An Evaluation of Novel Services for Opiate Users

A review based on quarterly reports from 2009-2011.

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Executive Summary

- Historically, l clients on substitute prescribing had a care plan in open ended prescribing regimes. However, re-commissioning of drug services in April 2010 created two divergent prescribing systems.

- . The Community Prescribing Service adopted Reversed Stepped Care approach. This highly structured prescribing model was a treatment innovation based on stakeholder and service user consultation that was informed by extensive clinical evidence.

- Prescribing data is limited prior to the implementation of the new models in April 2010. Community Prescribing Service figures suggested that an average of 0.2 per cent of clients on case load detoxified out of treatment every quarter prior to April 2010 under the old prescribing regime.

- The new Reversed Stepped Care model is currently detoxing an average of 19.3 clients out of prescribed treatment per quarter. This constitutes an average of 9.9 per cent of case load, four times higher than the adjusted national average in England of 0.5 per cent per quarter.

- Re-referral rates have decreased in the Community Prescribing Service. Analysis of 'referral by substance' shows only 2.6 heroin referrals are presenting to the Community Prescribing Service every quarter. This suggests that the Reversed Stepped Care has successfully moved opiate using clients out of treatment.

- Waiting lists have been eliminated in the Community Prescribing Service as a result of increasing its capacity at the outset of the treatment contract. The waiting list subsequently remained negligible due to increased throughput generated by high rates of treatment completion. The total number of treatment completion and declining non-clinical exits is now greater than the referral rate creating net gain in treatment spaces.

- The Reversed Stepped Care has increased treatment throughput to a high degree. This might suggest funding is reallocated to increase aftercare provision to ensure that these treatment gains are to be maximised in the long term.

- The quarterly report data did provide sufficient data to establish trends in service outcomes across the Community Prescribing Service. This data gave a clear indication of where more detailed Pal Base analysis was necessary. However, some important data is omitted and the way data is presented could be amended to offer greater insight into trends in outcome.

Introduction

In 2010 drug treatment services were re-commissioned across Site 1. The re-commissioning process introduced radical changes to the existing treatment system for clients in the Community Prescribing Service. This paper reviews the impact of these changes on opiate users in Site 1 between April 2009 and June 2011. The paper will also review why waiting lists have disappeared in the area since the new treatment systems were introduced. Furthermore, although data collection is a routine component of commissioning, there has not been as yet any analysis of the data collected across site 1. It is often not until data is called upon that a clear view of what data needs to be collected, how it can be presented and any important gaps can be identified. The paper will therefore also make recommendations on data reporting as well.

Treatment Models: Reversed Stepped Care

Prior to the implementation of the changes described in this paper the Community Psych-social Service offered a universal case management model for all clients in receipt of substitute prescribing. Prescribing was conducted through a GPwSI consortium. All clients on prescribed medication were care planned in opened ended prescribing schedules which are common practice across the UK. The new model was implemented after a competitive tendering process. As of 2010 a new Community Prescribing Service adopted the Reversed Stepped Care model alongside the same Psycho-social service. This prescribing approach was a treatment innovation developed after extensive review of the previously commissioned community services, consultation with key stake holders and service users, as well as emerging clinical evidence. As such it is a pioneering model derived from good practice within the commissioning cycle. The Reversed Stepped Care models would operate across four counties with a wide range of urban and rural communities.

The Reversed Stepped Care model attempts to resolve a paradox in drug treatment. Opiate users tend to seek treatment due to crises in their lives. At the stage of treatment entry these clients demonstrate high motivation for lifestyle change. Substitute medications are effective in reducing harm associated with use. This means that prescribing tends to negate the very pressures that motivate individuals to make wholesale lifestyle change. So whilst the provision of substitute provision is effective in reducing problems associated with opiate use it does not enhance positive lifestyle factors. The net result is that opiate users tend to remain ‘parked’ on prescribing indefinitely as motivation recedes.

After an extended period of harm reduction orientated policy, the central challenge for the UK treatment system is to identify how clients who have remained ‘parked’ on substitute prescribing for extended periods of time can be motivated to move through and out of treatment. Historically, this problem has been addressed through the adoption of either highly prohibitive or highly permissive prescribing regimes. Highly prohibitive models tend to increase drop out though outcomes for treatment survivors are positive. Alternatively, permissive prescribing has produced much lower dropout rates but fairly low rates of behavioural change. Addressing this paradox of treatment may be particularly important in light of demographic shifts in consumption.

The latest National Treatment Agency (NTA 2010)[1] figures demonstrate that the total number of drug users entering treatment for heroin or crack cocaine has fallen by 10,000 over the past two years. The fall in heroin use is particularly profound among people under 30s with the number of 18-24 year olds in treatment more than halving and the 25-29 age group almost matching this fall. Estimates from the University of Glasgow's drug misuse research center put the number of heroin and crack users in England in 2009/10 at 306,000 down from 332,000 in 2008/09.(Hay et al 2011)[2] This shift in demographics suggests that opiate use has peaked in the UK and that fewer young people are initiating opiate use. As such, treatment providers will increasingly be working with an ageing opiate population as the number of new initiates continues to decline.

The Reverse Stepped Care approach offers a pioneering third option. Opiate users seeking substitute prescribing must attend a 4 week preparation programme as a condition of their titration. Once the preparation stage is completed the client is offered a free choice between Low or High Intensity options. If they chose the Low Intensity option they will receive a harm reduction plan, be seen by nursing staff and remain on a fixed schedule of daily pick up for their substitute medication. The clients who are unmotivated for lifestyle change would be kept physically safe on their prescriptions but will not be offered any form of psycho-social intervention. By doing so, the model hopes to increase their motivation for change by not diminishing the psycho-social pressures that prompt lifestyle change whilst keeping them safe from harm at the same time. Those who chose the High Intensity option will receive a comprehensive care plan, be able to access a wide range of treatment options, access diversionary activities and be able to earn treatment privileges like take home doses on the production of clean urine samples. The use of take home doses of prescribed drugs is a powerful motivator that opiate using clients often value more highly than money or vouchers. As such, the Reversed Stepped Care approach hoped to offer harm reduction support to those who were seeking respite from use whilst targeting limited psycho-social resources at those are motivated and were most receptive to them. Those who take the High Intensity option must be engaged in psycho-social support and if they fail to meet these requirements, they will be rapidly detoxed from the service and exit. Drug using parents are not given an option. They must attend High Intensity treatment due to the very limited gains that can occur for their children through prescribing alone. Figure 1 shows the integrated treatment pathway for the Reversed Stepped Care model.

[1] NTA Report (2010) Drug Treatment in 2009-2010.

[2] Hay, G., Gannon, M. & Casey, J. (2011) National and regional estimates of the prevalence of opiate and/or crack cocaine use 2009/10: a summary of key findings'. The Centre for Drug Misuse Research, University of Glasgow, NTA.

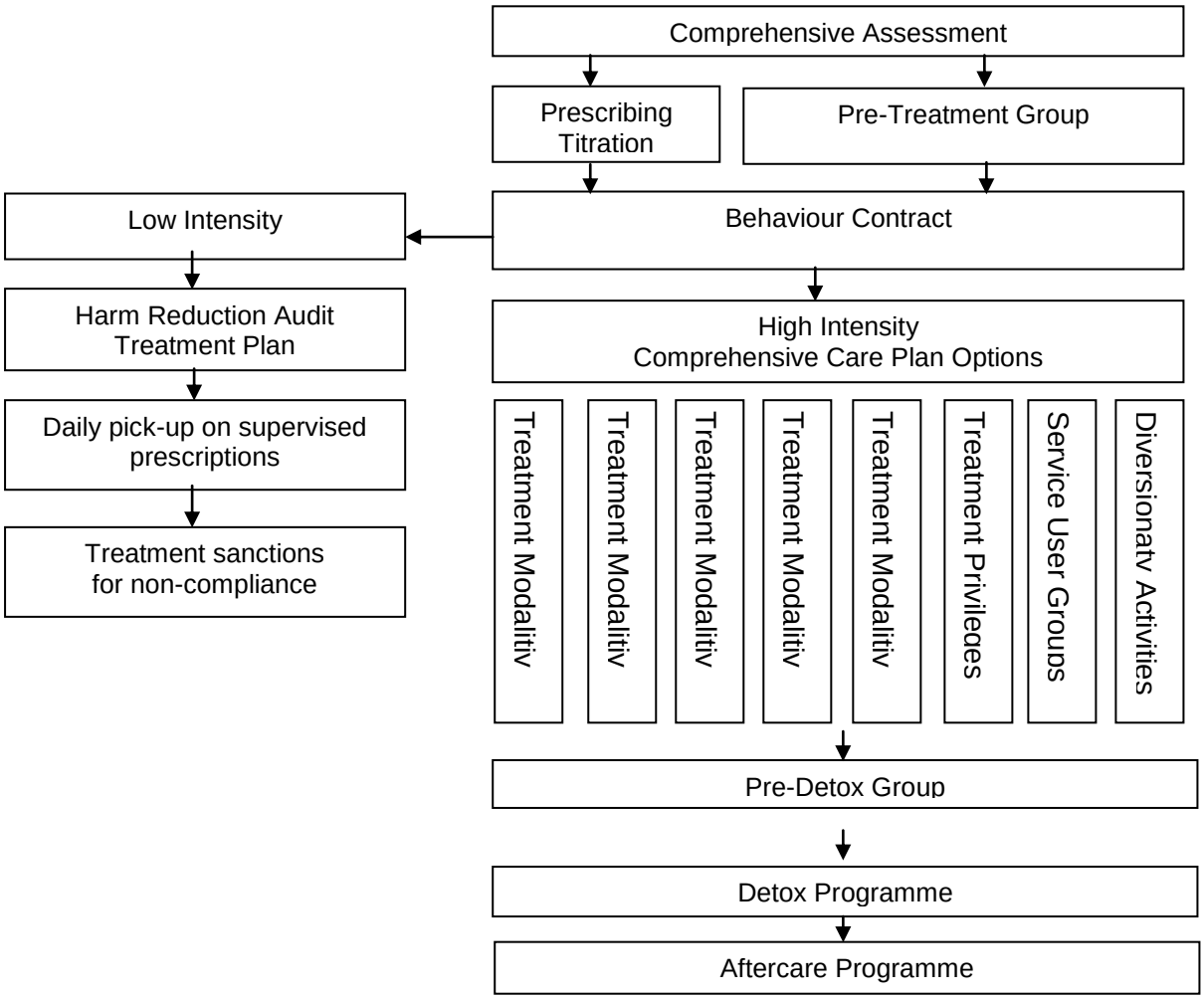


Figure 1: Integrated Treatment System for Reversed Stepped Care

Data Limitations

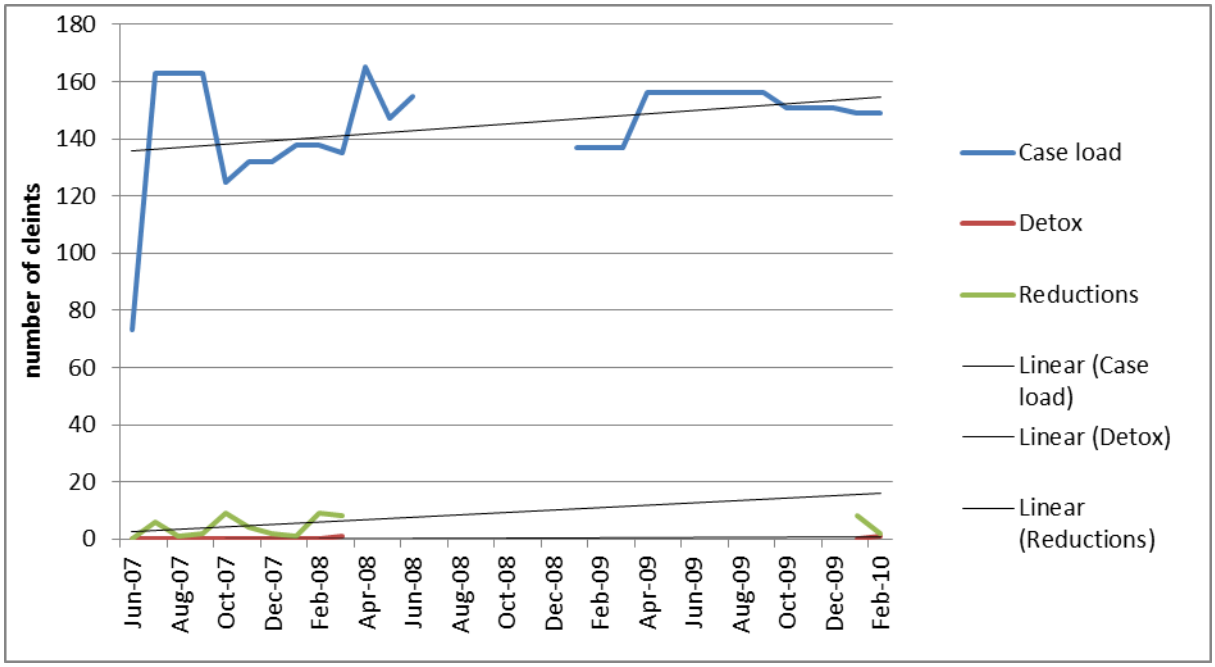
The data in this review is based on quarterly reports from three different sources which offer three different perspectives on the treatment journeys of clients. The first data set comes from GPwSI who were the prescribing service prior to the new contracts in 2010. This data was used to establish the baseline of treatment outcomes under the old commissioning arrangements in order to contrast them with the current system. However, this data was very poor. There was sufficient data to reconstruct some treatment gaps in the Community Prescribing Service using regression trend lines in the community service.

The second source of data is from the Community Prescribing Service's quarterly data. This service provides complete data on community prescribed and non-prescribed clients from April 2009 to September 2011 so straddles the old prescribing regimes and the new Reversed Stepped Care implementation period. As the provider also treats a wide range of non-prescribed clients there is some cross contamination in data as these two treatment sub- populations are not always

separated out. The provider's data is consistent and expansive so does offer the opportunity to track shifts and changes in treatment patterns across this entire time span. The third data source is the new prescribing provider's quarterly reports. This data commences at the outset of the new Reversed Stepped Care. This data offers a much clearer insight into the treatment outcomes for prescribed clients under the new prescribing regimes. This data is consistent and expansive with few compromises.

Data from GPwSI (Prior April 2010)

Data prior to the implementation of the new prescribing models is limited as reporting requirements were not fully met by the old prescribing provider. The data that does exist from the June 2007-March 2010 offers a snap shot of the service outcomes. Gaps in this data have been adjusted using linear trend lines (See graph 1). The average case load in Community Prescribing during this period was 145.4 clients per month. In terms of treatment detoxifications, there were 0.33 clients detoxed per month. Whilst, on average, there were 7.7 clients were engaged in a reduction prescription. In terms of overall trend, the rate of uptake for reductions did increase over the course of the contract though the rate of actual detoxifications remained static.



Graph 1: Linear trend lines in the old prescribing service (GPwSI)

A breakdown of clients by county demonstrates that urban areas had the highest rate of prescribing as did those areas with the highest levels of social deprivation also showed high rates of prescribing. Across the course of the old contract, and the new, these rank orders have been preserved with no major shift in prescribing in any county. Limited data was available on the profiles of these service users. The majority of treatment engagers during this period were stacked at the front end of their treatment episodes, with the majority of clients having been engaged in treatment for six months or under. However, this may not reflected their overall time spent in treatment. This data may reflect how long people had been in treatment

with this particular provider and may not account for previous treatment with other providers.

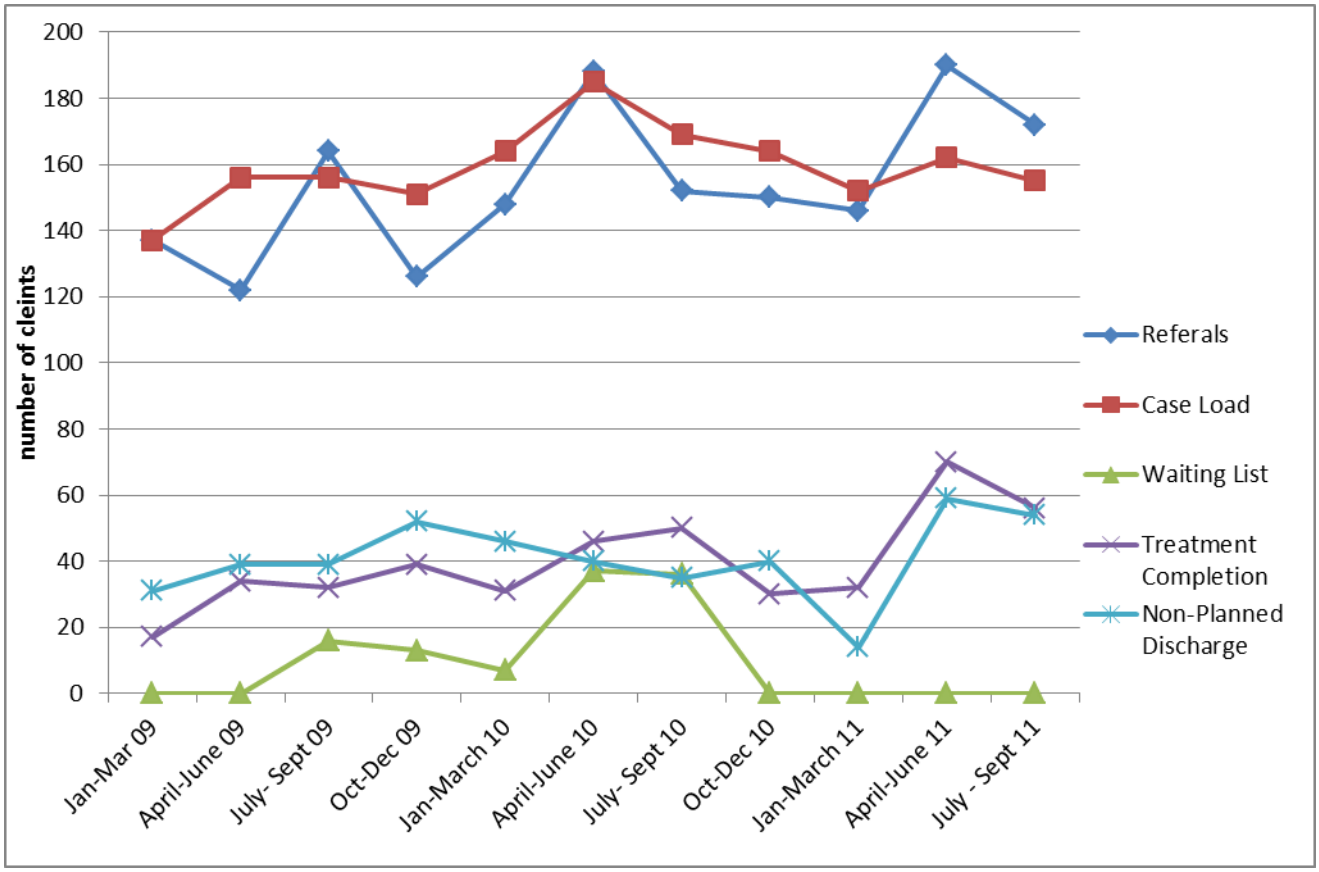
Treatment completions remained low throughout this period. No treatment completions are recorded from June 07-Jan 08. Those completing treatment increased in February 2008. However, this data confuses planned and non- planned treatment completions and so is difficult to ascertain why clients left the service. The data reports that 42 clients were on a planned reduction regime during this period but that only 1 client successfully completed treatment during this year.

In terms of treatment entry, during 2007-2008 the prescribing service received 122 client referrals. Self-referral accounted for 41 per cent of treatment entries. This was followed by GPs who accounted for 18 per cent of treatment entry. Whilst the number of referrals varied by county, they preserve rank order and offer a fairly consistent pattern of treatment entry with little variation by county.

Data from New Service Provider

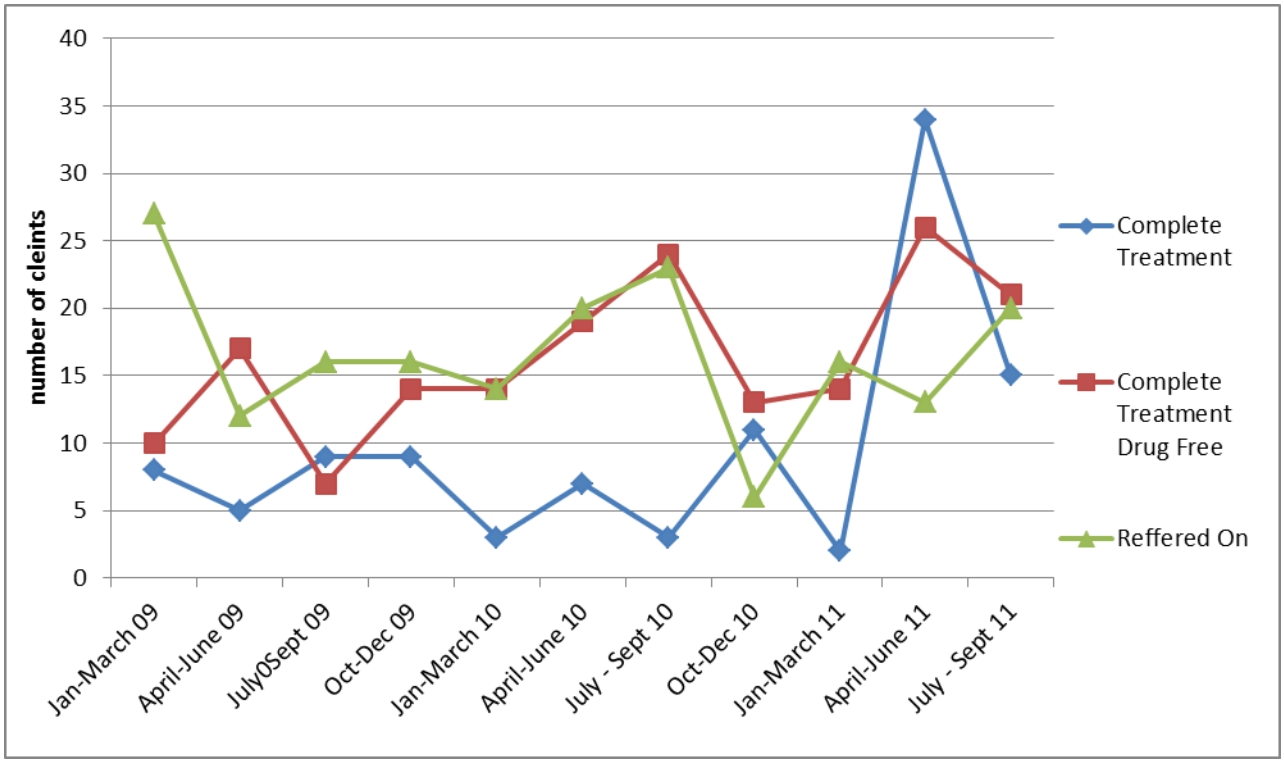
Data from the new psycho-social provider is more comprehensive but critical data is not always clear and may have to be derived by proxy. This service provides whole population data for all those that use their services. However, as opiate users are likely to remain in treatment for extended periods due to the de-motivational effect of substitute prescribing, it would be appropriate to amend reporting processes to offer a clearer picture of opiate users' response rates. The data presented here attempts to distil the data on those in prescribing regimes from the quarterly reports (See graph 5).

Reviewing trends in service we see some key changes. Prior to 2010, the Psycho-social Service data agrees with Community Prescribing in holding a case load of prescribed clients in the range of 145. Capacity for prescribing increased in April-June 2010 with the introduction of the new Reversed Stepped Care prescribing model and the new service provider. Waiting lists had been typically low prior to re-commissioning in April 2010, where they had remained below 13. In the run up to the implementation of the new treatment model the numbers on the waiting list escalate and peaked at 37 for two quarters. This may have been as a result of the old prescribing service not taking on new referrals during this transition period. At the same time referral rates and unplanned discharges have increased slightly but this is for all substances and not necessarily for opiates using clients (See Graph 2).



Graph 2: Trends in caseload, treatment completion and non-planned discharge in Psycho-Social Service
Jan 09-June 11
(Waiting list data missing for Jan-March 09)

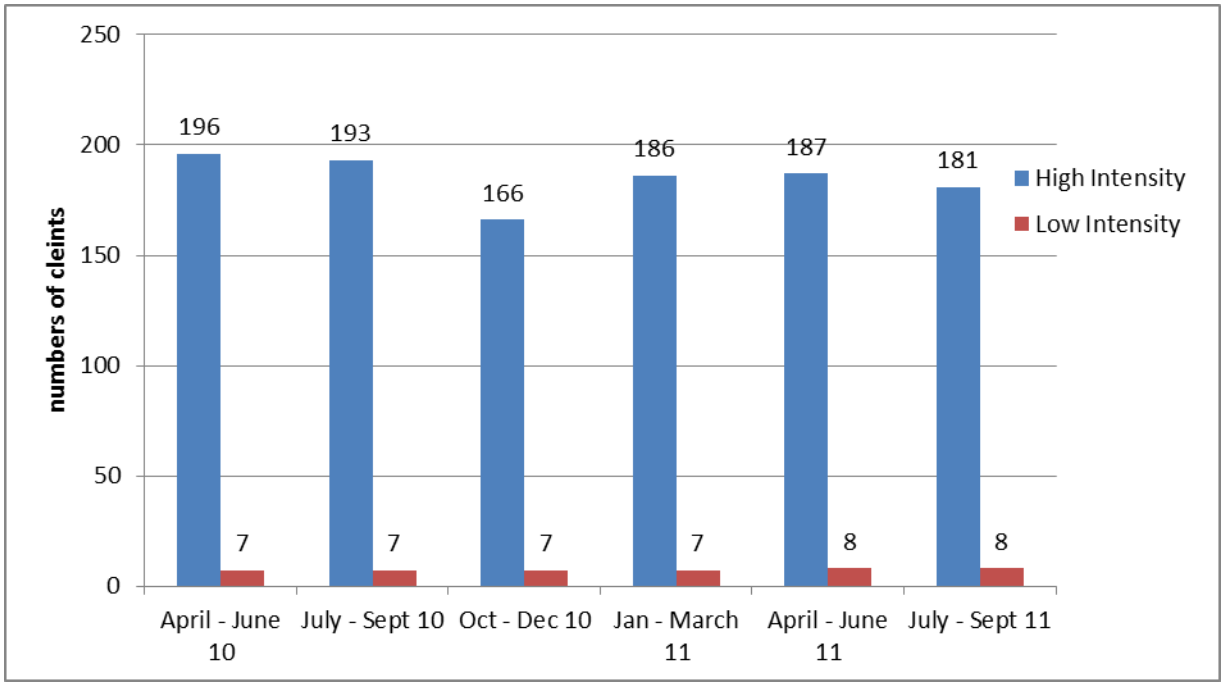
Reviewing reported reasons for treatment completion reveals an interesting pattern. Under the old treatment regime, treatment completions were largely determined by 'referral to other services.' Amongst the 45 clients leaving treatment during the first quarter (Jan-March 2010), 60 per cent of them were allocated to a different service. Only 17 per cent of clients actually completed their treatment and only 22.2 per cent completed treatment drug free. In comparison, across the course of the Reversed Stepped Care model, numbers of treatment exit via referral have decreased whilst the numbers completing treatment and completing treatment drug free have increased. It does suggest that that the client's journey through treatment has changed towards positive treatment exit as opposed to more treatment. However, this trend is reflective of all clients in and not just opiate prescribed (see graph 3).



Graph 3: Break down of treatment completion in the Pyscho-social Service Jan 09-June 11

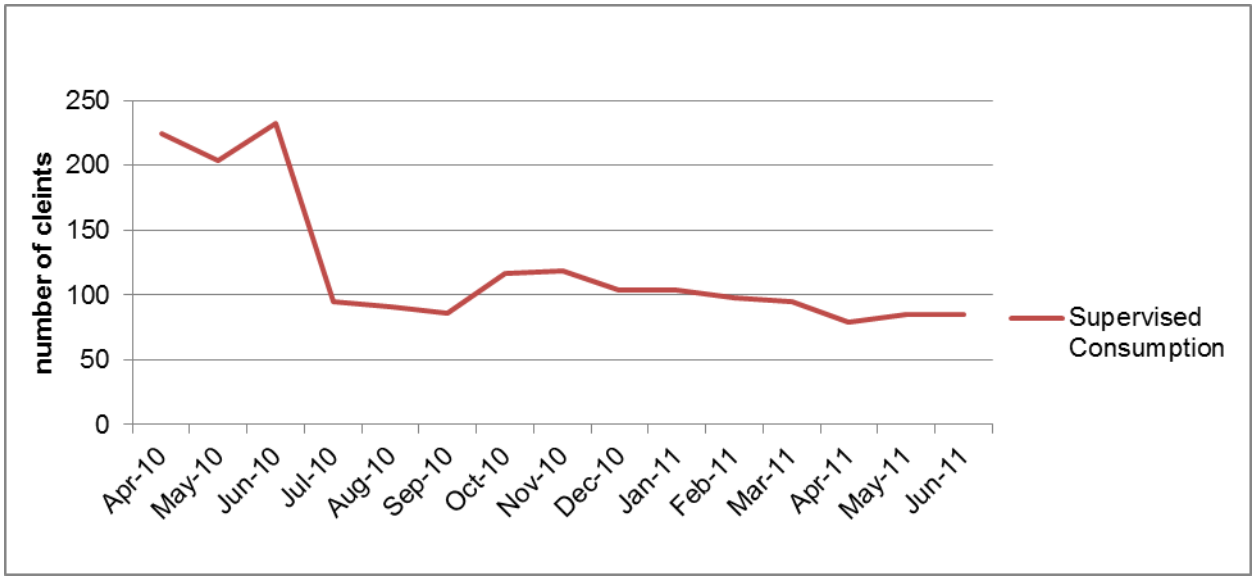
Data from Community Prescribing

Data from the new Community Prescribing service commences from April 2010 at the start of the new Reversed Stepped Care. It offers significant detail on treatment responses for both services with fairly comprehensive and defined data. In terms of transition to the Reversed Stepped Care model, existing clients receiving prescriptions were given free choice to enter Low or High Intensity options at the implementation of the model. Scepticism was aired prior to this implementation process that those long term and typically low response clients would simply opt for the Low Intensity model in high numbers. However, this was not the case. The vast majority of clients opted for High Intensity options with only 7 clients opting for the Low Intensity treatment schedule. This figure of minimal up take for the Low Intensity has remained static throughout the duration of the treatment programme. Similar results are reported in a second site who also operate a Reversed Stepped Care model with only 17 clients opting for Low intensity from a case load of 230. In the Community Prescribing Service, the percentage of clients on Low Intensity has remained stable at approximately 3.5 per cent of the case load (see Graph 4).



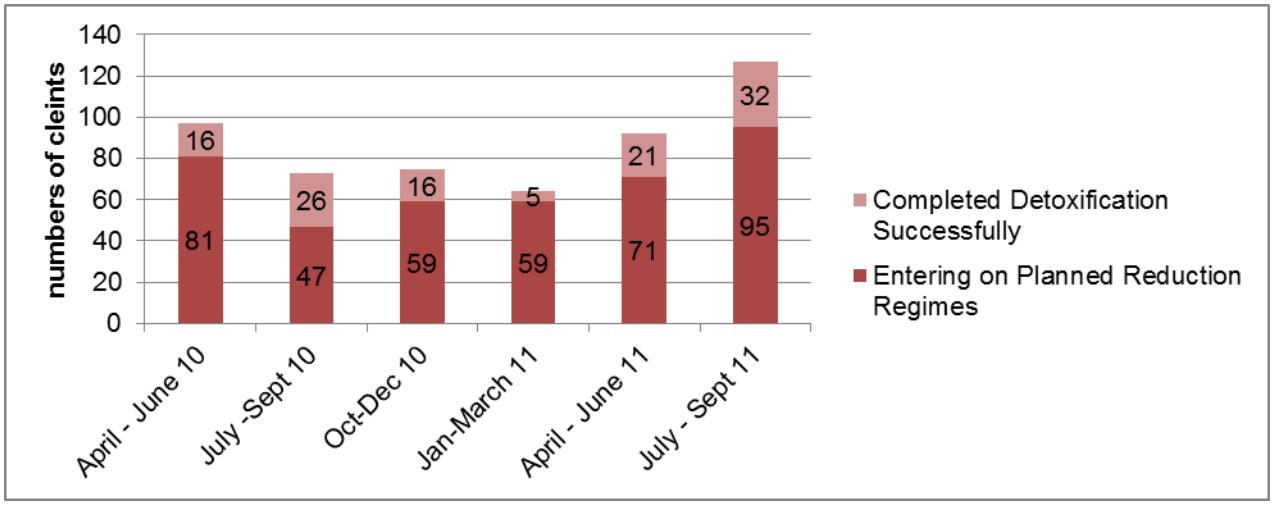
Graph 4: Clients on High and Low Intensity Schedules – Community Prescribing Service (April-June 2011)

The data in the quarterly reports specify how many urine tested are conducted in each county. However, the numbers reporting positive or negative test results are not reported and therefore this data was not included. In comparison, the use of treatment privileges such as take home doses is determined by the client producing clean urine screens and so is indicative of adjunct use of opiates on top of prescribed substitute medication. The numbers of clients on daily supervised treatment has dropped significantly during the introduction of the Reversed Stepped Care (See graph 5). Daily supervised rates are high across the first quarter that the models were introduced, peaking in June 2010 before stabilising. This reduction in numbers of clients on daily pick up occurs three months into the new models. This occurs at the same rate in which treatment privileges can be achieved. This suggests that as the new treatment privilege of take home doses become available to clients who produced clean urine samples, it had a dramatic effect on use of heroin on top of the prescribed substitute. Data from the Reversed Stepped Care model in another site also demonstrated a large reduction in positive opiate tests in the Community Prescribing Service and substantial increases in numbers of clients eligible for take home doses.



Graph 5: Numbers of clients on daily supervised consumption April 10- June 11*
(Last quarter data not included as reported differently.)

Not only have the numbers of clients on daily supervised consumption decreased but the number of client's successfully completing treatment has increased in the Community Prescribing Service. From the limited sample data under the previous prescribing service, only 42 clients opted for a clinically managed detox and only 1 client achieved this in the last 12 months of their contract. In contrast, the data from the Community Prescribing Service shows an initial increase in positive treatment completions for clients followed by a dip and subsequent rise (See graph 9). This may reflect two different influences on completion rates. An early peak immediately after implementation of the new model in April –June 2010 suggests that a portion of motivated clients were bottle necked in making lifestyle change under the previous prescribing regime. These early gainers may have perceived the transition to a new service as an opportunity to complete their treatment. However, the continued rise in clients on either reduction regimes or detoxing over a 12 month period also suggest that that new Reversed Stepped Care model is influencing motivation to change. Since the new model was introduced, 19.3 clients per quarter are successfully completing treatment whilst on average 66.6 clients are now engaging in structured reduction regimes (see graph 6).



Graph 6: Numbers of client entering onto reduction regimes and successfully completing in RSC April 2010-June 2011

The current data collection only identifies the numbers of clients who are referred to treatment rather than numbers who take up treatment post-assessment. This makes it difficult to ascertain treatment completion as a whole population as numbers of active treatment engagers in not clear. However, a comparison of caseloads against detoxification completion demonstrates what percentage of clients exit treatment each quarter. This offers some comparison with other services. The National Treatment Agency has reported treatment completion rates of 4 per cent a year for Problem Drug Users (PDUs) as a national average in England. However, PDU's comprise of primary heroin *and* crack cocaine users inflating opiate completion rates. Furthermore, researchers have questioned these figures as including non-completion data such as deaths. They suggest that currently in England agencies are achieving 2 per cent treatment completion rates per year (for a review see Gyngell 2011).[3] This equates to 0.5 per cent of case load exiting treatment drug free per quarter. In comparison, treatment completion rates in the Reversed Stepped Care model average 9.9 per cent of the case load per quarter. This is an average of 19.3 clients leaving treatment drug free per quarter. The fact that numbers entering planned reductions has also continued to rise suggests that treatment completions should increase over time as these individuals work their way through the treatment system (see table 1).

	April –June 10	**July-Sept 10**	**Oct-Dec 10**	**Jan-March 11**	**April-June 11**	**July-Aug 11**
Case load	203	200	173	193	195	189
Treatment completion	16	26	16	5	21	32
Average % completion under old regime	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%
% Case	40%	22%	34%	30.5%	36.4%	52.4%

[3] Gyngel, K. (2011) The UKs treatment war on drugs: a lesson in unintended consequence and perverse outcomes. The journal of global drug policy and practice, 5 (1)

load entering in voluntary reduction						
% RSC completion of case load	7.8%	13%	9%	2.5%	10.7%	16.9%

Table 1: Comparison of treatment completion against caseload in RSC and national averages for England

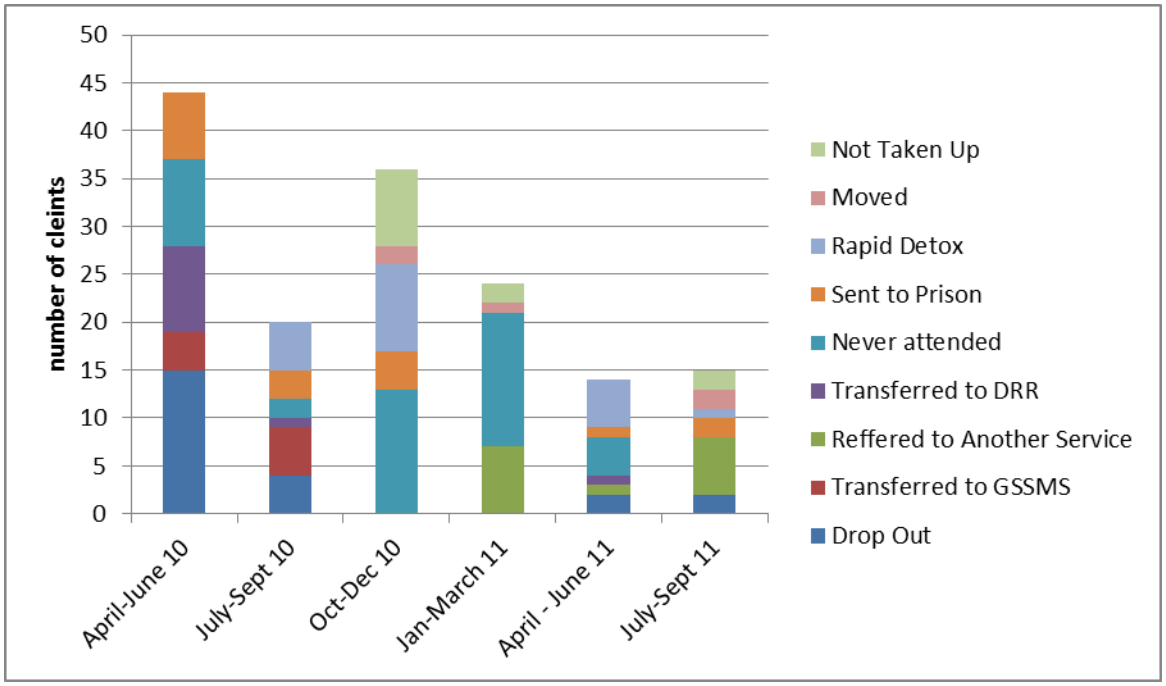
Whilst the number of clinical discharges (those successful completing treatment in a care planned manner has increased under the new model, the number of non-clinical discharges has decreased within the service. The number of clients leaving the service in an unplanned way in the first quarter of April –June 2010 was 44. This figure is similar to the reported non-clinical discharges (those who leave the treatment service without successful completing their treatment) reported under the previous prescribing regime (42 reported). Despite the additional disruption of a new prescribing service and highly structured prescribing arrangements, dropout rates did not increase. Similar findings were identified in the second site, where the transition to structured prescribing did not account for greater dropout of service as is often feared.

Data from the Community Prescribing Service confirms this with high rates of clients exiting treatment in a non-planned discharge prior to the onset of the Reversed Stepped Care model that begin to decrease swiftly after the implementation of the new model. Reviewing non-planned discharges in Reversed Stepped Care we can see a dramatic drop in unplanned discharges across each quarter except for a peak in Oct-Dec 2010. This peak is accounted for by a rise in non-attendance during a period of high referral rate. This may be a seasonal artefact. Again, the numbers of clients transferred to other services also declines across the reporting period suggesting better client allocation is now in place. The drop in the number of clients being awarded a DRR also declines hinting at a higher rate of treatment responsiveness in clients with criminogenic profiles to the Reversed Stepped Care approach.

Rapid detoxes are applied to clients in the prescribing service who have a high rate of non-compliance in the Reversed Stepped Care model in this locality. Research shows that non-response rates in substitute prescribing can run between 18-25 per cent (See Gossop et al 2000).[4] Rapid detoxes in the Reversed Stepped Care service only account for 20 treatment exits across the entire reporting period meaning that on average 3.3 clients were rapidly detoxed out of service every quarter. The average rate of monthly rapid detoxes account for 1.7 per cent of the case load, suggesting a significant reduction in non-compliance over all. In general, under the new Reversed Stepped Care, the numbers of clients leaving the service in an unplanned way has significantly reduced and appears to have stabilised at approximately 15 clients a quarter (See graph 7). This is an important finding as it is often suggested that in the interest of harm reduction, reducing the treatment

[4] Gossop, M, Marsden, J. Stewart, D. and Rolfe, A. (2000) Patterns of improvement after methadone treatment: one year follow up results from the National Treatments Outcome Research Study. Drug and Alcohol Dependence, 60: 275-86.

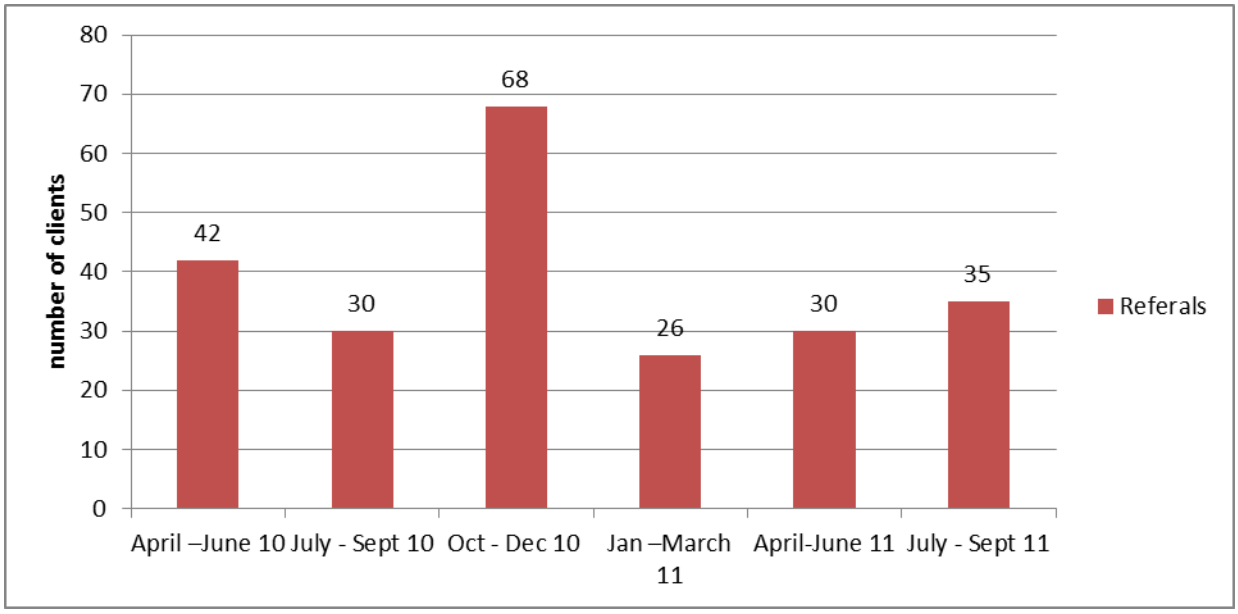
expectations on chaotic clients is the most appropriate approach to these clients. These research findings concur with US research that demonstrated that high structured prescribing regimes actually have a beneficial effect on these clients (See Griffin et al 2000). [5]



Graph 7: Reasons for Non-clinical drop out April 10-June 11

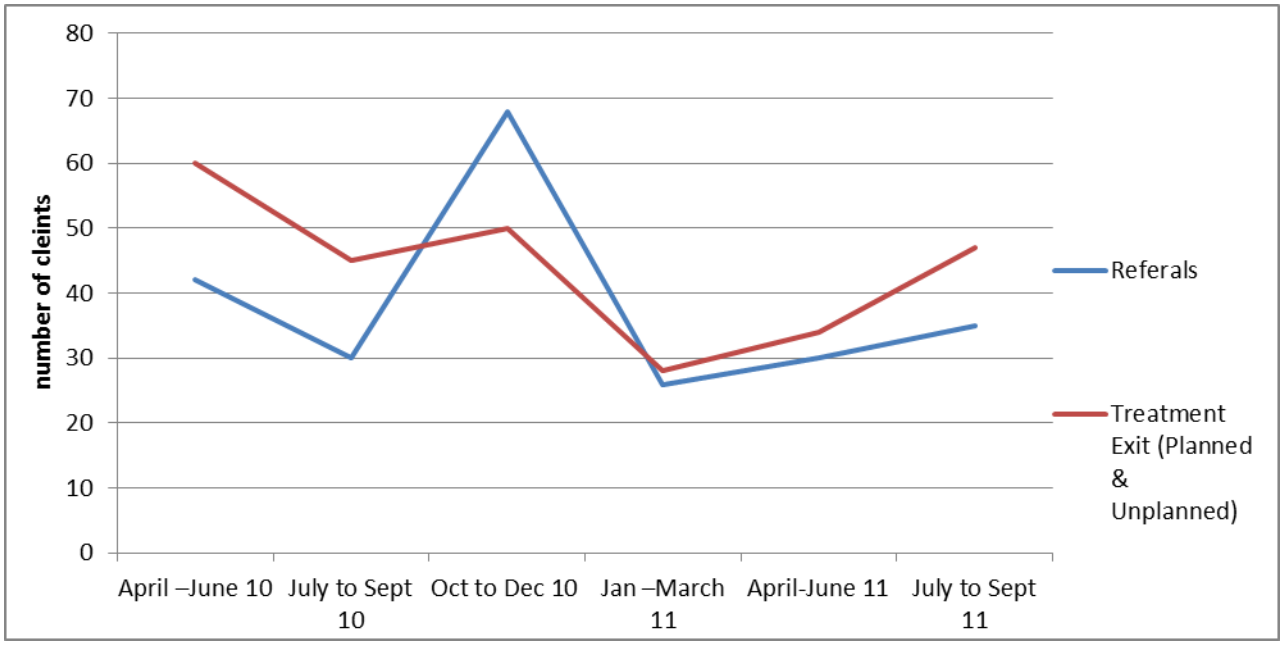
Referrals to the Community Prescribing Service remain relatively stable, ranging between 26-68 referrals per quarter with a peak in Oct-Dec 2010 that has already been discussed (see graph 8). A rise in referral's in April 2010 is accounted for by the increased waiting list during the transition from one service provider to another. On average 39.2 referrals have been made every quarter. However, it is not clear from the data how many referrals' attend the assessment or subsequently engage with the treatment process. The figure for actual treatment entry will be lower than the rate of referrals.

[5] Griffin, J.D., Rowan-Szal, G.A., Roark, R.R. and Simpson, D.D. (2000) Contingency management in outpatient methadone treatment: a meta-analysis. Drug and Alcohol Dependence, 58: 55-66.



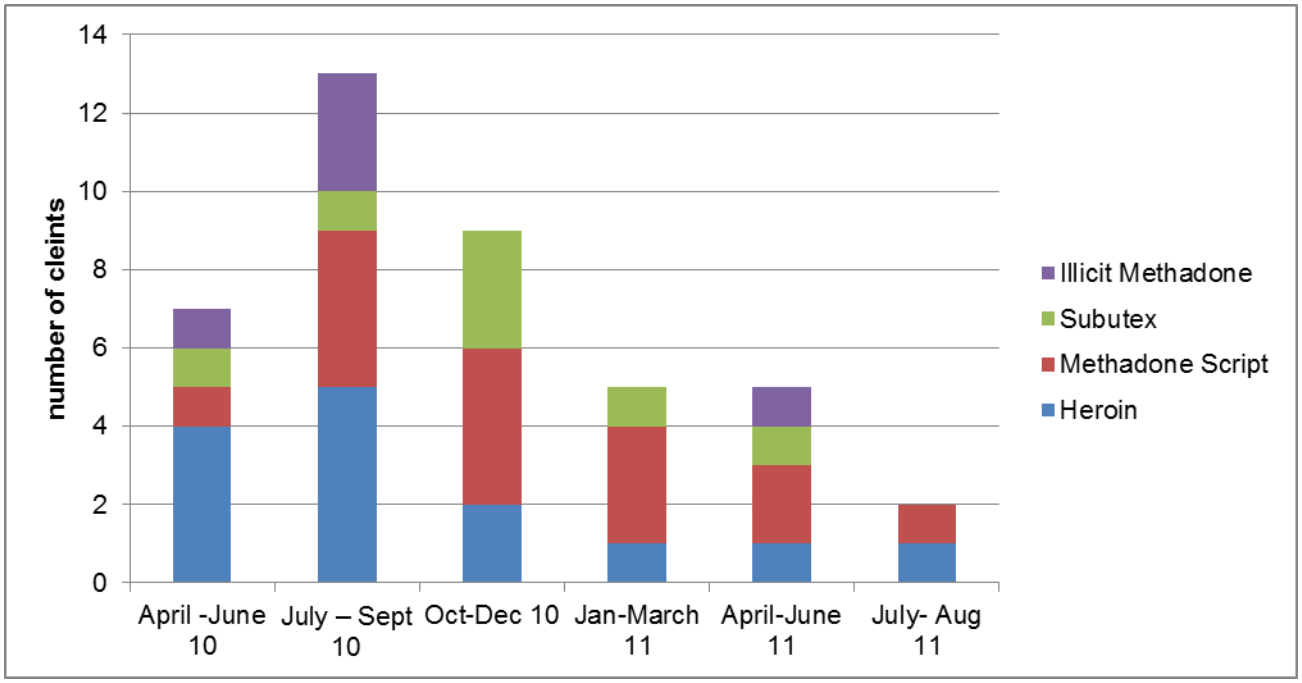
Graph 8: Number of Referrals to Prescribing Service

Changes in capacity could be established by comparing the number of treatment engagers during this period with the number of treatment exits. However, as actual treatment engagement figures are not presented this can be done using referral rate as a proxy measure. During the reported period, 231 clients were referred into the Community Prescribing Service. Unplanned discharges account for 153 exits during this period. Furthermore, 116 clients have left treatment drug free during this period. So, even in comparison with the artificially high figure of clients referred to the service, we see that the service has crossed a line where more clients are exiting the service through treatment completion and declining rates of unplanned exits than are now entering the service (See graph 9). Whilst 231 clients have been referred into the service a combined total of 269 have left service. Again, it is important to stress that referral rate is a crude proxy measure for comparison as the actual induction into the treatment system will be lower than referral rate, meaning the net gain of treatment space will be higher. This strongly suggests that the Community Prescribing Service and Psycho-social service have moved into a position of net gain. The treatment systems appears to be producing an average net gain of 6.3 treatment places a quarter which translates into 38 treatment places for this period *as a minimum*. This figure exceeds the typical waiting lists that were reviewed earlier, that had tended to fluctuate below 13. Based on this data, it appears that the eradication of waiting lists in the Community Prescribing Service has occurred for a number of reasons. Increased capacity at the outset of the contract, along with continued high rates of treatment throughput, have both combined to create increased capacity.



Graph 9: Comparison of referral and combined treatment exit rates in Community Prescribing April 2010-June 2011

Whilst the treatment completion rate now exceeds referral rate, there is always a danger that the treatment completers re-present to the service shortly after exit due to relapse. Reviewing data on new referrals from April 2010 to June 2011 reveals that very low numbers of opiate-related treatment subjects are re-presenting to the service with opiate related referrals *declining* and not increased during this period (See graph 10). Referrals for primary heroin use has dropped consistently to one client a quarter by the end of the reporting period. Methadone using clients are also in decline. There was little evidence for any significant trend in Subutex abuse which had been reported by staff on the ground. This offers a strong indication that not only is the Reversed Stepped Care model moving people out of treatment, they are not returning in significant numbers post treatment.



Graph 10: New Opiate-based referrals

Conclusion

The Reversed Stepped Care model has demonstrated highly effective treatment outcomes, which is over four times that of the average adjusted National Treatment Agency figures for England. At the same time it has significantly reduced premature unplanned treatment drop out. Opiate based referrals back into service have remained consistently low and referrals into the Community Prescribing Service have also declined. This suggests that clients have not returned back into treatment having exited it successfully. Whilst a peak in waiting lists at the outset of the new contract was addressed by the new provider increasing capacity at the start of the contract, the Reversed Stepped Care model has created sufficient throughput to eradicate a waiting list for treatment. However, it is important to state that these improvements in clinical gains may not just be the result of the implementation of the new model. Two other factors may also contribute to these clinical gains.

- Firstly, the poorer quality of heroin currently available nationally may influence outcome. Poor quality heroin may increase the number of people seeking treatment as they may no longer be able to sustain a comfortable level of consumption through their own means. However, the data does not reflect changes in the drug market. Referral rates into the Community Prescribing Service have stayed relatively stable and have not shown an upward trend during this time. Poor quality heroin may also influence the rate of positive urine testing. However, the quality and limited availability of heroin would not influence the number of clients taking up High as opposed to Low Intensity options where similar rates of prescribing can be secured in each wing of the programme. In fact, unmotivated clients who are seeking out treatment simply because of limited availability of heroin may be more inclined to opt for Low Intensity treatment rather than engage in the more demanding psycho-social support. Furthermore, the high treatment detoxification rate would

equally not relate to the quality and availability of heroin as there is no fixed time schedule for reduction imposed on either Low or High Intensity clients. Reduction and detoxification is free choice within this treatment system. Explaining these treatment gains purely in term of poor quality of heroin therefore feels a poor fit.

- Undoubtedly, the re-commissioning of Community Prescribing service and re-invigoration of Psycho-social outcomes would have had an effect on clinical outcomes. Greater partnership working and more consistent data collection and processes would have an up-lift on outcomes for clients. However, again, these results cannot be attributed to the 'Hawthorne Effect' of a new community prescribing service with improved data collection. The review of Reversed Stepped Care in a second site shows important similarities to these findings. For example, the ratio of Low Intensity to High Intensity caseloads is similar; both have seen an increase in clients engaging in reduction regimes and treatment completions and both have experienced a significant decrease in treatment drop-out. The same service provider operated in the second site both prior and post Reversed Stepped Care implementation and still demonstrated significant benefits from the Reversed Stepped Care approach. So whilst the appointment of a more efficient service provider working in partnership with a restructured services will have an uplift on treatment outcomes, the similarities in treatment outcomes suggest a pattern in treatment response created with the Reversed Stepped Care model.

It must be recognised that the current priorities in treatment policy and provision are 'front-ended.' This is to say that the majority of resources are focused at prescribing to clients. This means that limited provision exists for clients who move through the treatment system into aftercare. As clients exit prescribing in higher numbers, a greater balance of resourcing will be needed post-treatment. Greater throughput in services will require re-allocating resources into aftercare in order to preserve the gains that clients have made in the longer term and ensure clients have the greatest opportunity to move into independent lives beyond treatment. Research suggests that clients who engage in aftercare for 7 months achieve optimal long term outcomes. In conclusion the Reversed Stepped Care model has produced a good range of consistent outcomes that exceed the average to be expected from a drug treatment agency with little evidence of a rebound effect of clients returning to treatment.