existing data sources, it is not possible to determine the average time a person is in receipt of OST. Data is collected on the numbers of people in treatment for opiate misuse and the length of time of the current treatment episode. However this data set does not capture previous treatment episodes, whether the individual is in receipt of OST, how long the prescription is for or the dosage. This information is held in their individual care plan so it is not possible to determine the average length of time that a person is in receipt of OST and as this is not a useful indicator of successful treatment outcomes, there is little clinical value in collecting this data.

Entering and staying in treatment, coming off of OST and exiting structured treatment are all important indicators of an individual's recovery progress, but they do not in themselves constitute recovery. Coming off OST or exiting treatment prematurely can harm individuals, especially if it leads to relapse, which is also harmful to society. Recovery is a broader and more complex journey that incorporates overcoming dependence, reducing risk-taking behaviour and offending, improving health, functioning as a productive member of society and becoming personally fulfilled. These recovery outcomes are often mutually reinforcing. The evidence is clear that the likelihood of becoming and remaining employed is increased for heroin users who participate in methadone maintenance treatment; this evidence comes from multiple studies of addicts in similar programmes.

People in treatment or in the criminal justice system who have used opiates are six times more likely to die prematurely than people in the general population[3]. They are particularly at risk soon after leaving treatment[4] or prison[5]. People who use opiates and have never been in treatment are at greatest risk of drug-related death[6] (PHE 2016).

There are net benefits from drug treatment and for every £1 invested in drug treatment services there is an estimated return on investment of £4, which increases to £21 over 10

[3] Pierce M, Bird SM, Hickman M, Millar T (2015) National record linkage study of mortality for a large cohort of opioid users ascertained by drug treatment or criminal justice sources in England, 2005–2009. Drug and Alcohol Dependence 146: 17-23

[4] Cornish R, Macleod J, Strang J, Vickerman P, Hickman M (2010) Risk of death during and after opiate substitution treatment in primary care: prospective observational study in UK General Practice Research Database. BMJ 341:bmj.c5475

[5] Farrell M & Marsden J (2008) Acute risk of drug-related death among newly released prisoners in England and Wales. Addiction 103(2): 251-255

[6] Understanding and Preventing Drug Related Deaths, Public Health England (2016)

years. Costs of healthcare alone for adult drug users not in structured treatment is approx £5,380 per annum. In 2014/2015 there were 206,117 people engaged in treatment; if they had not been in treatment, they may have cost the NHS over £1.1bn. Healthcare costs fall by 31% when drug users are in structured treatment. Drug treatment reduces people's need for drugs, which in turn reduces their drug related offending so treatment is also associated with substantial crime reduction benefits. Looking at offending behaviour before, during and after treatment, it has been estimated that structured treatment prevented 4.9 million crimes with an estimated saving to society worth £1bn.[7] Investment in drug treatment services in Northumberland (excluding alcohol) is estimated to have prevented over 85,000 crimes per year and is likely to have a achieved a reduction in reoffending rates of approximately a third in the following two years after starting drug treatment[8].

Co-occuring mental health and substance misuse disorders

It is very common for people with a substance misuse disorder to experience problems with their mental health at the same time. Research shows that mental health problems are experienced by the majority of drug (70%) and alcohol (86%) users in community substance misuse treatment[9]. Some substances cause time-limited psychosis either in intoxication or withdrawal, whilst people with mental health issues often use substances to self-medicate. Unfortunately death by suicide is not uncommon; a history of alcohol or drug use has been recorded in 54% of all suicides in people experiencing mental health problems[7]. At the Full Council meeting, concerns were raised over links between methadone and suicide. The UK has a very robust medicines licensing process administered through the Medicines and Healthcare Regulatory Agency (MHRA). This includes post licensing surveillance through the 'Yellow Card' reporting system which allows anyone to report an adverse effect to a licensed medicine to the MHRA. There is currently no evidence from either the initial licensing process or from this post-licensing surveillance of an association between methadone and suicide.

In Northumberland, all deaths of service users who are in contact with the service are reviewed, including suspected suicides. It is often difficult to identify if these deaths are deliberate or an accidental overdose; national research suggests that the majority are accidental rather than intentional. For the deaths reviewed in Northumberland, methadone has never been the only substance involved and the individual has been taking a number of other substances concurrently including alcohol. The latest Drug Related Death data,

[7] Alcohol and drug prevention, treatment and recovery: why invest? Public Health England
[8] PCC support pack 2018-19: key drug and alcohol data Summary of area data for Police and Crime Commissioners.
[9] Better care for people with co-occurring mental health and alcohol/drug use conditions, Public Health England (2017)

which reports on the substances named on the death certificate, indicates that deaths where heroin is mentioned has increased by 150% nationally since 2012 (579 to 1029), whereas deaths where methadone has been mentioned remained static (414)[10]. It is rarely possible to identify the substance which was primarily the cause of the death. The management of mental health crises is therefore important for those seen in drug treatment services and effective substance misuse services, particularly those within a mental health NHS Trust such as NRP, need to have skills in appropriate assessment, immediate support and onward referral of individuals in such a crisis.

How OST is managed in the community

Drug misuse presents significant risks to both personal and public health. Treatment of drug misuse has been based on a harm minimisation philosophy, which aims to reduce the health, social and economic harms to individuals, communities and society. Key interventions include the provision of clean injecting equipment and OST, which for safety relies on instalment/supervised dispensing via community pharmacies.

The community pharmacist is a key figure in the overall care plan, providing a regular review of the service user, monitoring adherence to the prescribing regime and progress and also providing a crucial link between service user and drug treatment provider when necessary, raising professional concerns, and reinforcing harm reduction advice.

Supervised consumption also corroborates that the prescribed dose has been taken, allows regular monitoring of the individual during titration and helps check that the dose is correct for the patient (i.e. neither too high nor too low). It also helps ensure that the prescribed methadone is not being illegally shared, swapped or sold.

Community pharmacists are the best placed healthcare professionals to carry out the supervision of methadone. A valuable, supportive relationship can develop between the community pharmacist and the patient. Daily contact allows the pharmacist to monitor patient compliance (e.g. missed doses) and suspected misuse of illegal drugs and alcohol.

There are clear guidelines for prescribers and pharmacists in relation to supervised consumption and dispensing. It is important to clarify that supervised consumption is a hugely protective factor in drug treatment and optimising OST and following the introduction of supervised consumption in England and Scotland, methadone deaths reduced fourfold.

Conclusions

[10] Deaths related to drug poisoning in England and Wales: 2016 registrations, Office of National Statistics

OST (typically using methadone or buprenorphine) is the most widely studied medical intervention for heroin dependence, with consistent reports of reduced drug use, injecting and mortality.

The research literature suggests that investment in drug treatment is likely to substantially reduce social costs associated with drug misuse and dependence. Current estimates suggest that the net benefit-cost ratio is approximately 4 to 1.

All the evidence points to ensuring that there are evidence-based treatment interventions recommended by NICE and that arbitrarily limiting the time that people are able to spend in treatment is not supported by scientific evidence and can be counterproductive.

Implications

Policy	The current prescribing arrangements are in accordance with NICE guidance and UK Clinical Guidelines. This report is not proposing any change to this approach.
Finance and value for money	For every £1 invested in drug treatment services there is an estimated return on investment of £4, which increases to £21 over 10 years.
Legal	None
Procurement	None
Human Resources	None
Property	None
Equalities (Impact Assessment attached) Yes ☐ No ☐ N/A ☐	The drug and alcohol service complete an annual equality analysis to ensure they are compliant with equality duties.
Risk Assessment	Not applicable
Crime & Disorder	Investment in drug treatment services in Northumberland (excluding alcohol) is estimated to have prevented over 85,000 crimes per year and is likely to have a achieved a reduction in reoffending rates of approximately a third in the following two years after starting drug treatment.
Customer Consideration	The drug and alcohol service have a range of activities to ensure the involvement of service users including individual jointly owned care plans, a dedicated service user involvement

	officer, regular forums, an annual service user survey and `Points of You'.
Carbon reduction	Not applicable.
Wards	All

Report sign off.

	initials
Monitoring Officer/Legal	LH
Executive Director of Finance & S151 Officer	NB
Relevant Executive Director	VB
Chief Executive	DL
Portfolio Holder(s)	VJ

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