# Promoting abstinence for drug users is bad science

Despite overwhelming evidence that substitution therapy reduces harm, the UK government now advocates abstinence. **Jason Luty** wonders if this is because it seems cheaper

In Autumn 2009, Professor David Nutt publicly stated (more or less) that alcohol and tobacco were just as damaging as cannabis. Although he told the truth, he was immediately dismissed as head of the UK Advisory Council on Misuse of Drugs.[1] Since then we have had two ministers of health, a new government, and one reshuffle. Nevertheless, the message was clear: any bolshie academic who speaks out of turn is likely to get the chop.

In 2010 the new UK government announced that substance misuse services should follow a recovery model.[2] Basically, this means that patients receiving opioid substitution therapy are encouraged to reduce and stop all addictive drugs, including prescribed drug substitutes. (Opioid substitution therapy refers to use of drugs such as methadone and buprenorphine for treatment of heroin addiction; detoxification is the process of reducing and stopping addictive drugs such as methadone; and maintenance is the prescription of substitute drugs over years with no requirement to stop.) Substance misuse teams in England now have an "aspiration" (a target) to discharge (and detoxify) half of the 170 000 people probably receiving opioid substitution treatment.[3]

Professor John Strang of the National Addiction Centre was tasked to provide expert clinical guidance in response to the new government's favoured recovery model. This unenviable task resulted in the *Medications in Recovery* report.[4] However, almost all the evidence base shows that abstinence is far less effective than maintenance.[5-7] Indeed, a recent report from British Columbia of more than 25 000 methadone treatment episodes showed that only one in 40 episodes achieved a successful recovery (abstinence from prescribed methadone with no re-entry to treatment within 18 months).[8] There are several comparable research reports.[7 9] Almost identical results were sensationally reported from the UK in the press four years ago.[10] By contrast, about half of patients who are maintained on methadone can almost completely abstain from heroin.[11-13]

However, Strang's committee produced a document that spectacularly avoids stating the obvious: "the [vast] majority of patients attempting to taper from methadone maintenance treatment will not succeed."[8] To be brutally frank, any suggestion that

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detoxification is as effective as maintenance is poppycock. (This even applies to slow detoxification over one year, and let us be clear: detoxification is an unavoidable part of the recovery agenda.)

Of course, the government's recovery agenda is not only about recovery from substance misuse. It is also about recovery from the economic global recession and the need to cut public spending. Regardless of the evidence base, the UK government cannot, or will not, continue to fund treatment for 170 000 opioid users on indefinite prescriptions. It is not really that people are dependent on methadone: the problem is they are dependent on the health service to prescribe this. For example, substance misuse services are required to provide medical reviews of all patients taking methadone every three months. Consider a typical service of 400 patients receiving prescriptions for substitutes, and assume each review takes 30 minutes with a (conservative) 25% rate of non-attendance. A drug treatment service would have to employ a doctor full time just to do the routine reviews.

So what's to be done? Unless decades of international experience are wrong, the vast majority of patients will relapse back to heroin misuse before their methadone is stopped or within a few months. Savings can be achieved by streamlining the treatment process. There are reams of policies produced by chief executives burdened with accountability for clinical decisions that they are neither qualified nor competent to perform themselves. Clinicians are trained to perform, and be accountable, for their clinical practice. Even a casual visitor to a community drug team will notice that clinical staff spend more than half their time with bureaucracy—completing forms, management meetings, and maintaining written or electronic notes.

It has been proved beyond all reasonable doubt that opioid substitution reduces drug use and crime and improves physical and mental health and social functioning.[5 9 11] Nevertheless, commissioners demand that this is confirmed by means of the mandatory treatment outcome profile interview every six weeks in every patient in treatment—all 170 000. They also insist on collecting a large amount of information recorded by interview when people enter treatment with substance misuse services. We should abolish this time wasting control freakery and needless bureaucracy. The only function of this sort of nonsense is to keep policy writers and bureaucrats in employment at taxpayers' expense.

Governments should focus on three or four targets to ensure that treatment services function effectively, and one of these should be to ensure that clinical staff spend at least half their time in direct contact with patients. Similarly, we should be rid of the armies of bureaucrats, data managers, and commissioners that seem to have multiplied exponentially. Anyone who has no patient contact has no place working in the health service.

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FROM THE FRONTLINE **Des Spence**

# Kill the QOF

We are entering the 10th year of the world's largest public health experiment in evidenced based medicine—the target driven QOF (Quality and Outcomes Framework). It has cost £10bn in direct payments to general practitioners,[1] but this is just the tip of an expensive iceberg. Hidden are the appointments systems overloaded with arbitrary "reviews" and huge increases in investigations and prescribing. Once highly functional general practice computing systems are now clogged with constant pop-up reminders to enter data that are meaningless, useless, and frankly often erroneous. GPs now gaze on a computer, not the patient. A once simple, lean, and agile primary care has been made bloated and overcomplicated. No discretion, no judgment; this is flow chart medicine and a profession left in a persistent vegetative intellectual state. The QOF apologists trot out the "recorded" reductions in blood sugar, blood pressure, and the like, but these are mere soft surrogates.

**It's time to look away from the screen and at the patient once again**

What of hard endpoints? From 2004 to 2011 prescriptions for statins doubled, for angiotensin converting enzyme inhibitors and diabetic drugs near doubled, for antidepressants rose 60%, and for steroid inhalers rose 30%.[2] Polypharmacy is the norm not the exception, and research evidence validates this approach. Yet statins, for instance, are supposed to reduce heart disease by 30% within a few years.[3] The QOF has created three million new statin users,[2] so why has there been no demonstrable effect on heart disease trends?[4] Also we might reasonably expect within a decade to see a change in the trajectory of UK life expectancy, but we have not.[5] Likewise the QOF was designed to improve chronic disease management in general practice, but instead outpatient referrals have risen 5% annually,[6] with similar rates in acute hospital admissions.[6] This is leading to unsustainable pressure and costs throughout the NHS. Perhaps assessing the impact of QOF is impossible because there is no control group. But we can compare UK trends with other similar countries, and there is no evidence that UK healthcare is outpacing these countries.

The QOF simply hasn't worked. It is a bureaucratic disaster, measuring the measurable but eroding the all important immeasurable, and squandering our time, effort, and money. It has made patients of us all and turned skilled clinicians into bean counters. Incentives and centralised targets are under scrutiny throughout the public sector because targets just lead to gaming. It's time to look away from the screen and at the patient once again. Turn off the financial life support and let this failed intervention die.

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IN AND OUT OF HOSPITAL **James Owen Drife**

# A grandad writes

Most of my friends are grandparents, and they all say how enjoyable it is. For a retired obstetrician, however, the final run-up to grandparenthood is a bit fraught. After decades of being called to difficult labours, one becomes too aware of the risks. Statistically, I kept telling myself, things should be OK.

Indeed they were, and once the reassuring text and photo arrived from a distant delivery room overlooking Big Ben, I settled down to write about the rigours of experiencing pregnancy at third hand. But hold on: I've already written on "My grandchild's birth," years ago when my daughter was at school (*BMJ* 1988;297:1208). It was an attempt to predict the future. But how did it stack up against reality?

Not very well, I'm afraid. For example, I failed to forecast the communication revolution. Today the website Mumsnet is the source of all information on pregnancy and beyond. Phone calls to an obstetric parent are for quality control purposes only.

And I failed to predict the short postnatal stay for healthy women. My daughter was happy to go home after a few hours, but I've never liked the idea. Now, I see, an entrepreneur is planning a private retreat for new mothers who are willing and able to pay upwards of £2000 for the three days of rest they once got on the NHS.

Of course, my article was not really about the future. It was about the 1980s, when midwives were struggling to escape dominance by obstetricians, and labour wards were run by junior doctors who had little chance of becoming consultants. It all seems a very long time ago, and it did not take supernatural powers to see that the system could not continue.

**Today . . . Mumsnet is the source of all information on pregnancy and beyond. Phone calls to an obstetric parent are for quality control purposes only**

But the degree of change in 25 years is still surprising. How did I fail to foresee the gender shift in my own specialty? The influx of women obstetricians has removed the main barrier between doctors and midwives—the undercurrent of militant feminism that used to make our relationship so difficult.

I'm sure that in another 25 years people will again look back in disbelief. Separate royal colleges for midwives and obstetricians? Really? What won't change, though, is the joy of a new life, helped into the world by midwives who, my daughter tells me, were wonderful.

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