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▶ Long-term outcomes of office-based buprenorphine/naloxone maintenance therapy.

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Abstinence and recovery characterised by employment are priority UK policy objectives to which the extension of mutual aid is considered a major route. This US study illustrates that both the route and the objectives are not just compatible with, but may be promoted by opiate maintenance prescribing.

Summary Buprenorphine is the main alternative to methadone for substitute prescribing treatments for opiate addiction. Like methadone it offers the opiate-type effects patients have become dependent on but in a way which enables them to get on with their lives rather than dominating them. It can be taken daily or once every two or three days and fatal overdose is much less likely than with either heroin or methadone. These characteristics make it particularly suitable for non-specialist settings such as primary care. The addition of the opiate blocking drug naloxone to buprenorphine tablets (the combination marketed as Suboxone) is intended to reduce the risk of the tablets being crushed and injected rather than absorbed under the tongue as intended; when injected but not when absorbed under the tongue, naloxone blocks the opiate-type effects of buprenorphine, reducing the incentive to inject the medication. For this reason the combined medication is considered particularly suitable for non-specialist settings and where supervising consumption is not possible or desirable.

The featured study tracked the progress over 18 months of patients inducted on to buprenorphine/naloxone maintenance as inpatients at a specialist hospital addiction centre in Ohio in the USA and later generally transferred to primary care for ongoing maintenance treatment. As also described in an earlier paper, the 12-step based unit discharged patients to a five-week intensive outpatient programme of four three-hour sessions per week, including 12 step-based group therapy and an hour of individual therapy per week. After this the programme was scaled down to 12 weeks of weekly group therapy and one hour of individual therapy every other week. Completion of this

phase meant patients were eligible for transfer to primary care, but were still visited monthly by staff from the hospital and expected to attend 12-step mutual aid meetings three times a week. Patients who did not complete a phase of treatment and remain abstinent were referred back to the previous phase to try again, or of this had happened many times, withdrawn from the medication and discharged from the programme.

At first only patients with health insurance or who could pay could gain access to this treatment. In 2005 a grant enabled the programme to admit patients too poor to pay the fees and not covered by health insurance, on condition that they spend four to eight weeks in residential care after inpatient detoxification. Though generally stably housed, these patients were typically single unemployed injectors. Following the residential phase the programme proceeded to outpatient treatment and then primary care as for other patients.

Main findings

In all 176 patients started treatment. Between 18 and 42 months later, an attempt was made to assess their progress regardless of whether they were still in treatment. 110 were successfully interviewed over the phone of whom 85 (77% of the follow-up sample and 48% of those who started treatment) said they had remained continuously in buprenorphine/naloxone maintenance treatment. Generally they were strongly involved with 12-step groups, 86% considering themselves to be affiliated and two thirds attending groups at least three times a week. Affiliation and active involvement were significantly more common among patients who had remained continuously in treatment. For example, three quarters of those continuously in treatment and who started it with the aid of the grant for poor and uninsured patients were attending 12-step groups at least three times a week.

Very few (8%) of the retained patients but a substantial minority (28%) of those not continuously in treatment were still using heroin. Across the entire follow-up sample, 24% employed at the start of treatment had risen to 58% at follow-up. Retained patients were much more likely to be employed at the time they were interviewed, a difference due largely to the 52% of the uninsured patients among them who had become newly employed since starting treatment. Retained patients were also much more likely to report satisfactory social and personal lives.

Generally patients who had started treatment with the aid of the grant for poor and uninsured patients were doing as well as the better off insured or self-pay patients, While at the start of treatment they were significantly less likely to be employed than other patients, by the end this was no longer the case, though they were more likely to be drinking (7 of 62) or using heroin (11 of 62).

The authors' conclusions

This study confirms that buprenorphine/naloxone maintenance can effectively be combined with a rigorous, abstinence-based 12-step treatment programme and produce long-term improvements in sobriety and quality of life evident in both poor uninsured and the better off insured and self-pay patients. The 77% of patients still in treatment 18 to 42 months later reported dramatic improvement in many domains of quality of life and measures of sobriety when compared to drop-outs. The major reason for drop out or discontinuation was failure to fully adhere to abstinence-based 12-step treatment or

repeated evidence of substance use. This implies that the improved psychosocial functioning in retained buprenorphine/naloxone patients was due not solely to the medication but also to greatly decreased substance use. It should however be borne in mind that the uninsured patients in this study had to commit to up to eight weeks in residential care, a requirement which might have selected out those less keen on treatment.

FINDINGS Abstinence and recovery characterised by employment and an overall improved life and quality of life are priority objectives in current UK policy, and likely to be embedded in 'payment by results' outcomes to which services will be held to account by tying them to funding. Extension of mutual aid networks is considered a major route to these objectives. This study illustrates that such a route and the intended outcomes are not just compatible with, but may be promoted by maintenance prescribing, which acts partly as a means to retain people in forms of treatment (in this case, 12-step based) which they would otherwise not enter or drop-out from.

The earlier report from the same unit compared patients assigned to the treatment programme described above and those detoxified in the same inpatient facility and referred to the intensive outpatient phase of treatment without substitute prescribing. Like the poor and uninsured patients in the featured study, the detoxified patients were generally unemployed. None of these 30 patients went on to complete the outpatient phase of treatment compared to half those prescribed buprenorphine. This comparison and the comparison with the generally unemployed poor patients in the featured study suggests that substitute prescribing can be a way to hold patients in intensive outpatient rehabilitation programmes, including those based on the 12 steps and abstinence objectives.

However, this was done at the cost of terminating the treatment of patients who did not fully participate in the 12-step based therapy or who could not sustain total abstinence, the main reasons why patients left. Patients forcibly terminated from substitute prescribing are at elevated risk of death from overdose, and there are ethical concerns about making treatment contingent on embracing a particular philosophy of addiction and its treatment, especially one based on what US courts have seen as religious in nature. In the case of the service in the featured study, these concerns are mitigated by the fact that the buprenorphine/naloxone programme was conceived as an adjunct to an abstinence-requiring programme rather than as harm reduction or low threshold provision, which is available locally in the form of methadone and other buprenorphine/naloxone programmes for patients who do not want or who drop out of the featured programme. What the featured service aimed to do was to bolster an abstinence-requiring service and intensive rehabilitation programme with buprenorphine/naloxone rather than to replace local harm-reduction prescribing. The area's copious tally of 12-step groups includes several organised for agnostics. This context means that the lessons from the study are less applicable or not all to areas less richly provided with alternative prescribing and 12-step group options.

There seems no reason why methadone should not also aid intensive rehabilitation efforts, but buprenorphine does both seem more suited to abstinence, normalisation and reintegration objectives, and more likely to be chosen by patients for whom these are priorities (1 2). Buprenorphine is also easier to withdraw from, so fits better with current

UK national policy which emphasises moving patients through and out of treatment to (it is hoped) secure recovery via social reintegration and particularly employment. However, nothing will be gained from diverting patients to buprenorphine if many then drop out and return to dependent heroin use who would have been retained by methadone. Even among patients who chose buprenorphine, this seems to have been the outcome at a UK service which compared the progress of its methadone and buprenorphine patients. It would also be counterproductive to insist on intensive rehabilitation being part of substitute prescribing programmes if potential patients reject the whole package and fail to gain the benefits that would have accrued from a more typical substitute prescribing programme.

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