

## 5.5 Opiate detox: spending more may save long term

**Findings** Treatment cost data from NTORS has been used to shed new light on how to gain more successful outcomes per £ spent on detoxifying patients addicted to opiates.

NTORS data was integrated with outcomes from two earlier studies. The first had compared two specialist programmes: a 21-day inpatient methadone regime, and a low intensity eight-week outpatient programme. Patients with a strong preference could choose their regime; just 20 out of 60 were randomly allocated. The inpatient regime cost nine times as much but 81% of patients completed it compared to 17% as outpatients. This meant that per completion it was only twice as expensive. Since that study inpatient stays have commonly been shortened. Assuming the same outcomes from a 10-day stay, the inpatient regime would cost slightly less per successful outcome.

The second report had compared two settings for longer term inpatient detoxification and relapse prevention: a specialist addiction ward (average stay 69 days) or a general psychiatry ward (24 days). Completion rates were respectively 75% and 43%. Seven months after discharge 79% of addiction ward patients had been abstinent from opiates for at least a month but just 31% from the general ward. Specialist treatment cost over three times as much but per completed detoxification it was just twice as expensive, and per patient abstinent at follow up costs were roughly even.

**In context** Completion rates are much higher in inpatient than outpatient programmes. If the wider benefits of successful treatment (eg, reduced crime) are included, a 10-day stay on a specialist ward could well net cost savings several times greater than an outpatient programme. Two factors would weaken this apparent advantage. First, stays in the '10-day' programme at the centre which conducted the study were in practice nearer 19 days. Cost savings would still be several times greater than the outpatient regime, but cost per completion would be 66% higher. Second, the 17% outpatient success rate assumed by the study can be improved on by retention-enhancing therapies or by short, intensively supervised regimes using lofexidine, clonidine or buprenorphine. However, these cost more and have been tried mainly on less dependent patients with adequate social support.

In the comparison between specialist and non-specialist wards, an arguably more appropriate calculation would make the specialist ward cost three times as much per abstinent case. However, this setting was more attractive to patients who also stayed longer, the reason why it cost more. Attributes which encouraged long stays (perhaps staff attitudes and expertise and support from other patients) might have created harm reduction and other gains not reflected in the study.

Design features of the studies it drew on seriously weaken confidence in the featured study's conclusions. These include non-random allocation, poor follow-up rates, non-standard regimes which differed in ways other than setting or length

of stay, and sitting in a centre whose results may not be representative of other units.

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**Practice implications** Using non-specialist wards for inpatient detoxification risks deterring addicts from treatment and creates retention problems which reduce effectiveness. However, high retention increases costs if programmes are allowed to be lengthy. Regimes of around two weeks can achieve good completion rates, but there will remain patients whose illness and instability dictate longer stays to prepare for withdrawal, and others who need longer stay to consolidate gains. Less problematic patients with adequate housing and social support do well in short, intensively supervised outpatient regimes. Outpatient success rates among more problematic patients given inadequate supervision and support may be so low as to make such regimes less cost-effective than inpatient regimes.

**Featured studies** Gossop M., *et al.* "Price, cost and value of opiate detoxification treatments. Reanalysis of data from two randomised trials." *British Journal of Psychiatry*: 2000, 177, p. 262–266. Copies: apply DrugScope.

**Additional reading** Gowing L.R., *et al.* "The management of opioid withdrawal." *Drug and Alcohol Review*: 2000, 19, p. 309–318. Copies: apply DrugScope.

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