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VIEWS & REVIEWS

PERSONAL VIEW

Promoting abstinence for drug users is about saving money not science

Despite overwhelming evidence that substitution therapy reduces harm, the UK government now advocates abstinence. **Jason Luty** wonders if this is because it seems cheaper

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In Autumn 2009, Professor David Nutt publicly stated (more or less) that alcohol and tobacco were just as damaging as cannabis. Although he told the truth, he was immediately dismissed as head of the UK Advisory Council on Misuse of Drugs.[1] Since then we have had two ministers of health, a new government, and one reshuffle. Nevertheless, the message was clear: any bolshie academic who speaks out of turn is likely to get the chop.

In 2010 the new UK government announced that substance misuse services should follow a recovery model.[2] Basically, this means that patients receiving opioid substitution therapy are encouraged to reduce and stop all addictive drugs, including prescribed drug substitutes. (Opioid substitution therapy refers to use of drugs such as methadone and buprenorphine for treatment of heroin addiction; detoxification is the process of reducing and stopping addictive drugs such as methadone; and maintenance is the prescription of substitute drugs over years with no requirement to stop.) Substance misuse teams in England now have an "aspiration" (a target) to discharge (and detoxify) half of the 170 000 people probably receiving opioid substitution treatment.[3]

Professor John Strang of the National Addiction Centre was tasked to provide expert clinical guidance in response to the new government's favoured recovery model. This unenviable task resulted in the *Medications in Recovery* report.[4] However, almost all the evidence base shows that abstinence is far less effective than maintenance.[5-7] Indeed, a recent report from British Columbia of more than 25 000 methadone treatment episodes showed that only one in 40 episodes achieved a successful recovery (abstinence from prescribed methadone with no re-entry to treatment within 18 months).[8] There are several comparable research reports.[7 9] Almost identical results were sensationally reported from the UK in the press four years ago.[10] By contrast, about half of patients who are maintained on methadone can almost completely abstain from heroin.[11-13] However, Strang's committee produced a document that spectacularly avoids stating the obvious: "the [vast] majority of patients attempting to taper from methadone maintenance treatment will not succeed."[8] To be brutally frank, any suggestion that detoxification is as effective as maintenance is poppycock. (This even applies to slow detoxification over one year, and let us be clear: detoxification is an unavoidable part of the recovery agenda.)

Of course, the government's recovery agenda is not only about recovery from substance misuse. It is also about recovery from the economic global recession and the need to cut public spending. Regardless of the evidence base, the UK government cannot, or will not, continue to fund treatment for 170 000 opioid users on indefinite prescriptions. It is not really that people are dependent on methadone: the problem is they are dependent on the health service to prescribe this. For example, substance misuse services are required to provide medical reviews of all patients taking methadone every three months. Consider a typical service of 400 patients receiving prescriptions for substitutes, and assume each review takes 30 minutes with a (conservative) 25% rate of non-attendance. A drug treatment service would have to employ a doctor full time just to do the routine reviews.

So what's to be done? Unless decades of international experience are wrong, the vast majority of patients will relapse back to heroin misuse before their methadone is stopped or within a few months. Savings can be achieved by streamlining the treatment process. There are reams of policies produced by chief executives burdened with accountability for clinical decisions that they are neither qualified nor competent to perform themselves. Clinicians are trained to perform, and be accountable, for their clinical practice. Even a casual visitor to a community drug team will notice that clinical staff spend more than half their time with bureaucracy—completing forms, management meetings, and maintaining written or electronic notes.

It has been proved beyond all reasonable doubt that opioid substitution reduces drug use and crime and improves physical

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and mental health and social functioning.[5 9 11] Nevertheless, commissioners demand that this is confirmed by means of the mandatory treatment outcome profile interview every six weeks in every patient in treatment—all 170 000. They also insist on collecting a large amount of information recorded by interview when people enter treatment with substance misuse services. We should abolish this time wasting control freakery and needless bureaucracy. The only function of this sort of nonsense is to keep policy writers and bureaucrats in employment at taxpayers' expense.

Governments should focus on three or four targets to ensure that treatment services function effectively, and one of these should be to ensure that clinical staff spend at least half their time in direct contact with patients. Similarly, we should be rid of the armies of bureaucrats, data managers, and commissioners that seem to have multiplied exponentially. Anyone who has no patient contact has no place working in the health service.

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