REALITY CHECK

A snapshot survey of people in drug treatment provides the latest figures on topping-up, unemployment, crime, supervised doses and psychosocial support. But it also reveals that a lack of flexibility may inhibit successful recovery.

Fewer young people are using drugs, fewer under 30s are dying from drug misuse and more people are completing treatment. That was the encouraging news from the 2012 National Treatment Agency (NTA) report. However, it is also important to measure success in terms of the three principles of recovery outlined in the UK government's 2010 Drug Strategy – wellbeing, citizenship, and freedom from dependence. Determining our progress towards these goals is key, and to do this we need to assess what's actually happening on the ground.

Project Access UK, a national survey carried out in 2011, aimed to provide new insights into the current state of opioid dependence treatment in the UK. It wanted to find out what motivates patients to seek opioid maintenance treatment (OMT), how many are continuing to use heroin, how many have misused their medication or diverted it to others, as well as the answers to a range of questions on health, employment and crime.

The survey canvassed the opinions of three groups: patients in opioid-dependence treatment, users outside of treatment and physicians involved in the treatment of opioid dependence. More than 500 people participated, and formed part of a wider survey analysis involving 3,888 participants across 10 European countries, the European Quality Audit of Opioid Treatment (EQUATOR).

Project Access found that three of the most common reasons given by patients for starting OMT were to improve their health, end their dependence and stop committing crimes. Other reasons included wanting to gain work, change social circles, and take better care of their family. Patients said the benefits

of OMT were reductions in criminal behaviour, psychosocial and social support, improvements in health, reductions in drug use and management of withdrawal symptoms.

Despite patients' strong recovery ambition and their recognition of the benefits of OMT, the survey also highlighted that patients still had close associations with the illegal drug market. More than a third (39 per cent) of patients still took an illegal drug at least once a week. Forty-three per cent reported that they had ever taken heroin on top of their OMT and many also reported that they had at some time used cannabis, crack, benzodiazepines or cocaine during treatment. A quarter of patients admitted to having ever misused (injected or snorted) their OMT medication, while 30 per cent had diverted (sold, given away or swapped) it.

So why do so many individuals continue to use illicit drugs or engage in misuse or diversion of their prescribed OMT medication? One possible explanation is insufficient psychosocial support. Two fifths of patients reported that they were not receiving psychosocial interventions. Of those receiving such help, almost three quarters found it helpful. Inadequate doses of the prescribed opioid may also contribute to continuing opioid misuse during treatment, although it is not possible to determine whether this was the case in this survey.

Notably, success in achieving abstinence from illicit drug use differed according to which OMT medication patients were receiving. Those taking methadone showed the highest on-top use (51 per cent) compared with buprenorphine (21 per cent) and buprenorphine-naloxone (13 per cent). It is unclear whether this finding reflects differences in the pharmacology of these medications (for example buprenorphine's capacity to block the effect of opioid agonists) or differences in the types of patients that receive each option.

It is clear that supervised dosing, which more than 70 per cent of patients in the survey underwent, does not eliminate misuse and diversion entirely and may constitute a barrier to opioid-dependent individuals beginning and remaining in treatment. Daily dose supervision was the condition of staying in treatment cited most frequently by patients as having the biggest impact on daily life and was the number one reason out-of-treatment users gave for not entering treatment.

On average patients had been in treatment four times before. Three quarters had previously been prescribed methadone, compared to 29 per cent who had received buprenorphine or buprenorphine–naloxone. Almost half of patients reported asking their doctor for a specific medication, which was usually given, but while almost all patients were aware of liquid methadone before starting treatment, far fewer were aware of other treatment options.

TWO FIFTHS OF PATIENTS REPORTED THAT THEY WERE NOT RECEIVING PSYCHOSOCIAL INTERVENTIONS

The 2010 Drug Strategy recognises that improvement in mental and physical health and wellbeing are one of the best-practice outcomes of a recovery-orientated system. Although more than 70 per cent of patients considered their physical and mental health to be average or better, a substantial minority were in poor health. While the majority of patients reported that they were receiving psychosocial interventions of some kind, 40 per cent of patients were not receiving any psychosocial support. This is particularly important given that many individuals come to treatment with pre-existing, often complicated, health problems. In this survey, the vast majority had experienced depression or anxiety.

Just one in ten (eleven per cent) of patients in the survey reported that they were in employment, training or education, with only four per cent in full-time employment. These figures are the worst among all ten European countries in which similar surveys were conducted as part of the EQUATOR analysis. Although treatment supervision has an acknowledged role to play in ensuring the safety of and compliance with OMT, especially early in a patient's recovery, it can also constitute a barrier to recovery. The requirement to attend a clinic or pharmacy regularly for supervised consumption of their OMT medication is unlikely to allow a patient to maintain employment and therefore achieve this important element of recovery. When patients reach the point in their recovery at which employment is a feasible option, the use of medication options that require less supervision may be more conducive to employment.

With regard to prison, the Drug Strategy states that, 'the sentencing framework must support courts to identify options, other than prison, which will help an offender tackle their drug or alcohol dependence, whilst recognising that, for some offenders, custody is necessary'. Imprisonment was, however, a frequent experience for patients, with more than half having been in jail. Most of these prison terms were for drug-related offences. Many individuals who had been jailed, reported they had not received treatment for drug addiction while in prison. In addition, almost a third of patients who were receiving OMT before going to prison had to stop taking it completely once inside.

Patients seeking treatment for opioid dependence aspire to recover. However, under the current system, many are struggling to achieve sufficient progress, evidenced by high levels of on-going drug use, diversion of medicine, low levels of employment, high rates of drug-related imprisonment and repeated cycling through treatment.

But this survey provides clues as to what needs to be done. We need to ensure patients are adequately informed of the full range of treatment options and to encourage them to take advantage of psychosocial support opportunities. The need for supervised dosing needs to be assessed on an individualised basis to avoid negative consequences, and services should take advantage of the availability of abuse-deterrent formulations, such as liquid methadone and buprenorphine–naloxone.

Important changes in drug treatment in the UK are on the horizon: responsibility for drug treatment shifts from the NTA to Public Health England in April 2013 and local authorities will take charge of commissioning. The key message coming from Project Access is that, regardless of who is ultimately responsible for drug treatment in the UK, the current gaps between aspirations and reality need to be addressed.

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