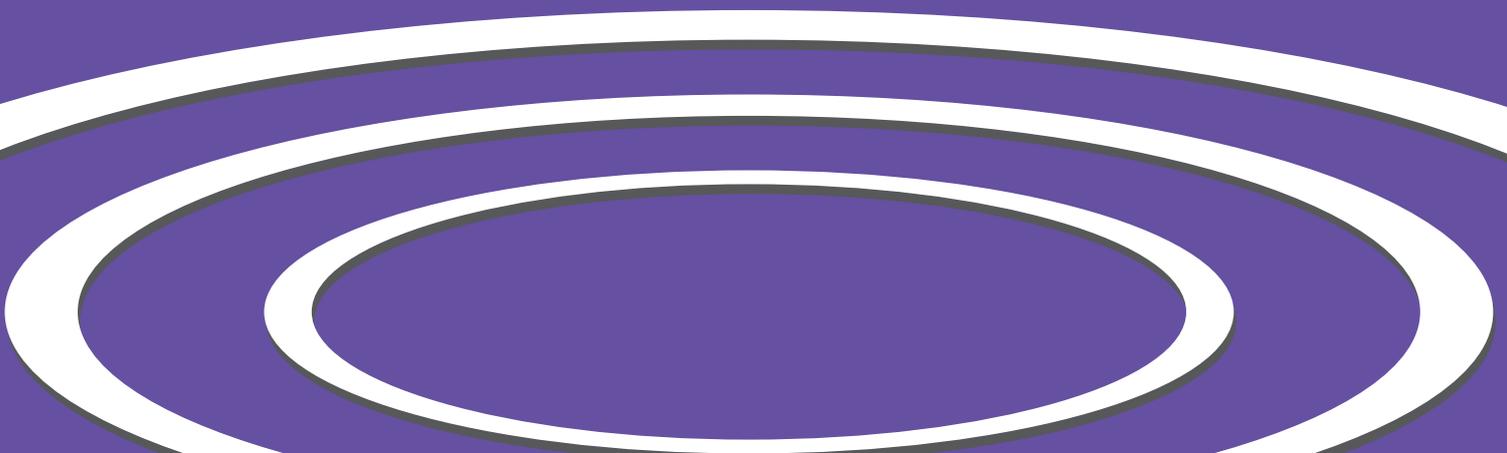




## Executive Summary

# Randomised clinical trial of the effects of time on a waiting list on clinical outcomes in opiate addicts awaiting out-patient treatment.

Report prepared by:  
Gayle Ridge, Dr David Best, Prof John Strang, Prof Michael Gossop  
and Dr Michael Farrell, Institute of Psychiatry/Maudsley Hospital



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## **Executive Summary**

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### **Disclaimer**

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## Study aims

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The study was a randomised clinical trial of drug users seeking out-patient treatment for opiate dependence in the London Boroughs of Lambeth and Southwark. The study's objective was to examine the impact of drug treatment waiting times on the likelihood of treatment entry (after the waiting period), treatment retention and changes in client behaviour, in order to consider the potential benefits of reducing waiting times.

Specifically, the project aims were:

- *To assess if the length of time spent on a waiting list is associated with successful treatment entry.*
- *To assess if the length of time spent on a waiting list is associated with an increased risk of patient drop-out after treatment entry.*
- *To assess if length of time spent on a waiting list is associated with changes in substance use, health, motivation and criminal behaviour.*
- *To examine other factors which may be associated with treatment initiation and retention.*
- *To assess the early benefits of treatment entry compared to waiting list participation.*

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## Methods

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The study was conducted at an NHS out-patient drug treatment service in South London, providing maintenance and withdrawal programmes, predominately with the use of methadone. One hundred and eighty-two individuals dependent on opiates (heroin, non-prescribed methadone) were recruited to the study over a 28-month period at their initial treatment-seeking contact at the service. Patients were excluded from the study if they were receiving an opiate substitute prescription from another source or if they met the prioritisation criteria set by the service to receive quicker access to treatment (e.g. pregnant drug users, recent release from prison).

Voluntary participants were randomly allocated to one of two treatment-entry groups prior to the start of treatment: (1) accelerated treatment-entry group - clients entered treatment two weeks after initial contact with the service, or (2) standard treatment-entry group - clients were placed on the clinic waiting list and waited for a conventional treatment slot to become available (as would occur under normal clinical procedures), typically involving a 4-12 weeks wait.

Clients were tracked prospectively from the time of first contact with the service to treatment entry (assessment and prescription of medication) at the end of

the waiting period, using a series of semi-structured interviews developed to assess substance use, health and psychological functioning, motivation and offending at three different time points. Clients who failed to accept the offer of treatment after the waiting period were contacted for follow-up data. Clients who successfully entered treatment were monitored for an additional year in order to assess treatment retention.

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## Findings

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### Treatment initiation after the waiting period

Of the 182 patient recruited to the study, 68% entered treatment after the waiting period. Allocation to the accelerated group was associated with a greater number of clients entering treatment (77% of the accelerated group, 59% of the standard group). Fluctuations in treatment demand and treatment resources over the course of the study resulted in a significant variability of waiting times within the standard group (4 -21 weeks). Despite this variation, there was no difference in the rate of treatment entry between shorter and more prolonged waiting periods within this group. This finding may suggest a threshold effect, according to which the beneficial effects of early treatment entry apply only up until a certain time. Patients who failed to enter treatment were more likely to experience a greater delay between initial service contact and scheduled treatment entry and were more likely to use crack cocaine and more frequently, than patients who successfully entered treatment. Patients who entered treatment were also more likely to cite work reasons as important in their decision to seek treatment.

### Treatment retention

64% of the sample that entered treatment were still attending three-months later and 49% continued beyond six months. At this point retention stabilised, with 48% of clients still in treatment at nine months and 43% at 12 months. Accelerated treatment entry was associated with a slightly lower proportion of clients being engaged in treatment at each of the three-monthly follow-up periods over the course of a year. The three-day dose assessment procedure, which occurred approximately 8 days after treatment entry, represented a risk period for treatment attrition, particularly for the accelerated group (28% of the accelerated group compared to 13% of the standard group failed to start or complete the procedure). Older age was the only consistent predictor of treatment retention at each interval studied over the 12-month period.

## Changes in behaviours

### **(1) Over the course of the waiting list:**

Of the 182 patients recruited to the study, follow-up data was obtained from 88% of the sample. For the sample as a whole, regardless of whether they entered treatment, treatment entry group randomisation was associated with different patterns of changes in substance use in the two groups. The prolonged waiting periods of the standard group were associated with reductions in the frequency (days of use per week) of substance use, and the shorter waiting periods of the accelerated group, with fewer clients using smaller quantities. The accelerated group also demonstrated improvements in health symptoms, yet an accompanying decrease in motivation, which suggests that even short delays prior to treatment are associated with reductions in desire to change drug-using behaviours.

### **(2) Treatment initiators and non-initiators:**

Comparisons of clients who entered treatment after the waiting period with those who did not, found a greater number of improvements among the initiators, which were mainly confined to the accelerated group. These included, improved drug abstinence rates, reduced quantities of substance use and improvements in psychological health (e.g. depression, anxiety). These improvements were accompanied by reductions in motivation to change substance-use behaviours, over the waiting period. The clients who failed to enter treatment reported a relative stability of behaviours over the waiting period. The changes noted, included, reductions in the frequency of heroin and cannabis use among the standard clients. This may suggest a commitment to substance use change unrelated to clinical involvement.

## Treatment versus waiting list

This study provides evidence of the early impact of treatment participation compared to being on a waiting list for a prolonged duration. The accelerated group, once in treatment, showed significant improvements in substance use, particularly in relation to heroin and non-prescribed methadone use. Treatment entry was also associated with physical and psychological health gains, reduced criminal activity and improved motivation. Less pronounced improvements in heroin use and motivation were also reported among the standard group, although remaining on the waiting list for a comparable amount of time was associated with either consistent or worsening health.

## Implications

The results indicate that while reducing delay was associated with successful treatment entry, it did not improve treatment retention. This finding, in addition to the lack of improvements among clients who fail to enter treatment after the waiting period, all highlight the importance of engaging drug users in treatment as early as possible.

The findings from this study point to several areas of potential improvements in service delivery. Structural factors (i.e. the waiting list) and clinical factors (i.e. crack cocaine use) can now be identified as related to poor attendance for some patients. Treatment providers and policy-makers can modify service delivery to high-risk patients in order to improve treatment initiation and retention. This could include the identification of high-risk subgroups at initial contact with the service for whom special interventions might be developed. Initiatives which permit treatment-seekers to maintain contact with services during the waiting period may also be warranted to ensure that the service continues to be seen as a meaningful resource and to help maintain tenuous motivation. The removal of non-essential components of the pathway into treatment and the provision of enhanced support during these times may minimise attrition at each of the different stages prior to receiving substitute medication. Efforts to re-establish contact with clients who fail to attend after the waiting period, or who drop-out of treatment, may enable clients to be brought successfully back into treatment. All of these factors may contribute to the development of services that are better prepared to engage and retain clients during the waiting period and in treatment. ■