

# The Treatment Journey

## An overview of Issues Trends in Europe and Australia

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# Acknowledgement of collaborative work

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John Marsden, Robert Ali,, Garry Stillwell, Matthew Hickman Nicola Singleton,

Metanalysis work with Sheila Gore and Elizabeth Merrill

Thanks for work from Jo Ross, Shane Darke, Maree Teeson and Kath Mills



# Summary of talk

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- Background history
- Trends in European and UK drug problems and access to treatment
- Issues of access to residential rehabilitation
- Fresh debate on role of Recovery and the appropriate level of support for Recovery



# Summary of Talk

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Risk of overdose on discharge from prison and on exit from community based OST

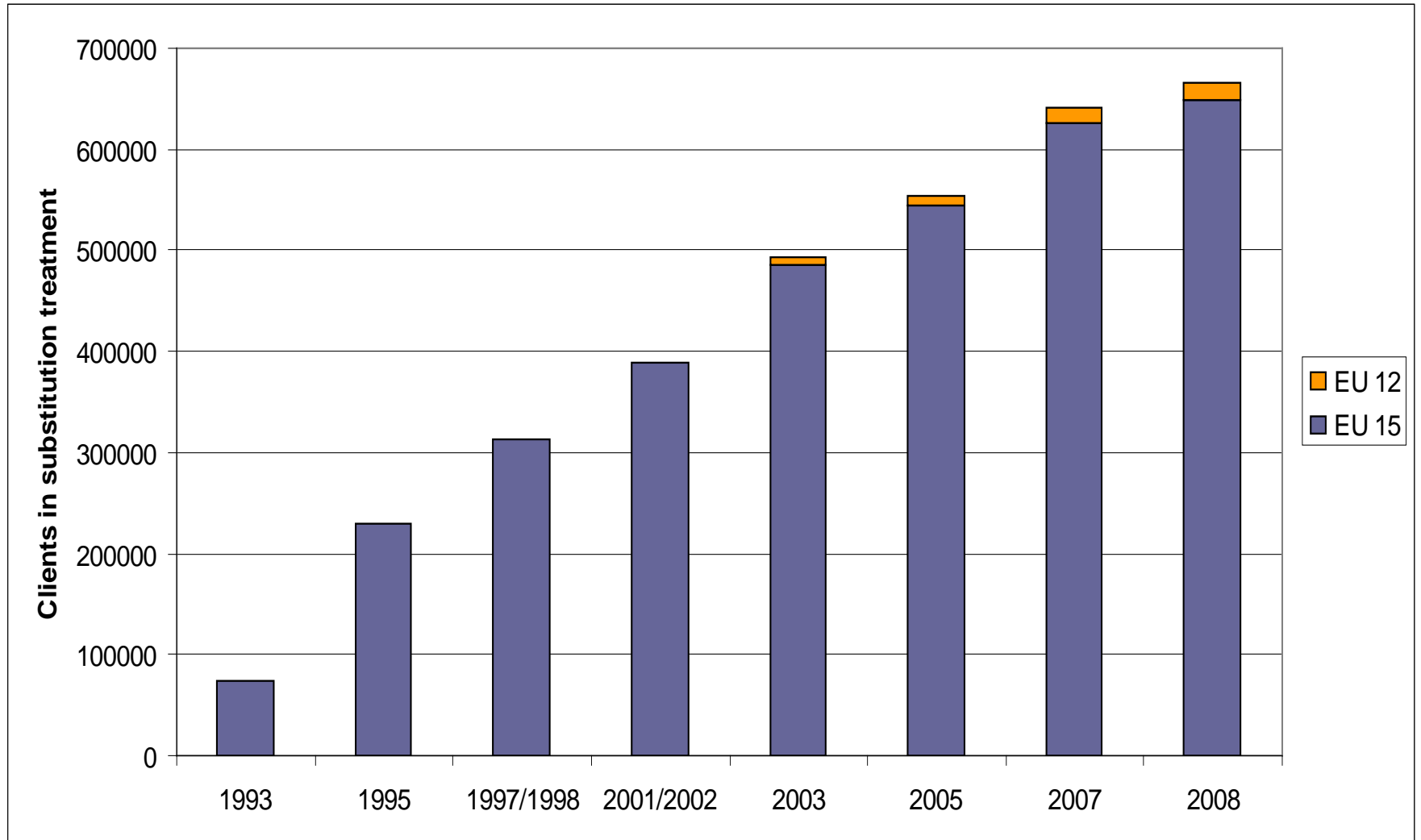
Risk of overdose compared to risk in other forms of discontinuity of treatment

Now need for focus on improving quality and impact of community based integrated treatment and care planning

Need for better care planning across a wide range of services

Challenge to ensure full workforce and skill base in time of financial cutbacks, concern around race to the bottom with new competitive commissioning culture

# Number receiving opioid substitution treatment from 1993 to 2008 in the EU-27



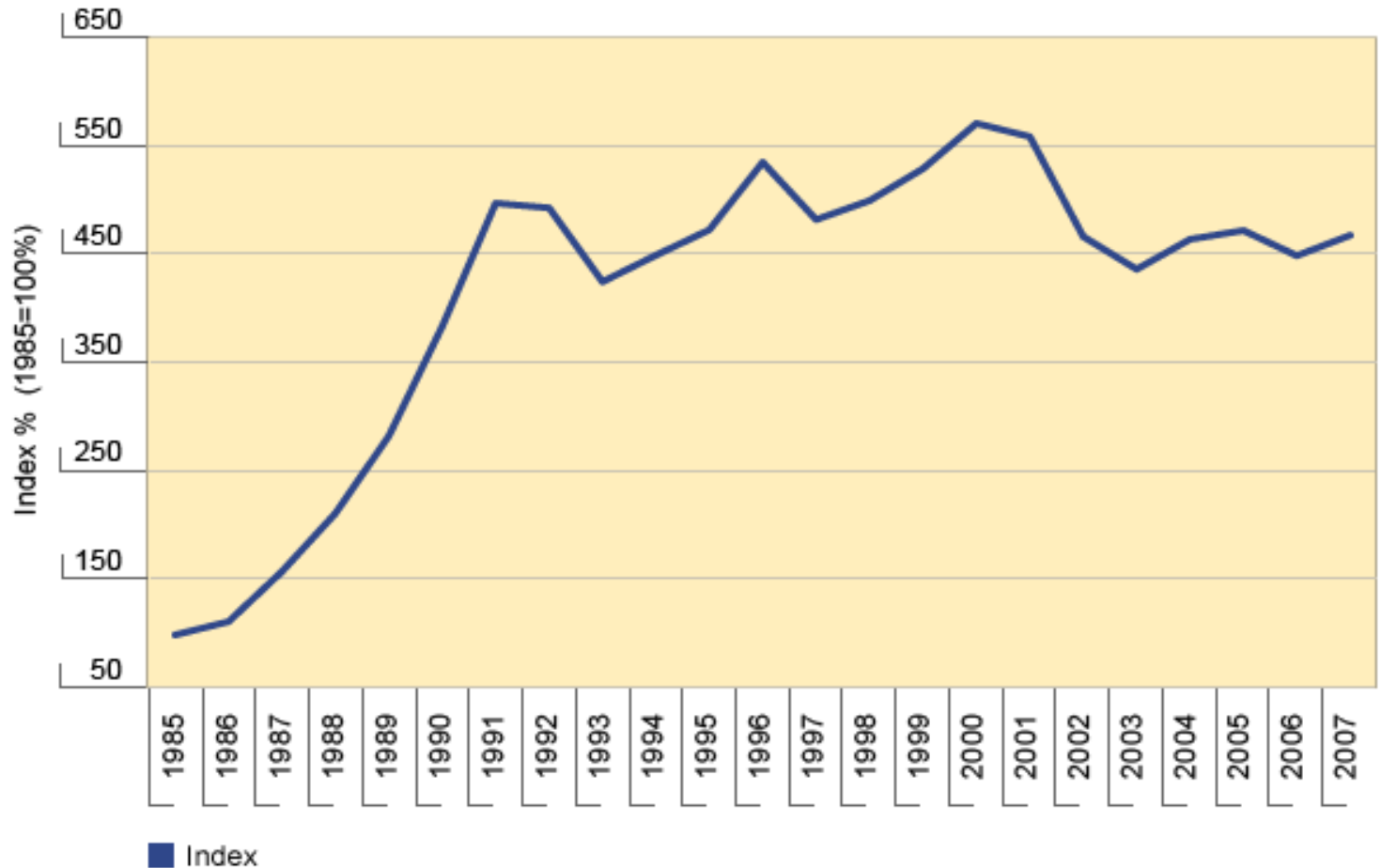
# Indexed long term trend in drug-induced deaths in the EU-15 Member States and

Overview

Recent situation

Characteristics

**Trends**

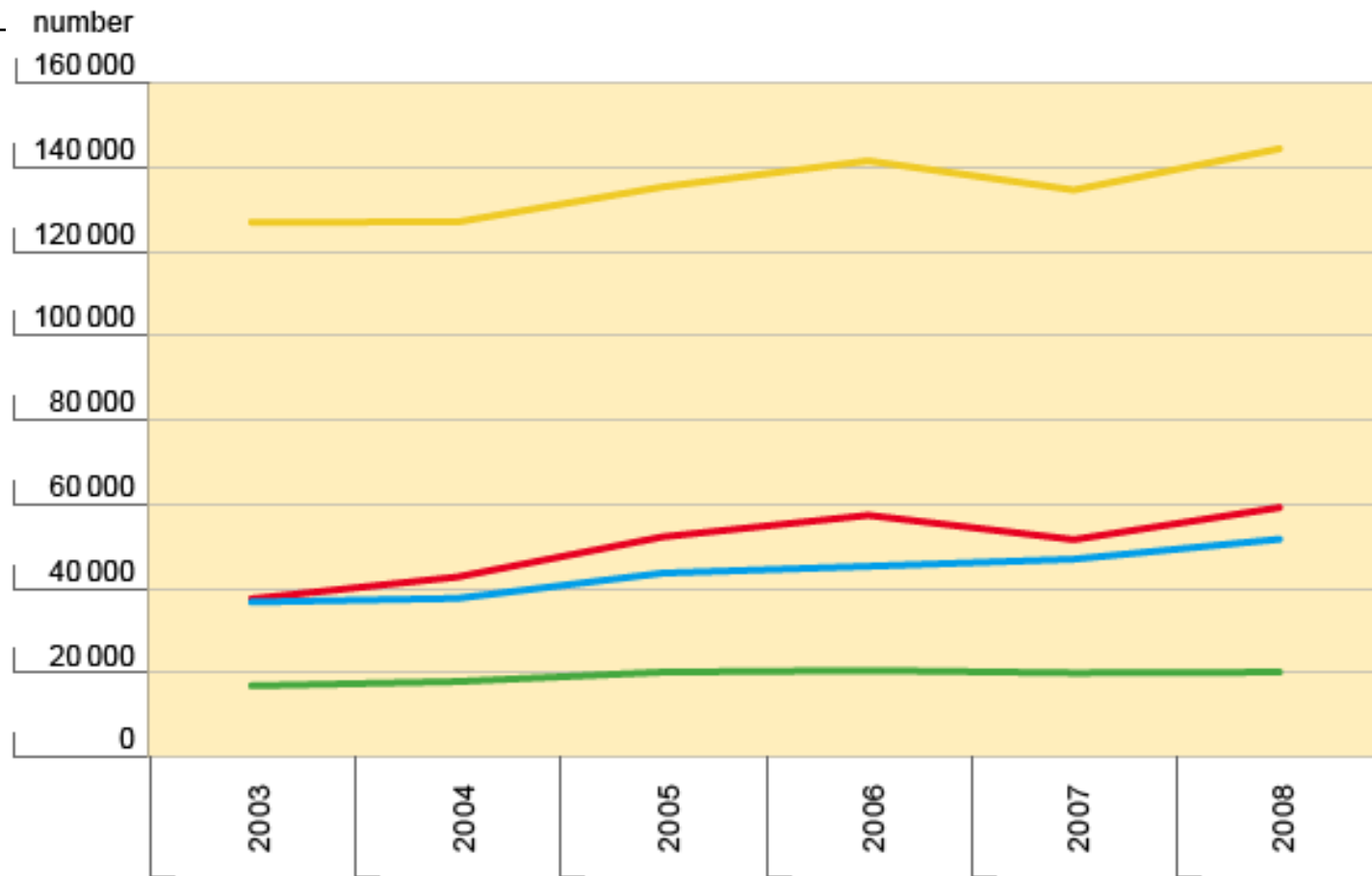


Overview

## Trends in treatment entries by primary drug

- Heroin
- Cocaine
- Cannabis
- Other stimulants

Recent situation



Characteristics

Trends



# SHAPING AND PLANNING SERVICES FOR THE 21<sup>ST</sup>

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## CENTURY

Criticism of existing services now too narrowly focused not adequate planning across different treatment modalities and poor linkage and care planning across different modalities,

Problems with ageing treatment cohort now moving towards issues of methadone in residential care for the elderly

Poly drug use population with mixture of alcohol, benzodiazepine and opioid and heroin dependence

Also falling numbers of new heroin users replaced with psychostimulants

Cocaine and methamphetamine



# Issues in UK and other EU settings

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- Growing debate on the relationship of recovery to treatment,
- Marked funding squeeze on residential sector perception that methadone with not great outcomes dominating
- A debate on quality and duration of methadone treatment in UK and Ireland

# UKDPC consensus statement

United Kingdom Drug Policy Commission

**“The process of recovery from problematic substance use is characterised by voluntarily-sustained control over substance use which maximises health and wellbeing and participation in the rights, roles and responsibilities of society”.**

[www.ukdpc.org.uk/resources/avisionofrecovery.pdf](http://www.ukdpc.org.uk/resources/avisionofrecovery.pdf)

# Recovery definition

- **Aspirational vision**
- **Inclusive of abstinence and maintenance goals.**
- **Recovery more than dealing with harms.**
- **Must encompass building a fulfilling life.**
- **Relationship with the wider world is part of the recovery process for an individual.**

**In our field this requires a long-term commitment and a balance of specialist care and building recovery capital.**

# What predicts recovery?

- **Resilience to social stressors.**
- **Social supports.**
- **Family life.**
- **Identity shift to functional from dysfunctional.**
- **Employment.**
- **Stable housing.**

# Recovery capital

## Personal recovery capital

### Physical

- Physical health
- financial assets
- Health insurance
- Safe and recovery conducive accommodation
- Clothing
- Food
- Access to transportation

### Human

- Values, knowledge, education/vocational skills
- Ps capabilities
- self-awareness – esteem – efficacy
- Hopefulness/optimism
- Perceptions of past present future
- sense of meaning & purpose in life
- Interpersonal skills

## Social/family recovery capital

### Relationships

- Intimate relationships
- Family & kinship relationships (family of choice)
- Social relationships supportive of recovery

### Indicators

- Willingness of partners/family to participate in treatment
- Presence of in recovery in the family & SN
- Access to sober outlets – sobriety based fellowship/leisure
- Relational connections e.g. school, workplace etc

## Community recovery capital

- Community attitudes/policies/resources related to addiction and recovery that promote resolution of substance use disorders
- active efforts to reduce addiction/recovery stigma
- Visible and diverse local recovery role models
- A full continuum of addiction treatment resources
- Recovery mutual aid resources that are accessible and diverse
- Sources of sustained recovery support and early re-intervention
- Cultural capital – availability of culturally prescribed pathways of recovery

# Recovery

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## □ Treatment Renewal Movement

(e.g. continuum vs. unit or episode, medication assisted treatments, performance and outcome, etc.)

## □ Recovery Advocacy Movement

(e.g. support groups, clubhouses, recovery support centers, recovery housing, recovery educational programs, recovery job co-ops, etc.)

In UK broad debate on definition of recovery with an important emphasis on the value of medication treatment as a core part of recovery

Also focus on developing recovery advocates who are external to and beyond traditional treatment delivery “Recovery Advocates”

A real risk that a vigorous recovery debate polarises the field into abstinence versus medication and overall regressive approach



# Issues for Treatment re Recovery

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- Greater focus on what happens BEFORE and AFTER primary treatment
- Transition from professional-directed treatment plans to client-developed recovery plans
- Greater emphasis on the physical, social and cultural environment in which recovery succeeds or fails
- After Bill White et al

# *The Australian Treatment Outcome Study (ATOS)*

First Australian large scale longitudinal study of treatment outcomes for heroin dependence

Involved treatment entrants from RR, detoxification & ORT services, and a non-treatment group

## Findings:

RR services attract a more 'hard core' group of heroin users than other modalities:

- more drug entrenched
- higher rates of severe psychological distress, overdose, suicide, PTSD &



## *ATOS Findings continued...*

Treatment works: Improvements across all modalities in drug use, criminality, and psychopathology at 3, 12, 24 & 36 month follow-up.

Longer retention & fewer treatment episodes were associated with better treatment outcomes.

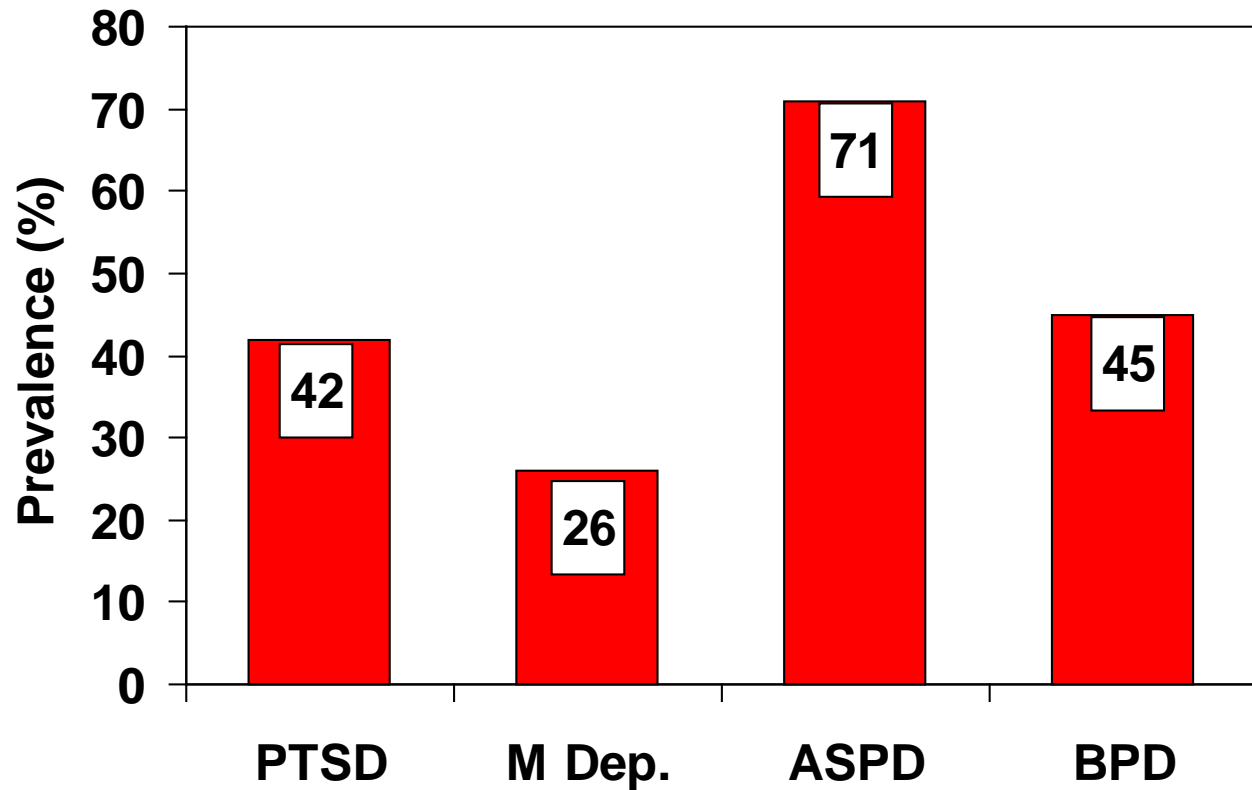
Successful graduation (programme completion and separation with consent) from a RR predicted better outcome, independent of treatment length.

18% of RR entrants maintained continuous heroin abstinence across 24 months.

41% of the cohort met criteria for PTSD at baseline, and the disability associated with PTSD remained at follow up.

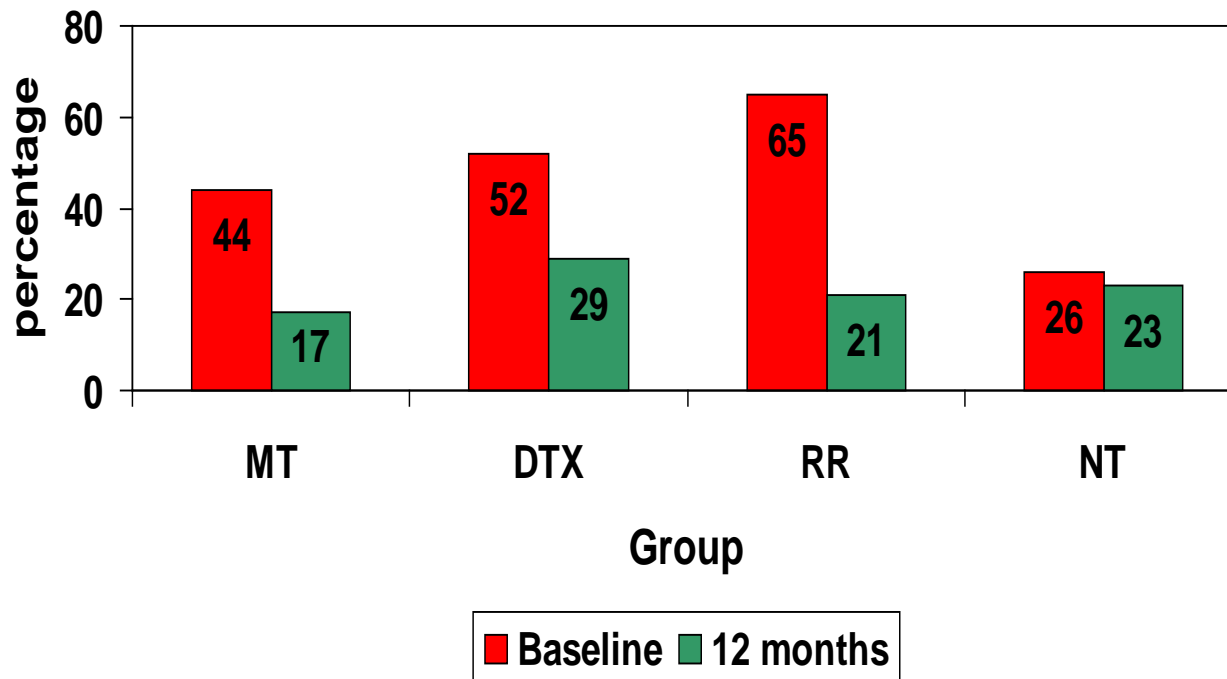
# Psychological Distress

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# Has their mental health improved?

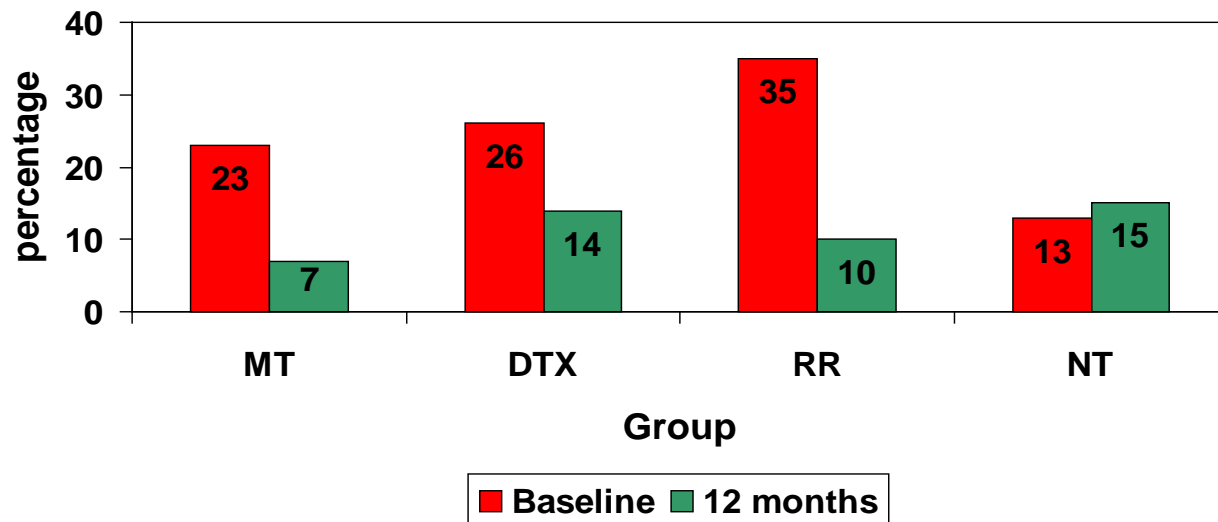
## Severe psychological distress: SF-12



- Predictors of better mental health
- Younger age
- Better baseline mental health
- More treatment days
- Fewer treatment episodes

# Has their mental health improved?

## CURRENT MAJOR DEPRESSION: CIDI



□ Predictors of Major Depression

- Being female

- Depression at baseline

- Fewer treatment days

- More treatment episodes



# *Suicide Risk Assessment Study*

How is suicide risk assessed and managed in RR services?

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Managers & volunteers from staff in 64 RR programmes across Australia were interviewed.

1/3 of agencies had no documented policies or procedures for managing suicide risk;  
1/4 of staff were never formally trained in SRA;  
In > 1/3 of agencies the use of structured suicide risk

assessment tools was not expected;

Inconsistency in the tools used across agencies;

Agencies were gathering information about psychiatric

# *Development of the Suicide Assessment Kit (SAK)*

1

- Acute Suicide risk Screener (Suicide-AS)

2

- Suicide Risk Formulation Template (Suicide-RFT)

3

- Suicide Policies and Procedures Pro-forma (Suicide-PPP)



# *Effect of drug trends on WHOS treatment admissions 2003-2008*

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Are changes in heroin and methamphetamine markets associated with changes in the profile of admissions and completion rates?

Admission & treatment completion data for WHOS (2003-2008) were analysed.

A significant decrease was seen in heroin as the primary drug problem (33 to 19%) and increase in methamphetamine (13 to 24%).

Despite this, retention and completion were not adversely affected.

Changes in case mixes do not necessarily cause major disruptions in treatment efficacy.

# *Longitudinal study of treatment entrants at WHOS*

What baseline client characteristics predict length of stay, treatment completion and early separation in a TC?

Prospective study of 191 treatment admissions at WHOS

Mdn length of stay: 39 days; 34% successfully completed.

Longer L.O.S predicted by: prior treatment completion, better physical health and no prison history.

Treatment completion predicted by: Being male & fewer stressful life events


Early separation predicted by: recent prison release & perceiving themselves as unlikely to complete treatment.

Primary problem drug and psychopathology were not prognostic indicators for treatment success



For further information on Suicide Assessment Risk  
Project please contact: [j.ross@unsw.edu.au](mailto:j.ross@unsw.edu.au)

National Drug and Alcohol Research Centre  
<http://ndarc.med.unsw.edu.au>



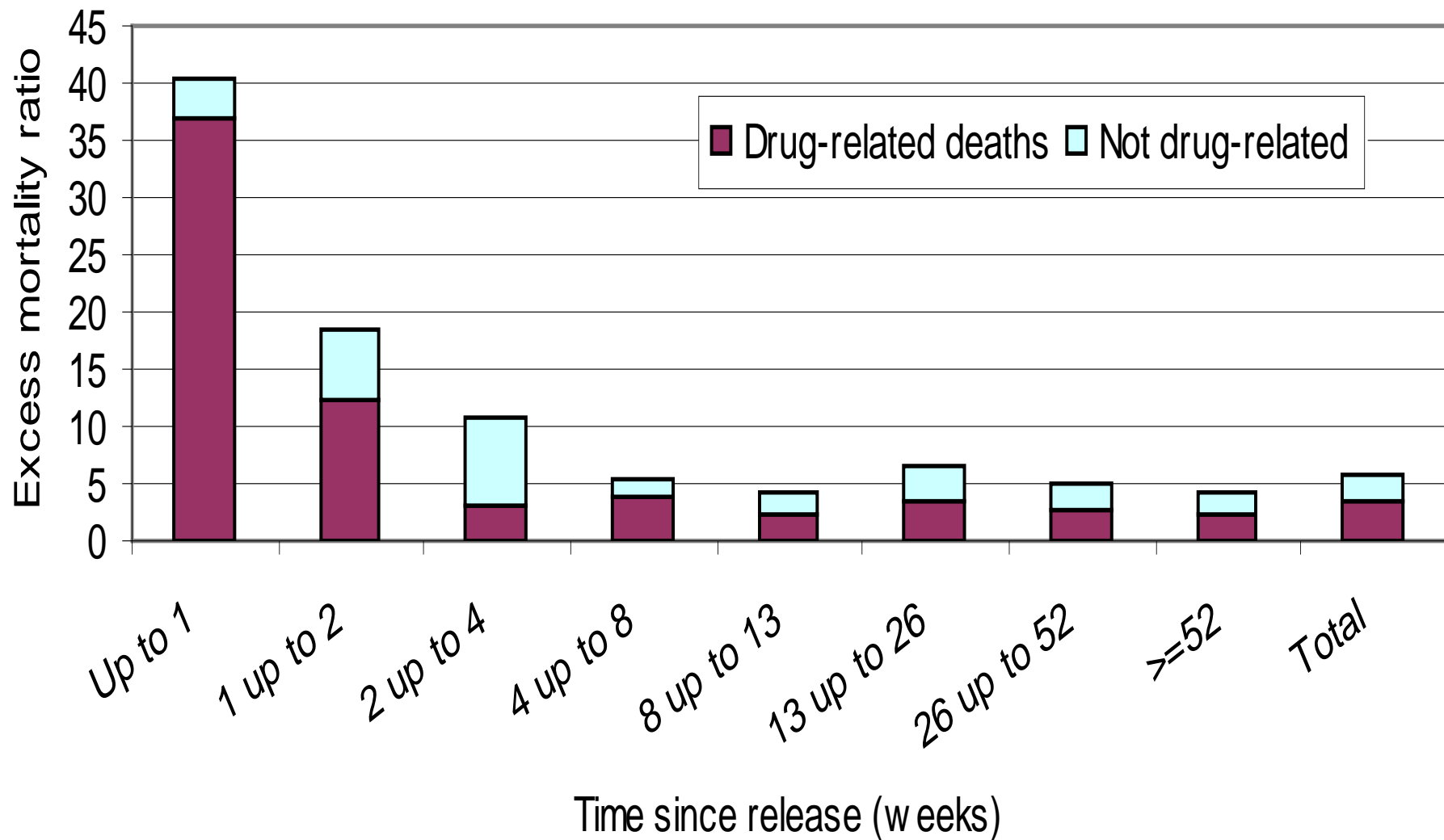
# Drug related death on release from prison and other institutions

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UNITED STATES NARCOTIC FARM

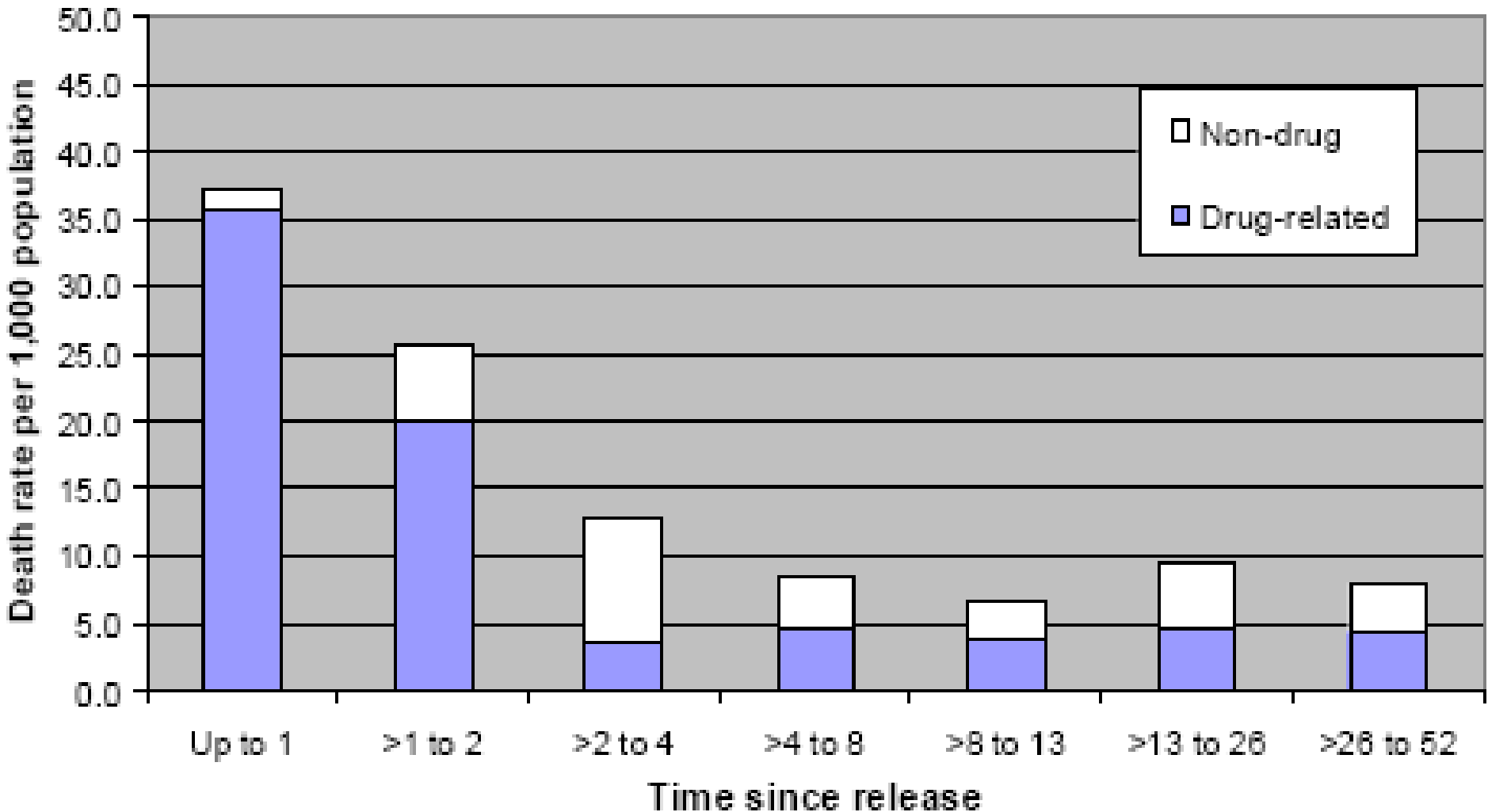


# Excess mortality ratio for different time periods post-release by cause of death (Singleton, Farrell, Marsden et al 2003)



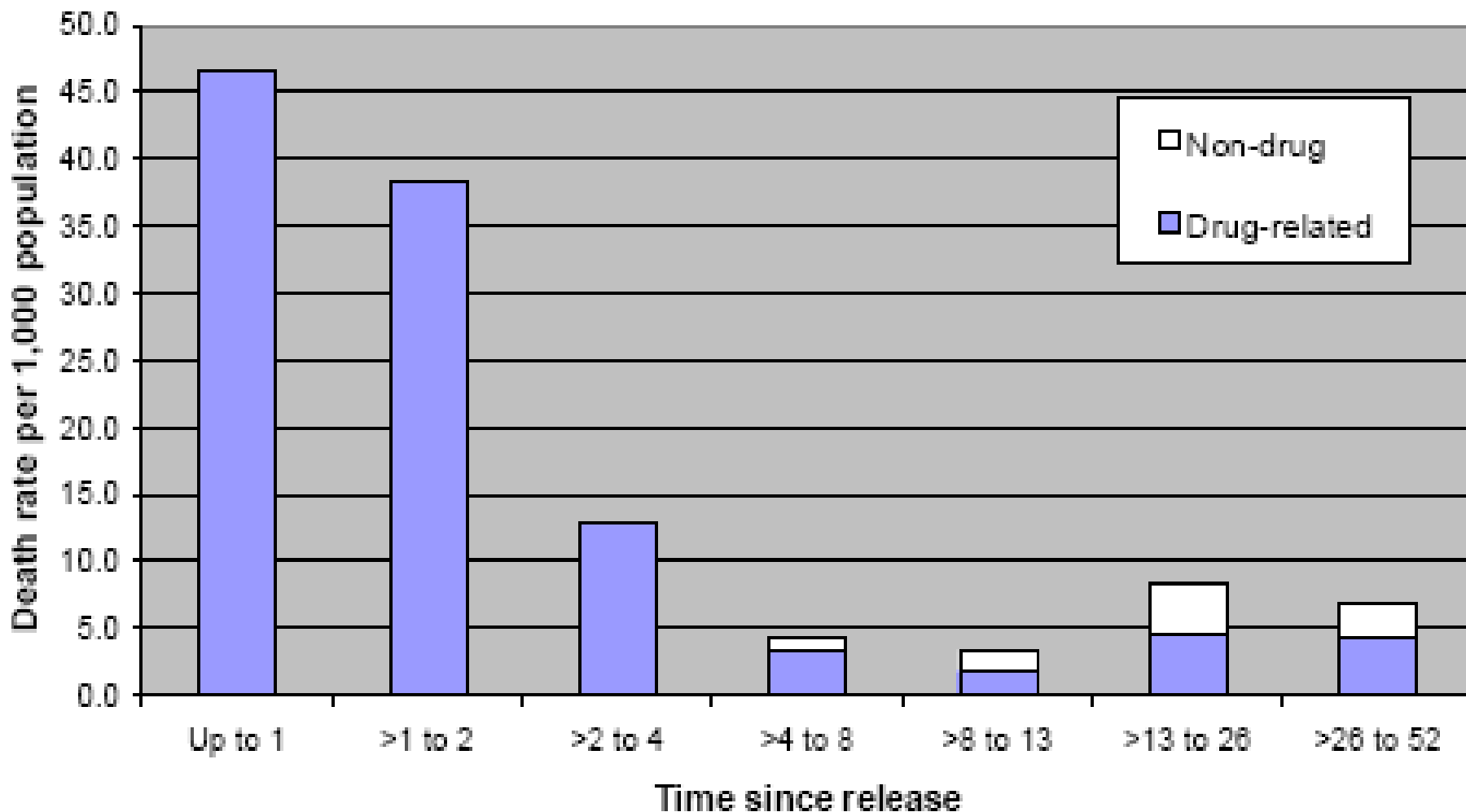
# Post-release mortality rates (males)

Farrell & Marsden [2008] n = 36,515



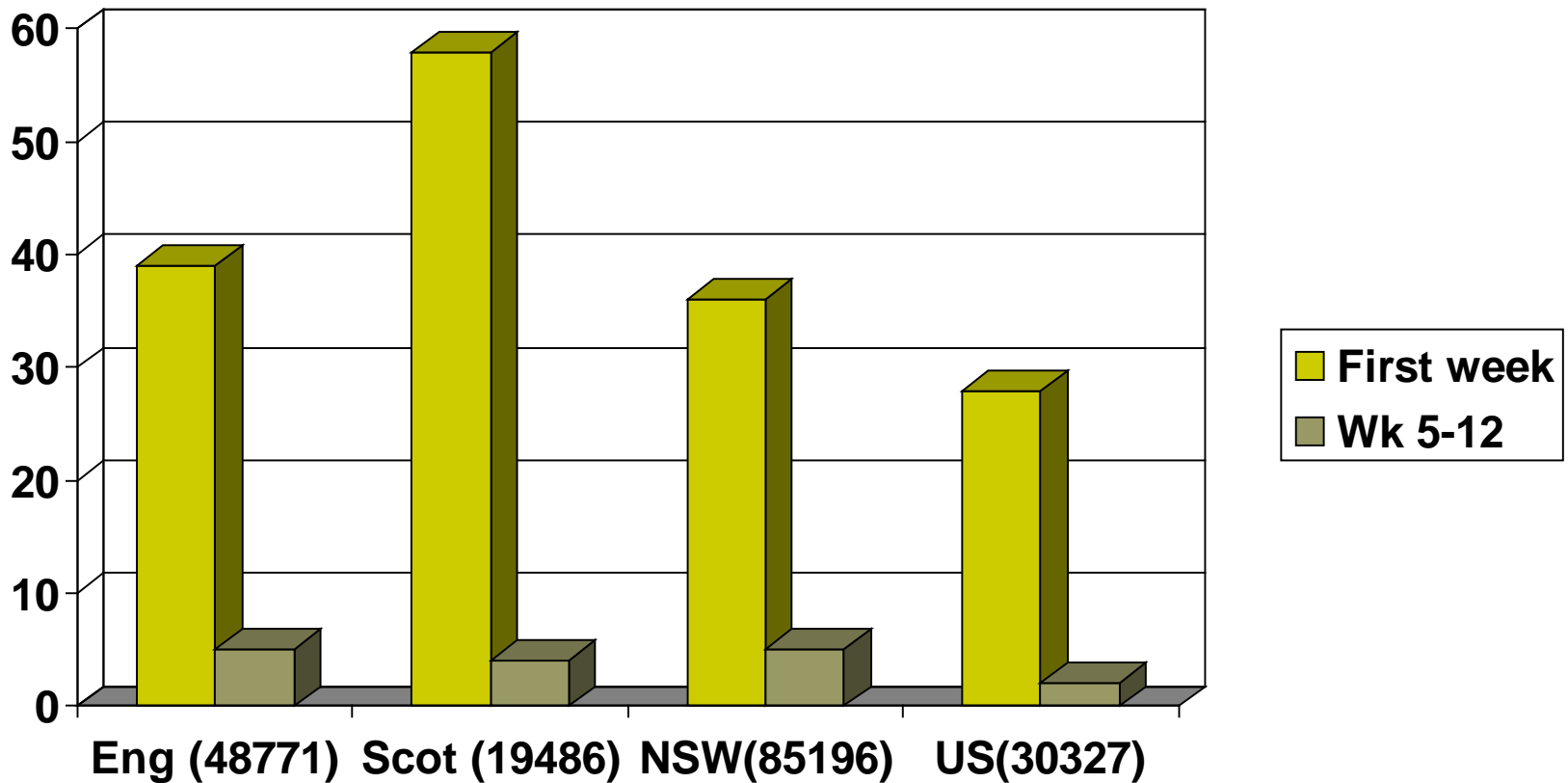
# Post-release mortality rates (females)

Farrell & Marsden [2008] n = 12,256



# Prison Release Mortality

## Total Sample 183780



Deaths per thousand person years Metanalysis Merrill et al 2010 Addiction


# Meta-analysis of major studies: when

Country: studies	Drug-Related Deaths (person-years)			RR in 1 <sup>st</sup> fortnight (95% CI)
	<b>DRD Rate per 1,000 pys</b>			
	Wks 1+2	Wks 3+4	Wks 5-12	
UK: E&W + Scotland	92 (2,588) <b>36</b>	20 (2,547) <b>8</b>	42 (10,795) <b>4</b>	<b>7.5</b> (5.7- 9.9)
Australia: NSW + <i>Western</i>	187 (7,759) <b>24</b>	64 (7,416) <b>9</b>	144 (27,334) <b>5</b>	<b>4.0</b> (3.3- 4.8)
<b>USA:</b> State = Washington	27 (1,466) <b>18</b>	5 (1,426) <b>4</b>	10 (5,409) <b>2</b>	<b>8.4</b> (5.0-14.2)
<b>USA:</b> State = <i>New Mexico</i>	8 ( 462) <b>17</b>	3 ( 462) <b>6</b>	10 (1,845) <b>5</b>	<b>3.1</b> (1.3- 7.1)

# Risk on release from residential and inpatient treatment

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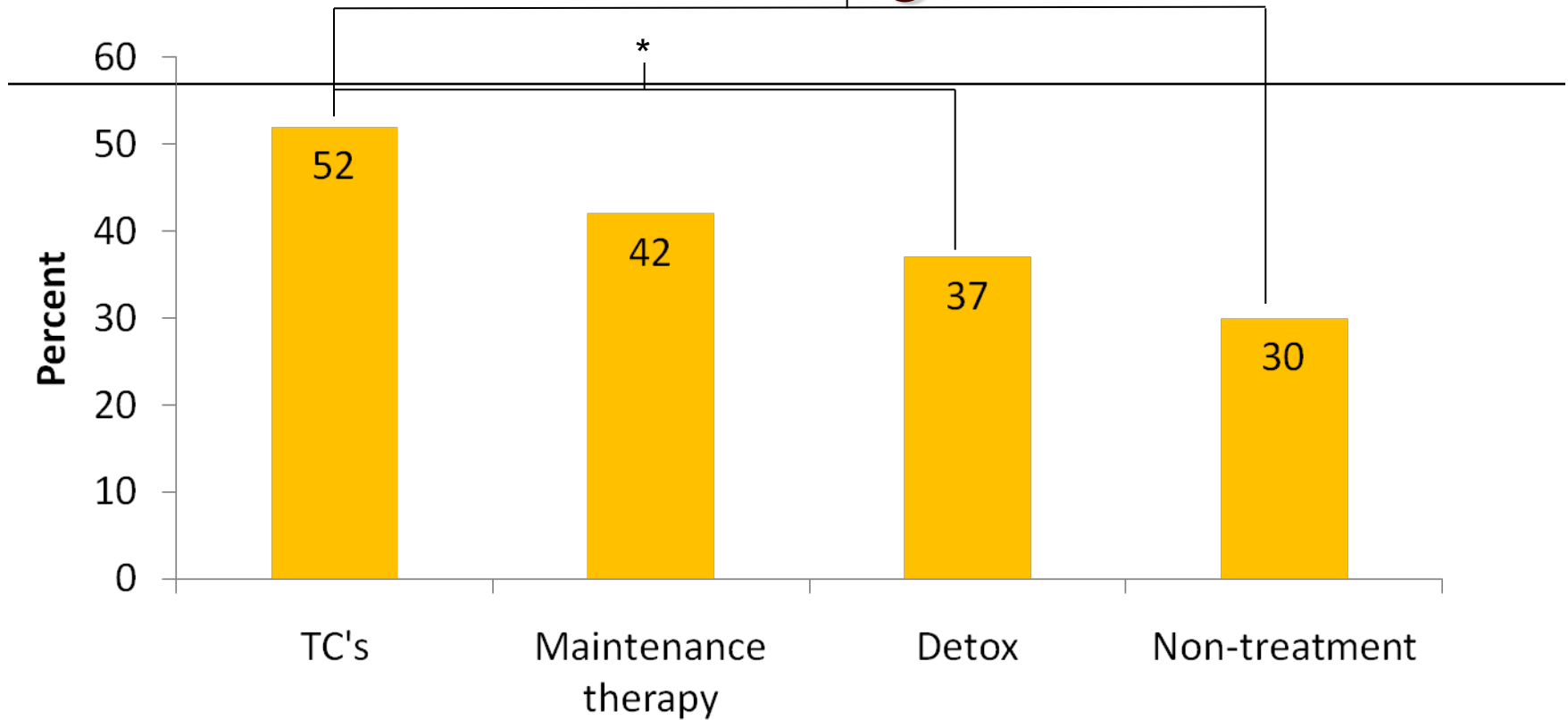
- Preliminary data indicates elevated risk but not very well enumerated
- Need for bigger cohort studies to clarify risk and protective factors
- Need good education for individuals and families about possible risk and approaches to reduce risk



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Substance use and  
post traumatic stress disorder  
(PTSD)

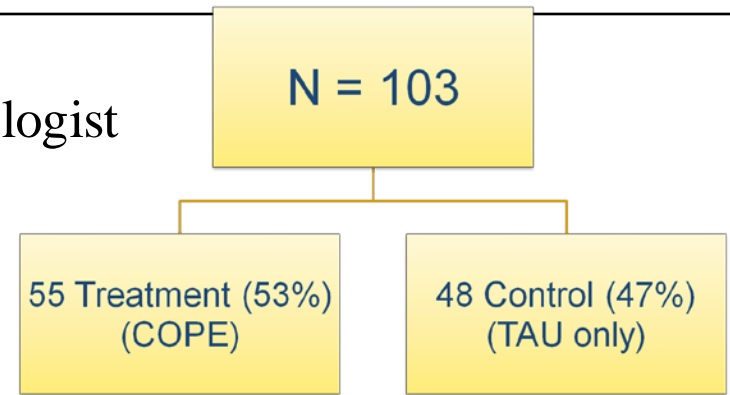
# How common is PTSD among TC clients?



# Treating PTSD

- NDARC leading randomised controlled trial of an integrated treatment for PTSD and SUD called Concurrent Treatment with Prolonged Exposure (COPE)

- **Sessions:** 13 sessions with a clinical psychologist
- **Format:** Individual
- **Program:** CBT with imaginal and *in vivo* exposure



Both groups may receive treatment as usual for their substance use in the community (e.g., detox, residential rehabilitation, maintenance pharmacotherapies, counselling etc)

Katherine L Mills<sup>1</sup>, Maree Teesson<sup>1</sup>, Emma Barrett<sup>1</sup>, Sabine Merz<sup>1</sup>, Julia Rosenfeld<sup>1</sup>, Philippa Ewer<sup>1</sup>, Claudia Sannibale<sup>1</sup>, Sally Hopwood<sup>2</sup>, Amanda Baker<sup>3</sup>, Sudie Back<sup>4</sup>, Kathleen Brady<sup>4</sup>

<sup>1</sup> National Drug and Alcohol Research Centre, University of New South Wales

<sup>2</sup> Traumatic Stress Clinic, Westmead Hospital

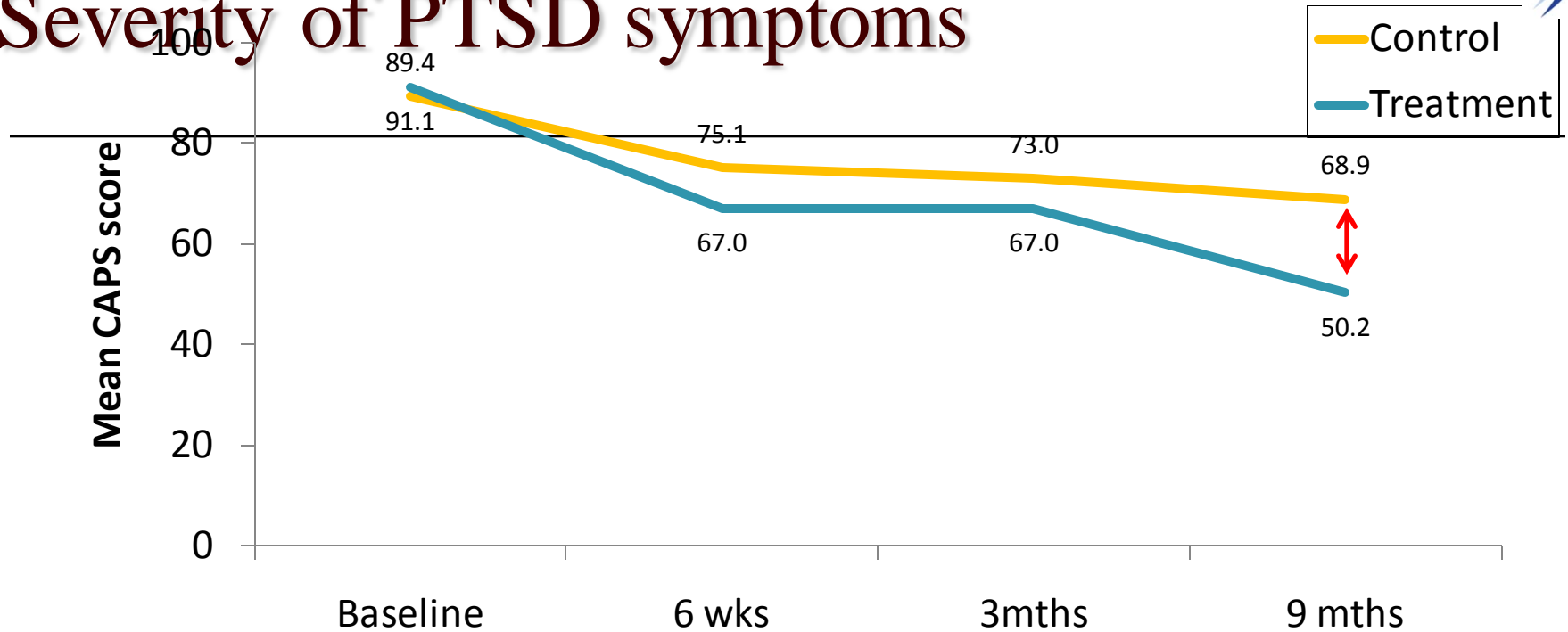
<sup>3</sup> Centre for Brain and Mental Health Research, University of Newcastle

<sup>4</sup> Department of Psychiatry, Medical University of South Carolina





# Severity of PTSD symptoms



*“It was really really great! I used to wonder how I would cope emotionally without smoking - now I don’t have to do that anymore - I’m so glad I did it”*

*“It helped me realise how much my addiction is linked to the trauma. I can now talk about the incident without freaking out”*

# Conclusion



- Across the 9 mth follow-up period:
    - Both groups evidenced improvements in their
      - Substance use
      - Severity of dependence
      - PTSD symptoms
      - Depression
      - Anxiety
      - General mental health
- THEY DID NOT GET WORSE!
- Participants randomised to **COPE** demonstrated significantly greater improvements in relation to their PTSD symptoms, particularly in relation to their avoidance and hyperarousal symptoms
- These findings provide evidence in support of treating PTSD among people with SUDs using COPE (Mills et al., 2007).



For further information on COPE please contact:

[k.mills@unsw.edu.au](mailto:k.mills@unsw.edu.au)

National Drug and Alcohol Research Centre

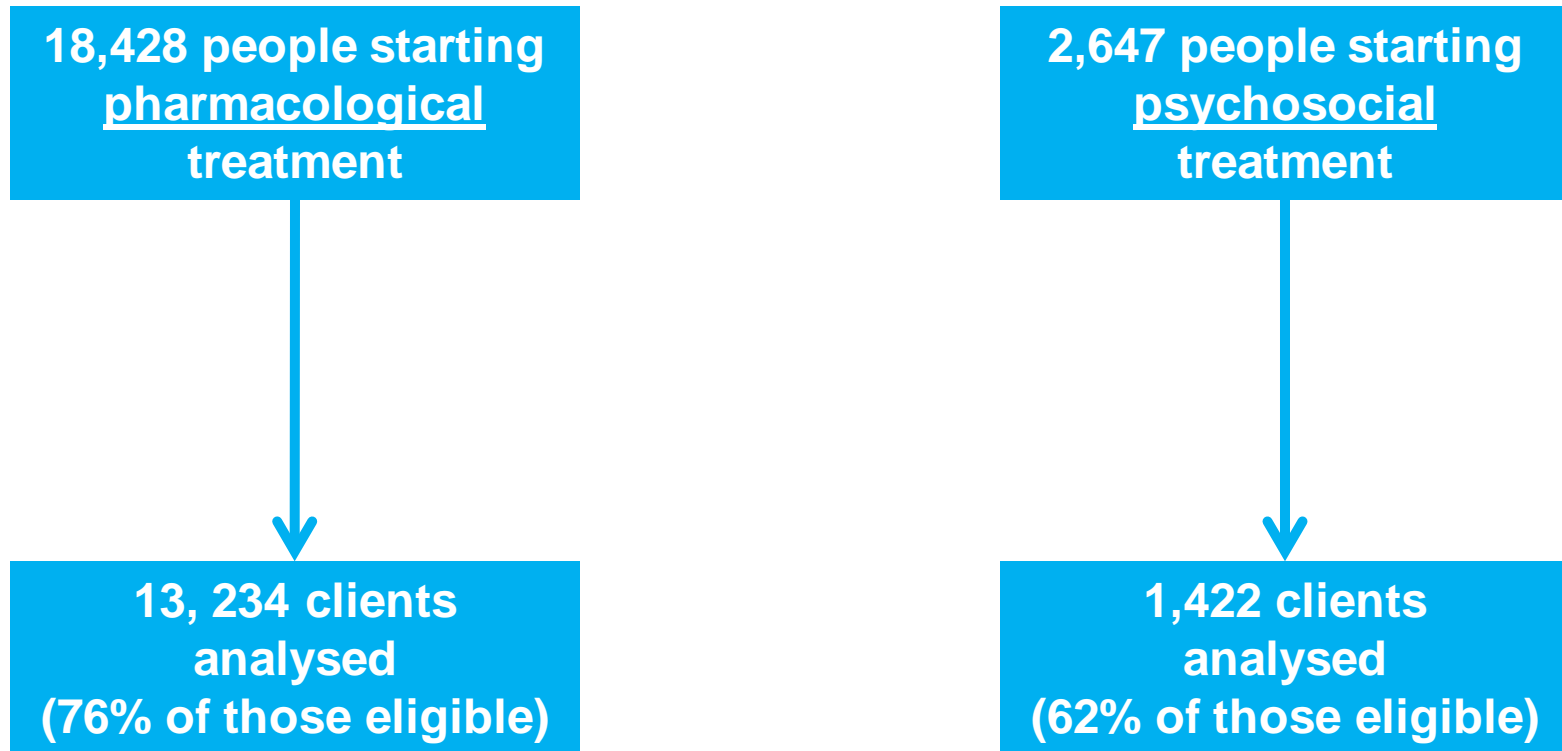
<http://ndarc.med.unsw.edu.au>

# Discontinuity and poor retention in community based treatment

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- We need to improve the quality of treatment and develop a more integrated approach across different treatment modalities
- We need to recognise the vast flows of drug users from community treatments into the criminal justice system and out again
- And also the complex nature of poly drug use

# The study cohort (n=21,075)



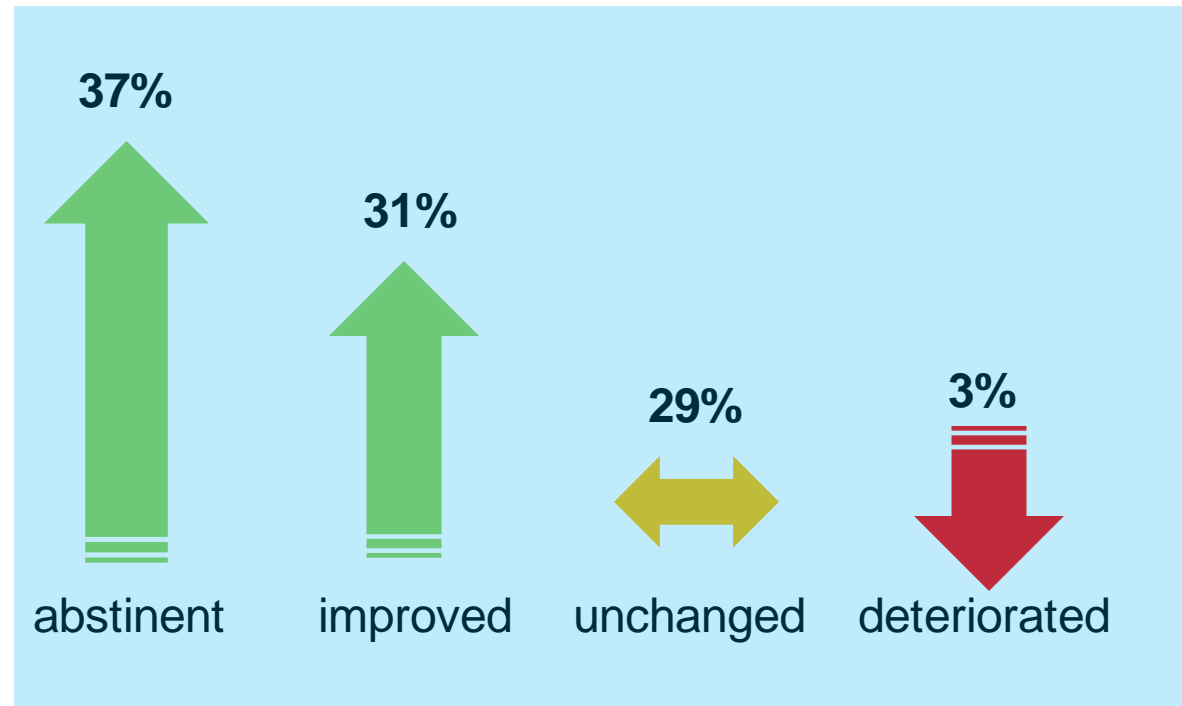
[substitute medication – e.g. methadone]

[talking therapy – e.g. CBT]

**Marsden, Farrell et al Lancet 2010)**

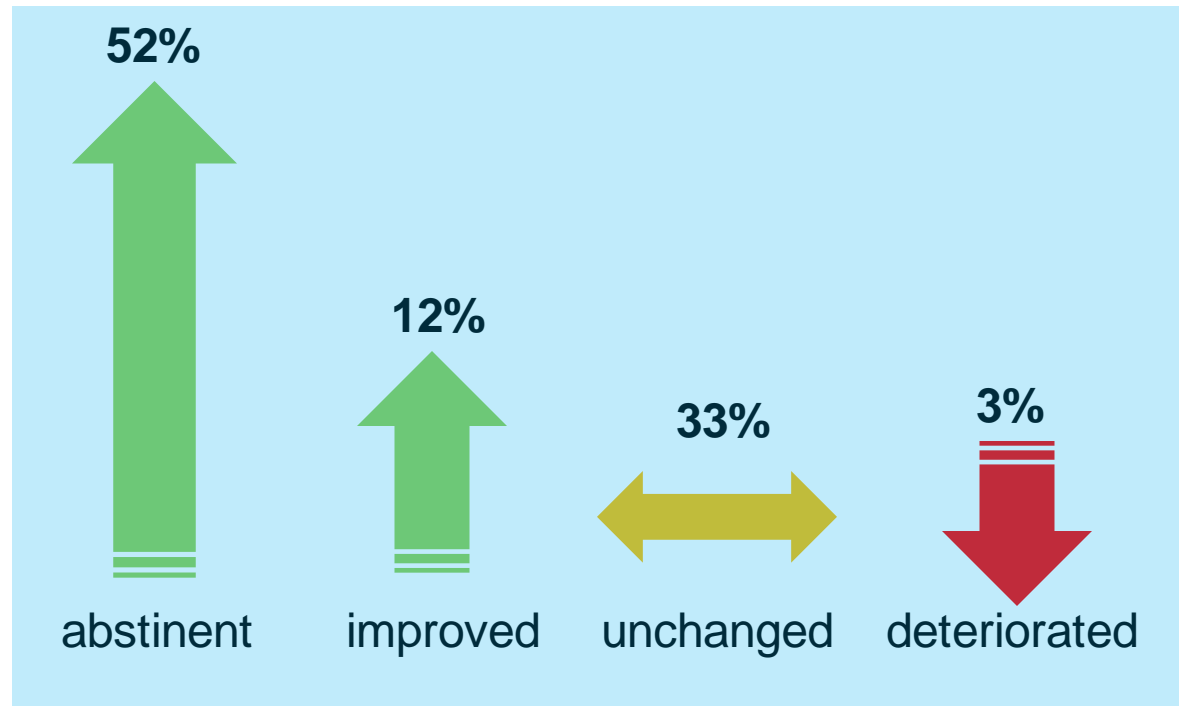
# RESULTS – summary (4)

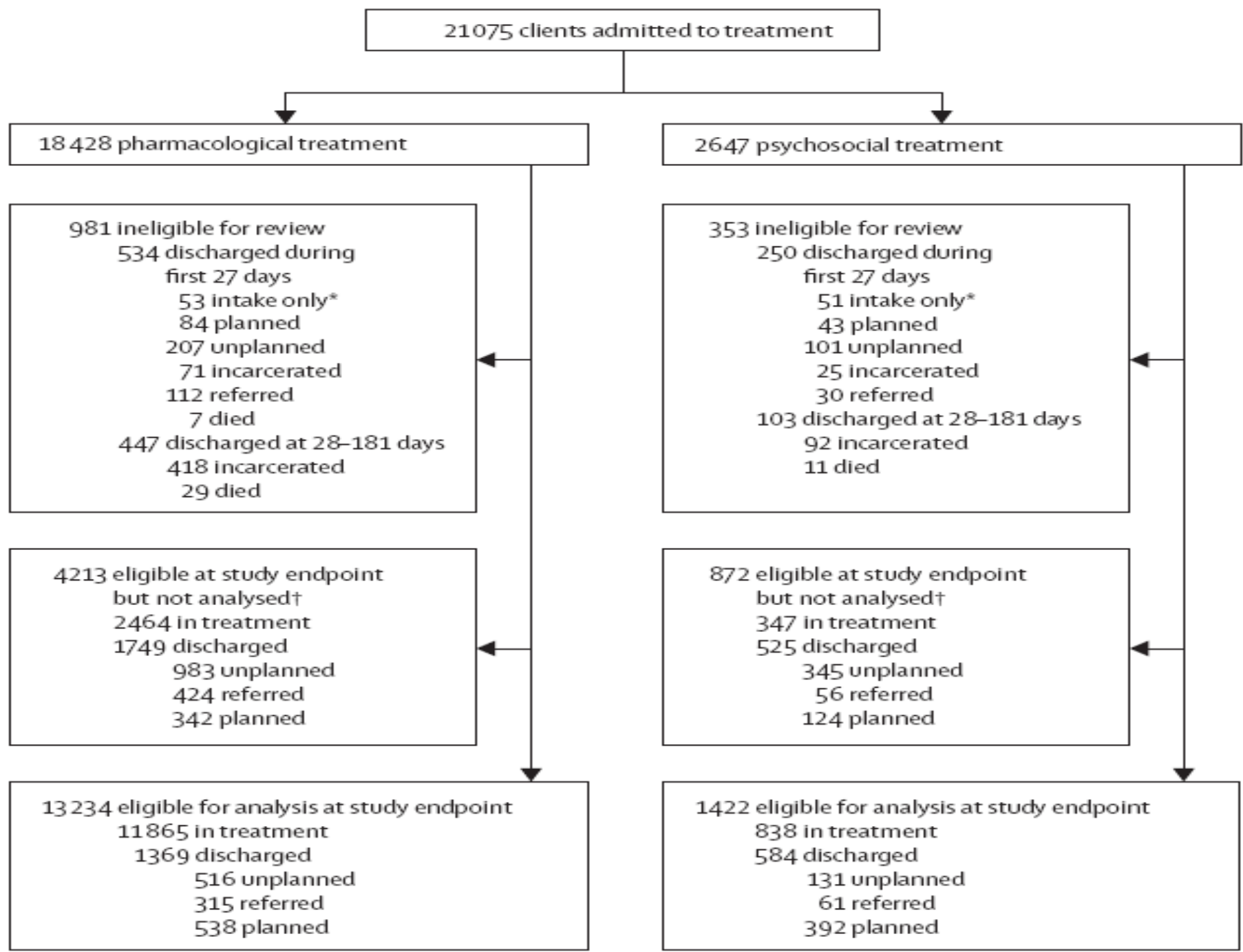
## Heroin outcomes



# RESULTS – summary (5)

## Crack outcomes





TREATMENT EXIT 2005-06  
(N=41,475)

NO SUBSEQUENT EVENT OF TREATMENT OR  
DRUG-RELATED CRIMINAL JUSTICE CONTACT  
N=19,047 (46%)

SUBSEQUENT EVENT  
N= 22,428 (54%)

n=11,641 (52%)

n=3,417 (15%)

n=5,571 (25%)

n=1,799 (8%)

TOTAL THAT RETURN TO  
TREATMENT  
N= 18,666 (45%)

RE-PRESENT TO DTR

RE-PRESENT TO PRISON

RE-PRESENT TO  
COMMUNITY DIP

TOTAL THAT HAVE INITIAL SUBSEQUENT DRUG-RELATED  
EVENT IN CJS N=10,787

n=7,025 (65%)



# Conclusions

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- Effective evidence based treatments needed for this high risk population
- Effective approaches need to be delivered across a range of modalities
- Need to look at continuity across different models of treatment in different settings
- Need for integrated multimodality care model
- Need for greater awareness of risk when change occurs
- Need to research better outcomes from planned compared to unplanned termination of service intervention