Centre for Drug Misuse Research

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Clear rhetoric and blurred reality - maintenance and abstinence

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The Clarity of Policy

UK Drug Strategy 2010

- A fundamental difference between this strategy and those that have gone before is that instead of focusing primarily on reducing the harms caused by drug misuse, our approach will be to go much further and offer every support for people to choose recovery as an achievable way out of dependency. UK Drug Strategy 2010 Reducing Demand Restricting Supply Building Recovery: Supporting People to Live a Drug Free Life)

Putting Full Recovery First

- The coalition government has set out its aspiration to challenge the status quo and build a recovery-oriented society. This will bring an urgent end to the current drift of far too many people into indefinite maintenance, which is a replacement of one dependency with another……Through changes to local commissioning structures we will re-orient local treatment provision towards full recovery by offering people more abstinence- based support and giving them genuine choice about their responsibilities and futures. (Putting Full Recovery First 2011:4)

Medications in Recovery

- The ambition for more people to recover is legitimate, deliverable and overdue. Previous drug strategies focused on reducing crime and drug-related harm to public health, where the benefit to society accrued from people being retained in treatment programmes as much from completing them. However, this allowed a culture of commissioning and practice to develop that gave insufficient priority to an individual's desire to overcome his or her drug or alcohol dependence. (NTA 2012:4)

The Recovery Agenda Accepted or Contested?

- The puritanical recovery agenda is stigmatising marginalising and endangering the health of people who use drugs and have a maintenance script.
- Elliot Ross Albers 2012 International Network of People Who use Drugs.

Treatments Provided

Intervention Received	N	%
Prescribing	149,994	
Structured Psychosocial	55,726	
Residential Rehab	4,026	
Inpatient Detox	8957	

National Treatment Agency Client Survey 2007

	Happy with level of Use	Would like to Reduce Use	Would like to Stop Using
Heroin	11.4%	8.1%	80.5%
Methadone	36.5%	12.9%	50.7%
Crack	16.3%	10.5%	73.2%
Amphetamines	27.5%	11.4%	61.0%
Cannabis	64.2%	14.7%	21.1%
Alcohol	53.6%	21.2%	25.2%
Benzos	50.4%	12.7%	36.9%

Length of Time in Continuous Prescribing (NTA2012)

	Number	%
Less that 12 months	49,265	33
1-2 years	24,495	16
2-3 years	17,342	12
3-4 years	14,458	10
4-5 years	10,524	7
5+ years	33,910	23
Total	149,994	1000

Methadone and Mortality

- Compared with the general population, opiate users in this study had a substantially higher risk of death. The overall risk of death during opiate substitution treatment was lower than the risk of death out of treatment. Patients started on opiate substitution treatment had a twofold to threefold higher risk of death in the first 14 and 28 days of treatment compared with the risk during the rest of their time on treatment. The risk of death increased eightfold to ninefold in the month immediately after the end of opiate substitution treatment. (Cornish et al 2010)

Drug Related Deaths in Scotland 2007-2011

Year	Total Deaths	Heroin	Methadone	% of Deaths Linked to Methadone
2011	584	206	275	47
2010	485	254	174	35
2009	545	322	173	31
2008	574	324	169	29
2007	455	289	114	25

Drug Related Poinsonings Eng Wales 2007-2011

Year	Total Poisonings	Heroin Related	Methadone Related	% of Fatal Poisonings Linked to Methadone
2011	2652	596	486	18
2010	2747	791	355	12
2009	2878	880	408	14
2008	2928	897	378	12
2007	2640	829	325	12

Challenge for Practice

- How to realise the goal of maximising recovery whilst meeting drug user needs?
- How to avoid increasing relapse?
- How to avoid increasing drug related deaths?
- How to avoid drug users remaining on substitute medication for longer than is necessary?

Maximising Recovery and Meeting Drug User Needs

- How much pressure can/should drug treatment services seek to exercise over clients encouraging their progression towards recovery?
- What should drug treatment service be providing to those drug users in contact with services but not seeking or interested in recovery?
- To what extent should treatment have a coercive component given that individuals who are drug dependent may not necessarily be able to act in accordance with the best interests?

Avoiding Relapse

- How quickly should individuals be expected/ encouraged to progress along the road to recovery?

- How can services avoid stimulating unrealistic expectations of recovery that may lead to disenchantment and a diminution in recovery capital at the same time as becoming too accepting of unnecessarily slow progress?

Avoiding Increasing Drug Related Deaths

- Within a recovery climate how can services tackle the increased risk of death associated with the onset and cessation of opiate substitution treatment?
- In a situation where the cessation or reduction in individual's drug use increases the risk of overdose how can services both encourage recovery and at the same time guard against the loss of tolerance associated with such a reduction and the risk of death associated with a resumption in individuals drug use

Avoiding Drifting into Long Term Maintenance Prescribing

- It is widely accepted that there are some people for whom long term, possibly life-long prescribing may be necessary.
- But what are the characteristics of those people?
- How do we ensure that the acceptance in principle of the fact that some people cannot recover does not translate into creeping poor prescribing practice in reality (parking people on medication)?