The Role of the Annual Review in Opiate Abuse:
A primary care quality and evidence audit

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With thanks to The Oswald Medical Practice, The Robert Darbishire Practice, Dr DJ Watts and Mr T Watts

Abstract

Methadone is a synthetic opioid commonly used in the treatment of opiate dependence. It is effective in its role as an adjunctive therapy with psychosocial interventions when used with the intention of stopping opioid use entirely. Methadone maintenance therapy (MMT) is the current 'gold standard' of treatment, helping people into recovery.

Previous addiction management has been undertaken by specialist clinicians however, its recent transfer into primary care ("shared care") requires a number of specialised roles of these primary centres for addiction management. One of these, the annual review, assesses the patient's general wellbeing and sets goals for their upcoming care in order to safely move the patient towards recovery.

Background

Addiction can be defined as the physiological and psychological need for reward associated with a substance. It is a chronic and evolving phenomenon characterised by the inability to abstain from use of the abused substance[1]. MMT has been shown to be the most effective therapy in reducing heroin use, compared not only to a number of different therapies, but also to methadone detoxification programmes. Inadequate dosing is found to be an issue in many cases where MMT is not able to reduce heroin use or compliance is poor[2].

Heroin use in the UK has stayed at around 0.1% of the population for the last decade however, opiate addiction and prescription in the community tripled in the 15 years preceding 2001[3]. It is not only this that has increased the role of GPs in their care, but also all the associated health and social risks that come with drug abuse must also be monitored[4,5,6,7].

The Audit

The aim of the original audit was to evaluate how well my assigned General Practice (GP A) was managing their patients undergoing methadone maintenance therapy (MMT), specifically through the annual review. This part of the care plan involves a number of different areas relating both to the patient's drug use and associated risk factors.

I researched the following areas;

- Liver Function Tests (LFTs)
- Medication Review
- Smoking
- Checking of Injection Sites
- Blood Borne Virus (BBV) testing
- HIV testing
- Alcohol
- Smear Testing (female)
- Sexual Health

The shared care contract states that these should be updated at least annually, with the necessary action(s) being taken.

The data was collected from the practice's EMIS system and the CRI website, used by the drug worker to log consultations.

Results

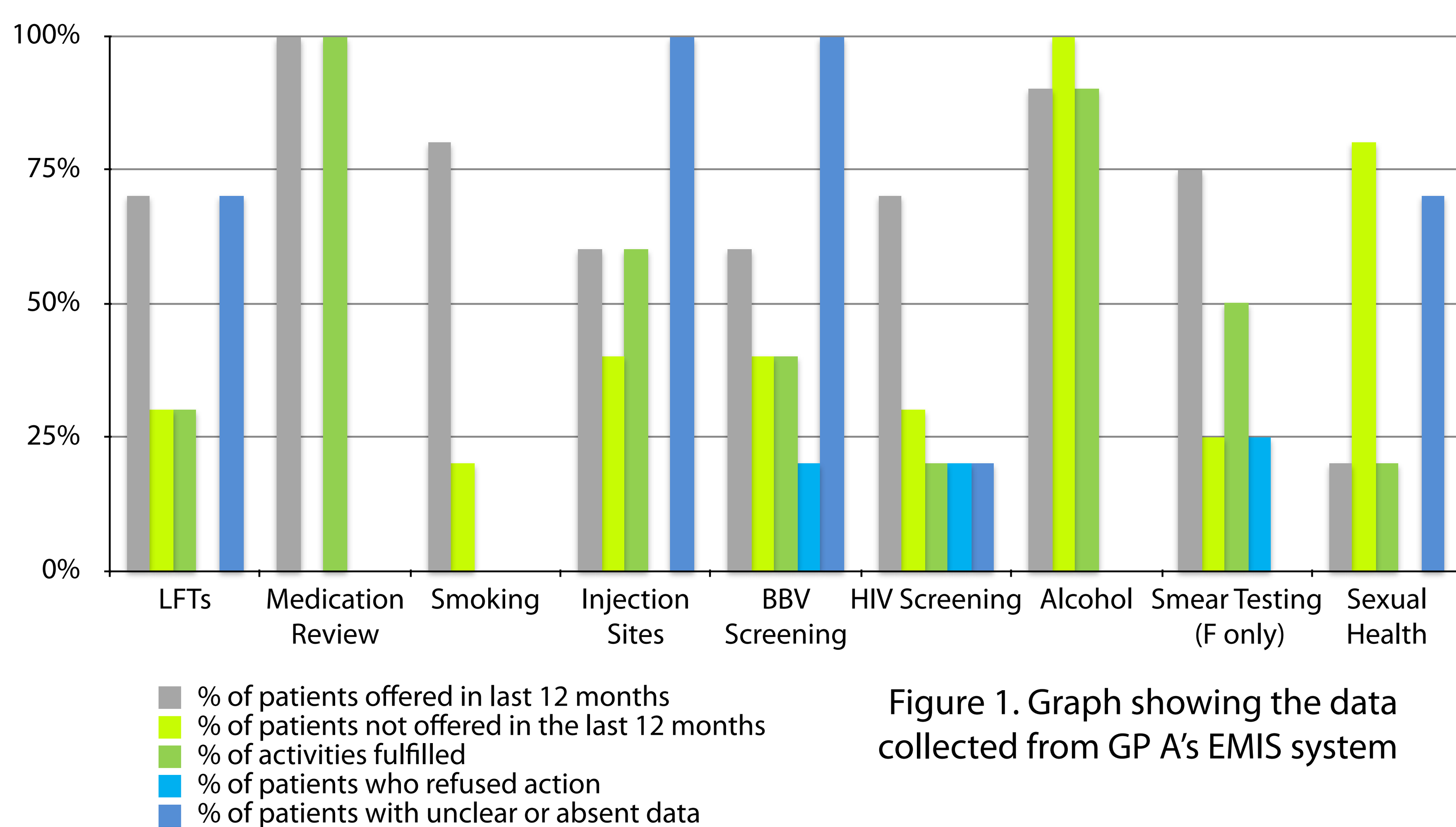

Figure 1. Graph showing the data collected from GP A's EMIS system

Section	% Complete
Drug and Alcohol Support Needs	*100*
Physical and Mental Support Needs	*90*
Criminal Justice and Other Support Needs	*0*
Changes to Risk	*0*
Unmet Support Needs	*0*
Discharge and Aftercare	*0*

Figure 2. Table showing the areas of the CRi website that have been completed during the patient's care under the drug team.

Initial Findings

There were 3 main improvements that I identified at the end of my research, namely;

- Improved communication between the CRI and EMIS systems
- Formation of a template for the annual review
- Ensuring that practitioners are fully informed regarding what an annual review involves so the necessary equipment and time is allotted.

I advised the practice that implementing these should greatly improve the execution of this service. When discussed with all involved health professionals at this practice, there was a general agreement that these steps should be taken in order to improve care.

Moving Forward

My original audit highlighted a number of areas where improvements needed to be made and government standards where not being met. The suggestions made are those that I believe would rectify these gaps in practice.

Currently, GP A is making a conscious effort to obtain the current HIV and BBV status' of all their patients. They are also updating their computer systems and are hoping to use my template design to create such a template once the new system is online. Unfortunately I have been unable to follow up on this further.

Follow-Up (In Second Practice)

Fortunately, my next assigned General Practice (GP B) placement also has addiction services in place, prescribing MMT. In this light, I decided to audit this surgery's management of these patients and in this way I can deduce whether the problems that I found at GP A are also issues in GP B. These practices not only differ in location within Manchester, but also in their size and consulting population. Another key point is that GP B already has a drug review template in place for use during consultations with this specific group of patients.

Results

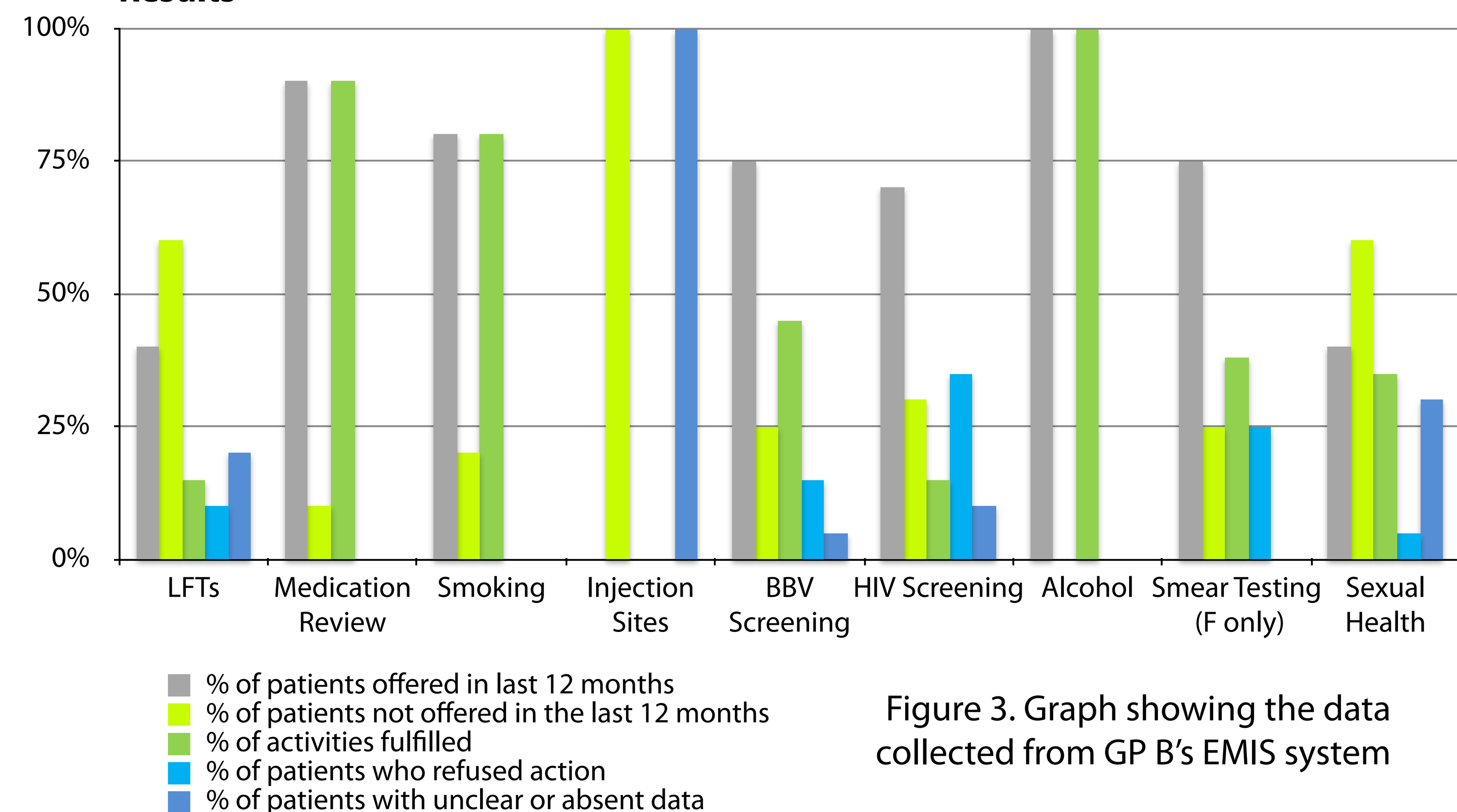

Figure 3. Graph showing the data collected from GP B's EMIS system

Conclusions

The findings from this practice seem to follow the same pattern as GP A with inconsistency in documentation as well as oversight in certain key areas. Again it was clear in many cases screening or tests such as LFTs were being offered but then not performed. I also looked into the template that GP B already had in place. From the notes I did see some evidence of its use, possible not as much as I should have! The results from this audit, despite the presence of a template, seem to show similar failings as GP A, suggesting that simply implementing a template is not enough to improve this service to a satisfactory degree.

Category	GP A	GP B
LFTs	*70*	*40*
Medication Reviews	*100*	*90*
Smoking	*80*	*80*
Injection Sites	*60*	*0*
BBV Screening	*60*	*75*
HIV Screening	*70*	*70*
Alcohol	*90*	*100*
Smear Testing	*75*	*75*
Sexual Health	*20*	*40*

Figure 4. Table comparing the percentages that each procedure was offered to patients in GP A and GP B.

Comparison

Despite the variations between the practices there seems to be recurring themes. Medication reviews, alcohol and smoking are all generally covered well although the occasional patient is not assessed. The areas that concern me most are the sexual health and BBV/HIV screening. I was surprised that the results for the latter were as high as they are as, in many cases, information was logged but unclear and there was often little investigation to back up what was written. For this reason, these are the areas I focussed on reporting to the practices. It was especially interesting to me that there was no option for sexual health screening in the preformed template for GP B, perhaps explaining the lack of data in this area.

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References

[1] American Society of Addiction Medicine, Definition of Addiction, http://www.asam.org/for-the-public/definition-of-addiction (accessed 8th February 2014). [2] Amato L, Davoli M, Perucci CA, Ferri M, Faggiano F, Mattick RP. An Overview of Systematic Reviews of the Effectiveness of Opiate Maintenance Therapies: Available Evidence to Inform Clinical Practice and Research. J Subst Abuse Treat. 2005;28(4):321-9. [3] Strang J, Sheridan J, Hunt C, Kerr B, Gerada C, Pringle M. The Prescribing of Methadone and Other Opioids to Addicts: National Survey of GPs in England and Wales. Br J Gen Pract. 2005;55(515):444-51. [4] The Centre for Public Health, Faculty of Health & Applied Sciences, A Summary of the Health Harms of Drugs. UK, Department of Health and National Treatment Agency for Substance Misuse. 2011. [5] Harding C, Ritchie J. Contraceptive Practice of Women with Opiate Addiction in a Rural Centre. Aust J Rural Health. 2003;11(1): 2-6. [6] Gordon RJ, Lowy FD. Bacterial Infections in Drug Users. New England Journal of Medicine. 2005;353(18):1945-54. [7] Marsch LA. The Efficacy of Methadone Maintenance Interventions in Reducing Illicit Opiate Use, HIV Risk Behavior and Criminality: a Meta-Analysis. Addiction. 1998;93(4):515-32.