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Protocol reduces benzodiazepine deaths

Introducing a benzodiazepine prescribing guideline in a drug and alcohol service cut the volume of prescribing for these drugs by more than one-third over a year and was associated with a reduction in diazepam-related deaths, showed a study from NHS Lanarkshire.

'In 2010 when we looked at the figures for drug-related deaths we saw a high prevalence of benzodiazepines reported as the cause – all diazepam,' reported Dr Steve Conroy, Lead Medical Practitioner for Addiction.

The team developed a guideline to review all patients being treated by the drug and alcohol service who were prescribed an opiate substitute and diazepam. The guideline increased the frequency of supply and supervision of benzodiazepines to daily. It also recommended prescribing only 2 mg (white) diazepam tablets, which have the lowest value if sold illicitly and make dose reduction simpler.

The guidelines were implemented from 1 April 2011. 'We saw a rapid reduction in the number of prescriptions for benzodiazepines and the volume supplied,' said Dr Conroy. Within 3 months prescribing of diazepam 10 mg had nearly stopped and use of diazepam 5 mg was significantly reduced.

Within 12 months the service recorded a 16% reduction in the number of prescriptions for benzodiazepines and a 35% reduction in the volume of benzodiazepine prescribed. There was a slight increase at 2 years but the volume of benzodiazepine prescribed was 26% lower than before the guideline was introduced.

Drug-related deaths involving diazepam in NHS Lanarkshire fell, in contrast to increases for Scotland as a whole. Diazepam accounted for only 6% of drug-related deaths in 2011 compared to 16% in 2010. The guideline is now used as part of routine practice and is also being used in GP surgeries.

Susan Mayor

1 in 3 patients divert opioid maintenance therapy

The European Quality Audit of Opioid Treatment (EQUATOR) questioned 703 physicians working in addiction management, 2298 patients in treatment for drug dependence and 887 drug users not in treatment in 2010 to provide a snapshot of treatment experiences.

The main reasons the 248 UK patients began treatment was to improve their health (68%), reduce drug costs (63%) and end their dependence for good (60%). But Dr Farrukh Alam, Consultant Psychiatrist and Clinical Director of Central and Northwest London NHS Foundation Trust, felt that aspirations to end dependence were falling short in the UK, as shown by high diversion rates.

Nearly one-third (30%) of the UK patients taking part in the survey said that they had ever sold, swapped or given away their opioid maintenance therapy – higher than the rate for Europe as a whole (24%).

Dr Alam suggested possible reasons: 'Supervision of dosing may not always happen as it should, enabling patients to divert their opioid maintenance therapy, and limited use of some abuse-deterrent opioid maintenance therapy formulations may also provide clues to diversion rates.'

Only 1% of UK patients in the survey were treated with the abuse deterrent form of buprenorphine (buprenorphine-naloxone), the lowest rate of any country taking part in EQUATOR (average 14%).

During a session on health policy, Mark Gilman, Strategic Recovery Lead at Public Health England, said that services will be making more assertive links to mutual support groups, including Narcotics Anonymous and SMART Recovery. UK clinicians in the audience challenged Mr Gilman to produce guidance on what clinical outcomes should be targeted and measured to establish that recovery is being achieved.

Susan Mayor

Mark Gilman, Strategic Recovery Lead, Public Health England

Outcomes system needed to evaluate opioid dependence management

A panel of European thought leaders agreed that universal outcome measures above the individual patient level are needed to more effectively assess the impact of services managing opioid dependence. These could define what recovery looks like at a clinical level.

'Medical assisted therapy is an important strategy to address the health and social consequences associated with opioid dependence, which is a chronic relapsing medical condition that requires lifelong management,' said Professor Icro Maremanni, Professor of Addiction Medicine, University of Pisa and University of Siena, Italy.

Many countries have an overall strategy for approaching opioid maintenance, but variations in treatment goals mean that it has not been possible to capture robust data on outcomes with opioid maintenance treatment.

When asked to vote on the issue, 92% of delegates agreed that developing a universal system for measuring outcomes would be a useful advance in opioid dependence management.

Susan Mayor

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