Attachment C

NATIONAL INSTITUTE FOR CLINICAL EXCELLENCE
SPECIAL HEALTH AUTHORITY
TENTH WAVE WORK PROGRAMME

DRUG MISUSE

Detoxification in opiate drug misuse

On 16th June 2004 the Department of Health and the Welsh Assembly Government formally requested the National Institute for Clinical Excellence to prepare a clinical guideline as described in the box below. Also attached is additional background information presented to the Advisory Committee on Topic Selection, plus any other relevant information.

Remit: To prepare a guideline for the NHS in England and Wales on the management ofdetoxification in opiate drug misusers in the community, hospital and prison settings

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The guidance will:

- by using the evidence base examine the effectiveness and cost effectiveness of detoxification regimes for the management of opiate, misusers;
- identify those groups of drug misusers who are most likely to benefit from detoxification regimes ; and
- identify the key components of the effectiveness of detoxification , within a wider package of pharmacological interventions, and the overall care provided for drug misuers.

Suggested working titles for NICE:

Full Title: Drug misuse: opiate detoxification of drug misusers in the community, hospital and prison settings.

Short Title: Drug Misuse - Detoxification

Additional background

Source

Sexual Health and Substance Misuse Team (SHASM), Department of Health, agreed with Lord Warner and supported by Mary Agnew (No 10)

Overview

It is estimated that there are at least 280,000 problem drug users and approximately 145,000 in treatment in any year with a Government target of ensuring 200,000 are in effective treatment in 2008. The majority of those requiring treatment are opiate dependent (using illicit heroin). The number of illicit opiate users is largely stable. Many opiate dependent users regularly use cocaine.

Severe opiate dependence is a disorder of multi-factorial aetiology (with multiple and varied perpetuating factors). It has a central feature of psychological reinforcement of repeated drug-taking behaviour and it also has a marked withdrawal syndrome. Disturbances of the brain reward pathways (involving opoid receptors) are important underlying pathological mechanisms. For this reason it is usually considered that a range of interventions may be required in addition to drug treatments. For severely dependent opiate addicts the disorder has characteristics of a long-term chronic relapsing disorder with periods of remission and relapse, so whilst abstinence is a long-term goal for treatment this is not always easy to achieve and may be associated with periods of relapse.

The costs of opiate dependence may be due to individual health problems (bacterial infections, overdoses, HIV and hepatitis viral infections), criminal justice costs and other costs to family and wider society. The societal costs of problem drug users has been estimated at many billions of pounds, with opiate dependence and other Class A drugs constituting the main cause of these costs.

Opiate substitution therapies (methadone and buprenorphien and most commonly used) allow the addict to replace street heroin with a longer-acting, less euphoriant and safer drug whilst avoiding the withdrawal syndrome. Once stabilised many patients remain on maintenance treatment (with consequent improvements in illicit drug use, physical health, well-being, social stabilisation and very substantially reduced criminality and costs to society). Buprenorphien is substantially more expensive than oral methadone and it takes longer to supervise its consumption (as it is not swallowed).

Only a minority entering treatment choose abstinence initially and enforced abstinence appears highly ineffective. However, approximately one third entering treatment services generally are abstinent 5 years later (at least for a period of time).

Those drug users incarcerated in prison usually receive assistance with withdrawal symptoms and some receive a treatment programme in prison. Access to regular high levels of illicit drugs in prisons is limited so most dependent drug users lose tolerance and are at risk of overdose when they commonly relapse on release. Prison guidance is being developed indicating that methadone maintenance should be continued in some patients (e.g. short term or remand prisoners) when this has already been started in the community. Methadone maintenance treatment is rarely initiated in prison.

Determining when to offer detoxification and the setting in which in might be provide (for example, hospital or community) is often a difficult clinical decision. Clarity about the purpose of any treatment strategy is crucial and confusion between detoxification or maintenance programmes can lead to lack of clear treatment aims and poorer quality care. The guideline will help to inform this important area and support the provision of more effective and targeted detoxification regimes.

Evidence base

A number of studies (Amato et al 2003) have examined pharmacological strategies for managing opiate withdrawal. They have compared methadone with adrenergic agonists showing no clinical difference in terms of completion of treatment and degree of discomfort other have compared methadone reduction schedules, showing that different types of methadone withdrawal schedule produce different responses in terms of time course and severity of withdrawal. Other studies have compared methadone with other opioid agonists, showing that methadyl acetate performed similarly to methadone on most process and outcome measures, while methadone reduced severity of withdrawal and had fewer drop-outs than propoxyphene. One study compared chlordiazepoxide versus methadone, showing similar results in terms of overall effectiveness. The results indicate that the medications used in the included studies are similar in terms of overall effectiveness, although symptoms experienced by subjects differed according to the medication used and the program adopted. The concurrent provision of psychosocial interventions improved outcomes.

Related guidance

1. The Task Force to review services for drug misusers, Department of Health, 1996, HMSO.
2. Tackling drugs to build a better Britain. Department of Health, 1998, HMSO.
3. Drug misuse and dependence guidelines on clinical management. Department of Health, 1999, HMSO.

Timing

Targets for updated drugs strategy are 2008. Maintenance prescribing is a key factor in engaging patients in effective treatment.

The interface between prison and community is a key opportunity to reduce relapse and enhance involvement in treatment.

Hence, action on both proposals is required quickly if NICE guidance is to affect delivery.

Peer review

The proposal was discussed with a number of leading addiction specialists during initial scooping and with the National Treatment Agency for Substance Misuse (NTA), with broad consensus on these topics.

Potential costs/workforce/management implications

There is increasing funding for drug treatment to deliver effective treatment to increased numbers. There is also guidance on developing more holistic care-planned approaches, so outputs from NICE are likely to enhance these meetings and to focus on and inform clinicians in a credible way the role of these specific drug interventions.

The guidance is likely to increase costs of treatment if more appropriate, treatments are delivered but this should have a positive impact on outcomes and retention in treatment.

An analysis of what the evidence informs us about how these interventions sit within wider packages of care (rather than as stand-alone interventions) should support the current guidance on care planning and integrated care pathways that is already an expectation for development.

Proposed remit

Whilst the majority of evidence on the use of these treatments is in community populations, there is an emerging evidence base on criminal justice and prison populations, with international studies to support this. There is also a wide evidence base on effective components of psych-social care for problem drug users generally and in relation to these particular treatments. This can form the basis for the analysis to develop evidence-based clinical guidelines on the proposed treatments and care packages in both community and criminal justice populations.

The guideline should cover what the evidence tells us about the effectiveness and cost-effectiveness of detoxification regimes and the appropriate patient groups for each treatment and the appropriate psychosocial package of care in the context of the use of these drugs. This should include the role of such treatment in prisons and continuing after release (or on licence), as well as its more established role for community treatment.

Annex B

The York Study

More recently the University of York conducted a study on the costs of drug use on behalf of the Home Office that was presented to the HASC Drugs Inquiry in 2002.

The authors classified total number of drug misusers into different types:

- Problem users (PDU) – users of any age whose drug use is no longer controller or undertaken for recreational purposes and where drugs have become a more essential element of the individual's life. A sub-group is injectors associated with additional health problems. Lowest estimate is 281,125.
- Young recreational – class A drug use for age under 25 but not PDU. A sub-group is young people considered to be a high risk of moving on to PDU. Lowest estimate is 399,000.
- Older regular users – regular use of class A drugs for age 35 or over but not PDU. Lowest estimate is 1,091,000.

Key points on costs from the York Study:

- PDUs account for about 99% of total costs of drug misuse.
- The annual economic costs of drug misuse (mainly to health service, criminal justice system and state benefits) are estimated at between £3.7bn and £6.8bn. Adding social costs (mainly victim costs of crime) increases figures to between £10.9bn and £18.8bn.
- Average economic costs range from under £20 for non-problematic, primarily recreational or older regular users to £11,000 for problematic users

It is not clear the number of PDUs estimated by the York study who met a clinical definition of problem drug use that would relate to need for, or suitability for, treatment, but it is likely to be a substantial majority of the group who will also be dependent.