DRUG & ALCOHOL FINDINGS *Review analysis*

This entry is our analysis of a review or synthesis of research findings considered particularly relevant to improving outcomes from drug or alcohol interventions in the UK. The original review was not published by Findings; click Title to order a copy. Links to other documents. Hover over for notes. Click to highlight passage referred to. Unfold extra text The Summary conveys the findings and views expressed in the review.

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▶ An evidence review of the outcomes that can be expected of drug misuse treatment in England.

Burkinshaw P., Knight J., Anders P. et al.
Public Health England, 2017

English treatment systems perform at least as well as other countries on a number of measures, but have a considerably higher rate of drug-related deaths than elsewhere in Europe. As well as pursuing harm reduction and recovery, this report stresses the importance of social integration as an objective.

SUMMARY In March 2015, the Department of Health commissioned Public Health England to "review … what can be expected of the drug treatment and recovery system and provide advice to inform future policy".

Public Health England published their report in January 2017, addressing the following seven questions (and dedicating a chapter to each):

1. What is the history of drug misuse and drug treatment in England?
2. What is the prevalence of drug misuse and the profile of the treatment population, and how are they changing?
3. What harms does drug treatment reduce?
4. Does drug treatment England achieve the outcomes we should expect?
5. What is the impact of housing, employment and social deprivation on treatment outcomes and what are the interdependencies between drug treatment and other services?
6. How should treatment be configured and resourced to meet the needs of an ageing heroin using population and respond to new patterns of drug use?
7. What are the appropriate outcomes to evaluate treatment effectiveness?

Main findings

Drug use and dependence are associated with a range of harms, including poor physical and mental health, unemployment, homelessness, family breakdown, and criminal activity. In monetary terms, illicit drug use costs UK society an estimated £10.7 billion, and costs family members and carers of heroin and crack cocaine users alone around £1.8 billion.

Public health, crime reduction, and recovery objectives have all influenced drug treatment policy and funding over the years, to varying degrees. The 1995 drug strategy was interpreted by commentators as the end of health-driven policy, and the beginning of over a decade of policies which took the view that "the most problematic users were responsible for the majority of criminality in society and that if they could be treated (either voluntarily or through coercive measures) then crime rates would decline." The 2010 drug strategy marked a turn towards putting recovery outcomes at the centre of policy.

The vast majority (75%) of people in drug treatment in England are receiving help for problems related to the use of opiates, mainly heroin, which, along with cocaine, is associated with the majority of the social costs of drug use.

The proportion of older heroin users (aged 40 and over) in treatment with poor health has been increasing in recent years and is likely to continue to rise. Many started using heroin in the 1980s and 1990s, and are now experiencing cumulative physical and mental health conditions.

The proportion of people in treatment with "entrenched dependence and complex needs" is predicted to increase, and the proportion who successfully complete treatment, therefore, predicted to continue to fall.

There are reports of increasing problems with prescription and over-the-counter medicines, as well as new psychoactive substances – the latter a particular problem in prisons. New patterns of drug use and risky behaviour are becoming established, including new psychoactive substances being injected, and drugs being used alongside high-risk sexual behaviour ('chemsex').

New psychoactive substances

These psychoactive drugs used to be referred to as 'legal highs'. The Psychoactive Substances Act 2016 changed their legal status in the UK, making supply and possession with intent to supply an offence.

Synthetic cannabinoids (which mimic the effects of cannabis) are increasingly being used by vulnerable groups. Controlling the availability of new psychoactive substances in prisons is a significant challenge.

The number of drug-related deaths has increased over the past 20 years, with a significant rise in the last three years to the highest number on record. [The crisis of overdose deaths in the UK is discussed in this Effectiveness Bank hot topic.] In the next four years, Public Health England estimates that there will be an increase in the proportion of people in treatment for opiate dependence who die from long-term health conditions and overdose. Older heroin users, especially, are susceptible to overdose.

Below are some of the recorded positive outcomes of interventions for problem drug users:
• There is consistent evidence that community-based needle and syringe programmes are associated with reduced rates of HIV and hepatitis C infection.
• Opioid substitution treatment (typically using methadone or buprenorphine) is the most widely studied medical intervention for heroin dependence, with consistent reports of reduced drug use, injecting and mortality. It is also a driver of crime reduction, with reduced offending proportionate to the time people spend in treatment.
• Specialist drug treatment services are also associated with reductions in offending.

How do treatment systems in England measure up?

It is difficult to compare the performance of treatment systems in England to those in other countries – one reason being that the breadth of data collected by the National Drug Treatment Monitoring System about public drug treatment services in England is rare in other countries. Alongside this, treatment interventions evaluated by researchers are often tightly controlled and may relate to such specific populations and contexts that comparisons prove difficult.

With these caveats in mind, the evidence still suggests that treatment outcomes in England are equivalent to or better than other countries:
• The proportion of problem drug users in treatment is among the highest reported (60% of opiate users).
• Access to treatment (97% within three weeks) is comparable to other countries.
• The rate of drug injecting among all 15–64 year olds (0.25%) is relatively low (1 2).
• The rate of drop-out from treatment before three and six months (18% and 34%, respectively) is comparable to the literature (28% on average) (1 2 3 4 5).
• England has a very low rate of HIV infection among the injecting drug user population (1%), which compares favourably internationally.
• The rate of hepatitis C virus infection (50%) is lower than several other countries with available data.
• The rate of stopping injecting (52% after three months; 58% after six months; 61% after one year) is comparable to, or better than, the scientific literature.
• Treatment in England is associated with a marked reduction in convictions (47% among those retained in treatment for two years or successfully completed treatment after being retained for at least six months).

However, there are opportunities for improvement:
• The rate of illicit opiate abstinence after three and also six months of treatment in England (46% and 48%, respectively) points to poorer performance in comparison with the literature (56% on average).
• The drug-related death rate in England (34 per million in 2013) is substantially lower than in the USA but considerably higher than elsewhere in Europe.

Housing needs

While the UK employment rate has improved in recent years, housing availability and affordability have worsened in some parts of the country. There have also been recent increases in the number of people rough sleeping, the number of statutory homeless applications accepted,

Social factors known to moderate and influence treatment effectiveness include unemployment and housing problems. Gaining employment and receiving employment support can lead to improvements in treatment outcomes and reduce the risk that someone will relapse after treatment.

and the number of households in temporary accommodation.

Among opiate users, the proportion starting treatment with an urgent housing need has increased since 2009–2010. Around 12% are homeless at admission, compared to around 5% for non-opiate drug users.

Advice for commissioners and providers

• Ensure there are arrangements to meet the physical and mental health needs of people in treatment, particularly older people.
• Implement evidence-based interventions to reduce the use of illicit opiates at the start of and throughout treatment.
• Implement evidence-based treatment interventions recommended by NICE.
• Don't implement a policy of limiting the time that people are able to spend in treatment – it is not supported by scientific evidence and can be counterproductive.
• Ensure there are robust and integrated pathways between drug treatment and all points of the criminal justice system, including pathways between prison and community-based treatment.
• Closely monitor changing patterns of drug use, including new psychoactive substance use and prescription medicines. Coordinate responses for specific sub-populations, including managing prescribing practice, developing workforce skills and developing new service pathways.

Advice for national and local government

• Ensure drug treatment continues to address a broad range of outcomes (including harm reduction, social integration and recovery) through integrated treatment and recovery support systems.
• Improve the current primary outcome measure (successful treatment completion and no return to treatment, used as the proxy measure of success) to better reflect progress made by individuals, through the national and local monitoring of: the proportion of people in need who are in treatment; good treatment access; incident rates of bloodborne viral infections; cessation of illicit opiate use while in treatment; longer-term rates of treatment re-presentation; treatment entry rates following prison release; and access to employment and housing support services.
• Separate drug treatment outcome indicators for opiate users new into treatment and existing cohorts to allow tracking of the progress of those for who evidence tells us we can expect higher recovery rates.
• Maintain a realistic recovery ambition for the ageing cohort of heroin users with complex needs, accepting that the proportion of people who successfully complete treatment is likely to continue to fall.
• Provide longer-term employment and housing support, including in-work support, to help people gain and maintain employment and appropriate housing.
• Develop strategies to address the recent increases in drug-related deaths, including integrating healthcare with drug treatment, and improving local processes for reviewing incidents.

The authors' conclusions

Good progress has been made in reducing drug-related harm and promoting recovery through the widespread implementation of evidence-based drug treatment. Drug treatment should continue to address a broad range of outcomes, including harm reduction, reduced drug use, social integration, and recovery. The assessment of outcomes should also be expanded to better reflect the breadth of the benefits of drug misuse interventions.

Social factors, including housing, employment, and deprivation, are all associated with substance use, and moderate the success of treatment. It is important to provide longer-term employment support, including in-work support to help people maintain employment, and integrated housing support. Given the rise in the number of older heroin users in treatment with poor health, it is also vital to facilitate access to appropriate healthcare services.

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