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Concern over abstinence outcomes in Scotland's treatment services

A study of drug users starting treatment in Scotland revealed low rates of abstinence nearly three years later, findings which have been widely misinterpreted. The figures derived from the Drug Outcome Research in Scotland study (DORIS). Like NTORS in England, this sampled patients entering different types of treatments and observed their progress during and after normal treatment delivery.

The study's most significant outcome report to date documented the progress 33 months later of 695 (all who could be reinterviewed) out of 1033 people who started treatment in 2001.[1] Though using other drugs, most saw their main problem as heroin. Abstinence was the sole drug use outcome reported, defined as totally avoiding drugs except alcohol or tobacco over the preceding three months. DORIS excluded from this designation anyone prescribed legal substitutes such as methadone.

On this criterion, overall just 8%[2] of the sample were abstinent. For patients who had started treatment at detoxification or counselling services, it was 6%, for prison-based services, 5%, and for residential rehabilitation 25%, significantly higher than the other modalities.

No corresponding figure was presented for patients who started the study in methadone maintenance. Instead a figure was given for patients who had started methadone *after* their first DORIS treatment, about 3% of whom were abstinent. Another 8% confined their (non-alcohol, non-tobacco) drug use to prescribed methadone, meaning that 11% were no longer using illegal drugs. For residential rehabilitation this figure was 33%.

Abstinence was associated with positive outcomes in terms of social integration (education/employment and crime), self-perceived health and mental health. For example, 39% of non-abstinent (ex)patients had committed acquisitive crimes over the past 17 months compared to 9% who were abstinent, and 11% and 2% respectively had attempted suicide or harmed themselves.

These associations were said to underline "the benefits ... of drug users having an extended period of abstinence", implying that abstinence caused or enabled other improvements. Yet abstinence was measured over the past three months, associated " benefits" over the past 17. To establish causality, cause must be shown to come before effect. It seems equally conceivable that other life changes enabled abstinence or that there was a complex multi-way interaction. Also, an analysis based on drug use

frequency or severity might have found similar improvements associated with less than total abstinence.

As DORIS researchers warned, potential caseload differences make it unsafe to assume that the various treatment modalities caused the associated differences in abstinence rates. Similar considerations led NTORS to avoid using statistical tests to compare the performances of different modalities because a level playing field in terms of caseload could not be assured.[3] Since so few patients enter residential care in Scotland, and since selection procedures should ensure that this expensive option is reserved for those who could benefit most, it seems likely that they differ from the average methadone patient. Another complication is that in DORIS as in other studies, over the years patients traversed several treatment modalities, complicating the assessment of what led to the eventual outcomes.

Nevertheless the research has highlighted how few drug users enter residential rehabilitation in Scotland and how few become abstinent from illegal drugs after an episode in methadone maintenance, raising questions over the balance of investment in treatment modalities. However, for the reasons given above, it would be unsafe to reset the balance solely on the basis of these findings. Internationally, research on residential rehabilitation is sparse, methodologically weak and ambiguous about its benefits relative to less expensive treatment options, while that favouring methadone is more extensive and more convincing.[4 5 6] Evidence for the special benefits of residential care is mainly confined to multiply problematic and more severe cases.[7]

For similar reasons it would be unsafe to assume that the findings support the diversion of methadone patients to services aimed at abstinence from illegal drugs and legal substitutes. Compared to well run methadone services, such services have been associated with an extremely high rate of relapse and resultant deaths because the short spell of abstinence has left patients unprotected by tolerance to opiate-type drugs yet failed to create the circumstances in which they could do without them.[8]

Rather than or in addition to rebalancing there may be a case for reviewing the resourcing of methadone treatment in Scotland and the services provided by the clinics. English figures show that nearly three times as much is spent on an episode of residential care as on an episode of methadone treatment.[9] From its inception social reintegration has been a major benefit of effective methadone maintenance.[10] In this and other respects, services vary widely. Among the critical factors are adequate, flexible dosing, procedures which minimise both drop-out and throw-out, sufficiently comprehensive services able to draw on wider social resources, staff committed to the welfare of patients and if indicated to indefinite maintenance, and good organisation.

In 2007 an official report on Scottish methadone services suspected that insufficient resources were devoted to rehabilitating patients, found patchy adherence to UK dosing guidelines, differing views on the desirability of long-term prescribing, and widely differing policies on supervised consumption.[11] Such differences are bound to affect patient retention and outcomes and the possibilities for rehabilitation.

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1 **FEATURED STUDY** McKeganey N. et al. Abstinence and drug abuse treatment: results from the Drug Outcome Research in Scotland study. Drugs: Education, Prevention & Policy: 2006, 13(6), p. 537–550.

2 Probably fewer given the numbers not followed up. This applies also to other abstinence estimates.

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5 Drug misuse: psychosocial interventions. National Clinical Practice Guideline Number 51. National Collaborating Centre for Mental Health, 2007.

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7 Systematic but simple way to determine who needs residential care. Nugget 8.9. Drug and Alcohol Findings: 2003, 8, p. 13.

8 Best D. et al. Overdosing on opiates parts I and II. Drug and Alcohol Findings: 2000, issues 4 and 5.

9 Healey A. et al. Criminal outcomes and costs of treatment services for injecting and non-injecting heroin users: evidence from a national prospective cohort survey. Journal of Health Services Research and Policy: 2003 8, 134–141.

10 Ashton M. Methadone maintenance: the original. Drug and Alcohol Findings: 2006, issue 14.

11 Scottish Advisory Committee on Drug Misuse Reducing harm and promoting recovery: a report on methadone treatment for substance misuse in Scotland. SACDM, 2007.

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